



CODE RED

The Fatal Consequences of Dangerously Substandard Medical Care
in Immigration Detention





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A HEARTLAND ALLIANCE PROGRAM



DETENTION
WATCH NETWORK

Code Red

**The Fatal Consequences of Dangerously Substandard Medical
Care in Immigration Detention**

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The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention

Summary	1
Recommendations	4
To the US Congress.....	4
To Immigration and Customs Enforcement (ICE)	4
To State and Local Governments	6
Methodology	7
Background	10
Deaths in Detention	15
Evidence that Substandard Care Contributed to 8 of 15 Deaths, 2015-2017	15
Deaths in 2017 and 2018	39
Deaths in ICE Custody by Fiscal Year	39
Lack of Effective Oversight Leads to Repeated Deadly Failures	45
Unreasonable Delays.....	45
Poor Practitioner and Nursing Care.....	46
Botched Emergency Responses	48
Dangerous Use of Isolation for People with Psychosocial Disabilities	51
Systemic Deficits in Medical Care	54
US and International Legal Standards	58
Right to Reasonable Medical Care and Health	58
Rights of Persons with Psychosocial Disabilities	62
Limits on the Use of Detention for the Control of Immigration	63
Acknowledgments	65
Appendix: Deaths in Immigration Detention March 2010 – May 2018	66

Summary

On the morning that Jose Azurdia died, an officer at the Adelanto Detention Facility in California told a nurse Mr. Azurdia was ill and vomiting. The nurse told him “she did not want to see Azurdia because she did not want to get sick.” This began a series of unconscionable delays in getting Mr. Azurdia care for what turned out to be a fatal heart attack.

Thongchay Saengsiri suffered from the symptoms of congestive heart failure for most of the 15 months he was detained at the LaSalle Detention Facility in Louisiana, including fainting, swelling, anemia, coughing, and shortness of breath. Instead of properly diagnosing and treating these classic symptoms, a nurse recommended he increase his fluid intake, which likely increased his risk of heart failure.

Rafael Barcenas Padilla died from bronchopneumonia after a delay in transferring him to the hospital from the Otero County Processing Center in New Mexico, where nurses recorded his dangerous low oxygen levels over the course of three days that should have prompted immediate hospitalization.

More people died in immigration detention in fiscal year 2017 than any year since 2009, and the most recent detailed information we have about immigration detention deaths shows that they are still linked to dangerously inadequate medical care. This report, a joint effort of four organizations that have long worked to advance the rights of detained immigrants, analyzes publicly-released government investigations known as Detainee Death Reviews of 15 deaths in immigration detention from December 2015 to April 2017, which represent all but one of the deaths reported during that period. At least two independent physicians with expertise in correctional health separately reviewed each file for us and concluded that substandard medical care contributed or led to eight of the 15 deaths, including the deaths of Mr. Azurdia, Mr. Saengsiri, and Mr. Barcenas.

In all but one of the 15 deaths we analyzed for this report, our experts found evidence of subpar and dangerous practices including unreasonable delays, poor practitioner and nursing care, and botched emergency response. In line with cases we have previously documented, one of the 15 cases involved the suicide of a person with a psychosocial disability who was inappropriately placed in isolation.

As we have noted in previous analyses of Detainee Death Reviews, the reviews do not constitute a representative sample of detainee healthcare outcomes but the fact that the same types of healthcare and oversight failures are present in so many of them point to larger, systemic deficits in immigration detention facility health care. The lapses occur in both publicly and privately run facilities, and are not being addressed by existing oversight and monitoring systems. As detailed below, we believe these deficits warrant immediate attention and action by Congress, Immigration and Customs Enforcement (ICE), and state and local governments that have authority over the facilities.

The past 25 years have seen an unrelenting expansion of ICE's network of immigration jails in the United States. In 1994, on any given day approximately 6,800 people were held in immigration custody in civil detention awaiting action on their deportation cases. That number steadily increased over the years, hovering between 28,000 and 34,000 for most of the past decade. After a spike over the past two years beginning under the Obama administration, detention numbers are now at highs previously unimaginable. In fiscal year 2017, ICE held a daily average of nearly 40,500 people. The Trump administration has asked Congress to allocate US\$2.8 billion for Fiscal Year 2019 to lock up a daily average of 52,000 immigrants in immigration detention facilities, a record number representing nearly 30 percent expansion over the previous year.

Despite President Trump's repeated statements painting immigrants as dangerous, the vast majority of the detained population—71 percent as of the first month of fiscal year 2018—were mandatorily detained with no individualized consideration of whether they posed a risk or should be detained. ICE itself classified 51 percent of the detained population in that month, the last for which we have data, as posing “no threat.”

Along with new growth in immigration detention, the Trump administration has requested less money for Department of Homeland Security (DHS) oversight of detention to assure that conditions of confinement are safe, indicating that it plans to abandon basic standards developed over the past decade intended to protect the health, safety, and human rights of those held in immigration detention centers. These proposals would place more human beings than ever before into an abusive and wasteful system that already suffers from substandard medical care.

Since March 2010, ICE has reported a total of 74 deaths in immigration detention, completing and at least partially releasing death reviews in 52 of them (death reviews were either not completed or have not been released in the remaining 22 cases). Medical experts—including the independent physicians who analyzed 33 of the reviews and government-contracted subject matter experts who recorded their conclusions directly in other detainee death reviews—have determined that medical care lapses contributed or led to 23 deaths in 19 different detention facilities since March 2010. However, most of the Detainee Death Reviews we have examined since 2010 include evidence of dangerous and subpar medical care practices.

ICE, the agency with authority over the United States' sprawling system of immigration detention centers, has proven unable or unwilling to provide adequately for the health and safety of those it detains. Oversight and accountability mechanisms have too often failed, and the current administration's proposal to weaken existing standards will further endanger lives. This is the third report in which our organizations have found that significant numbers of the deaths in detention are linked to inadequate medical care in detention.

In light of these consistent findings and the continuing rapid expansion of immigration detention, Congress should immediately act to curtail the abuses by: pressing ICE to decrease rather than expand detention; demanding robust health, safety, and human rights standards for all types of immigration detention facilities; and monitoring and engaging in strong oversight through frequent information requests, hearings, and investigations. States and localities have a role to play as well by declining to contract with detention facilities in their jurisdictions, and creating state and local monitoring programs to expose abuse in detention and provide accountability.

Recommendations

To the US Congress:

1. Immediately reduce the number of people who are needlessly held in immigration detention and ensure accountability for abuses by
 - Reducing annual appropriated funds for immigration detention;
 - Opposing all requests to fund expanded detention capacity, including ICE's requests for additional funds not allocated in appropriations legislation to cover its overspending between budget cycles;
 - Exercising meaningful oversight and withholding funds should ICE fail to abide by reporting deadlines or other obligations.
2. Ensure that the ICE Health Services Corps (IHSC) is the direct health care provider at all immigration detention facilities, including privately-run facilities and Intergovernmental Service Agreements, in order to improve transparency and accountability. Remove IHSC from ICE supervision and provide IHSC with an independent budget to maintain clinical independence and the authority to engage in independent oversight.
3. Appoint an independent medical oversight board with jurisdiction over the quality of medical and mental health care in ICE detention composed of medical doctors and advocates at the national level and require ICE and its contractors to begin implementing local medical oversight boards at individual detention facilities.
4. Require increased transparency regarding the immigration detention system, including eliminating exemptions under the Freedom of Information Act that have been applied to private companies operating detention centers.

To Immigration and Customs Enforcement (ICE):

5. Take immediate steps to reduce detention and utilize alternatives such as community-based supervision programs and parole.
6. Refrain from detaining individuals with serious medical and mental health needs.

7. Ban the use of prolonged or indefinite isolation in immigration detention (whether for administrative or disciplinary reasons) and prohibit without exception the use of isolation for vulnerable populations including those with psychosocial disabilities.
8. Provide reasonable accommodations and respond appropriately to the support needs of detained people with disabilities. Ensure detained people with a disability have adequate access to support and mental health services.
9. Ensure all detention facilities have appropriate clinical staffing plans and publicly disclose whether positions are filled as a compliance component during ICE Enforcement and Removal Operations (ERO) and Office of Detention Oversight (ODO) inspections.
10. Address issues with quality control of practitioner care and with medical staff practicing beyond the scope of their licenses.
11. Reform the monitoring system to task a single fully independent entity with responsibility and authority for reviewing and approving corrective action plans, monitoring compliance with applicable standards, and imposing sanctions for non-compliance, including closure of detention centers.
12. Require that detainee death review investigations include subject matter experts with sufficient expertise to evaluate clinical decisions and conduct a full mortality review focused not solely on technical compliance with standards but the factors contributing to poor care.
13. As required by Congress in the Explanatory Statement accompanying the Fiscal Year 2018 spending bill passed in March 2018, make ERO inspections, ODO inspections, and Detainee Death Reviews (including those conducted by ODO, DHS Office of the Inspector General, and DHS Civil Rights and Civil Liberties) available to the public within 60 days of the inspection or, in the case of death reviews, within 30 days of the death. Provide regular public and congressional reporting on the frequency and circumstances of unanticipated events resulting in death or serious physical or psychological injury to a patient or patients in detention (also known as sentinel events).

To State and Local Governments:

14. Increase state and local oversight capacity, especially over subcontracted local jails, by authorizing monitoring and reporting on immigration detention conditions.
15. Decline to contract with ICE and private prison companies to expand immigration detention capacity.
16. Safeguard the basic rights of people in detention by passing legislation or enacting policy reforms ending prolonged or indefinite isolation, including by banning the use of isolation for vulnerable populations including people with psychosocial disabilities.

Methodology

This report updates our prior analyses of immigration detention deaths from 2010 through 2015. Our focus here is on new records released by ICE on its website in November 2017 and March 2018 summarizing investigations into 15 additional deaths that took place between December 2015 and April 2017. We provided each of these records to at least two independent physicians with expertise in correctional health who separately reviewed the reports and shared their conclusions with us.

The 15 cases we discuss in this report represent all but one of the individuals believed to have died in detention between December 2015 and April 2017. These cases represent a small fraction of the hundreds of thousands of people detained during the period in question, and do not allow us to make general conclusions about the conditions in many of the 200-plus jails and prisons that ICE uses to detain immigrants. However, they raise serious concerns about ICE's ability to detect, appropriately respond to, and correct serious deficiencies in medical care that arise in many of these facilities. They also point to specific facilities that appear to be plagued by repeated problems with care and oversight.

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

The Detainee Death Reviews analyzed in this report were conducted by the ICE Office of Detention Oversight (ODO) and made publicly available by ICE on its website. Our analyses rely upon the facts and conclusions included in the ODO's report from each investigation.

All 15 ICE death reviews were analyzed by Dr. Marc Stern, an expert in correctional health, assistant affiliate professor of Public Health at the University of Washington, former health services director for Washington State's Department of Corrections, and former subject matter expert for investigations conducted by the Department of Homeland Security Office for Civil Rights and Civil Liberties.

Though Dr. Stern previously investigated medical care in ICE facilities for the Department of Homeland Security, his conclusions communicated to Human Rights Watch are not based upon any confidential information obtained through that work and were drawn

exclusively from his review of publicly available ODO death reviews. Human Rights Watch made these documents available to Dr. Stern for review after he discontinued his work with the Department of Homeland Security.

Dr. Palav Babaria analyzed six cases.¹ Dr. Babaria is the chief administrative officer of Ambulatory Services at Alameda Health System in Oakland, California, and assistant clinical professor in Internal Medicine at the University of California, San Francisco. She has over a decade of health-system improvement and global health experience working in urban underserved areas of the United States, South Africa, India, and Haiti. She regularly provides expert opinions on medical records for lawsuits involving medical care in correctional settings. The content expressed by Dr. Babaria is solely her responsibility and does not necessarily represent the official views of her employers or affiliated institutions.

Dr. Robert Cohen reviewed eight cases.² Dr. Cohen worked on Rikers Island as the director of the Montefiore Rikers Island Health Services, served as the vice president for medical operations of the New York City Health and Hospitals Corporation, and as the director of the AIDS Center at St. Vincent's Hospital. He has served as a federal court appointed monitor overseeing medical care for prisoners in Florida, Ohio, New York State, Michigan, and Connecticut. He represents the American Public Health Association on the National Commission for Correctional Health Care. Dr. Cohen received his undergraduate degree from Princeton, his MD from Rush Medical College in Chicago, and trained in Internal Medicine at Cook County Hospital.

A physician in public service with expertise in correctional health reviewed four of the cases.³ This reviewer requested not to be publicly identified.

The Detainee Death Reviews include each person's immigration and criminal history, if any, and a timeline of relevant medical and detention events. The reviews conclude with specific findings as to which detention standards were violated, and note further "areas of concern," but most of the 15 reviews also explicitly state that the findings are included "for

¹ Dr. Babaria analyzed the deaths of Raquel Calderon de Hidalgo, Esmerio Wenceslau Campos, Juan Luis Boch Paniagua, Rafael Barcenás Padilla, Saul Enrique Banegas Guzman, and Jose Manuel Azurdia Hernandez.

² Dr. Cohen analyzed the deaths of Sergio Alonso Lopez, Osmar Epifanio Gonzalez Gadba, Igor Zyazin, Jose Leonard Lemus Rajo, Rafael Barcenás Padilla, Thongchay Saengsiri, Saul Enrique Banegas Guzman, and Jose Manuel Azurdia Hernandez.

³ This doctor analyzed the deaths of Olubunmi Joshua Toyin, Moises Tino Lopez, Santo Carela, and Luis Alonso Fino Martinez.

information purposes only” and that violations “should not be construed as having contributed to the death of the detainee.” ICE released these reviews, without attached exhibits, on its website. These appendices are enumerated in the review and often appear to include selected primary medical records and the report of a government contractor, Creative Corrections, hired to provide subject matter expertise in the medical care review.⁴

In the independent reviews conducted for this report, each physician assessed whether care was adequate considering standard practices in correctional health, as well as the standards applicable to ICE facilities. Under international standards, detained individuals are entitled to the same level of medical care as individuals in the community at large and must be treated with humanity and respect for their inherent human dignity.

We also sent written questions to and requested comments on the report’s findings from private prison company executives and ICE officials. We have reflected the responses of those that responded in the relevant sections of this report. The companies’ full letters are available on the Human Rights Watch website.

⁴ Immigration and Customs Enforcement, FOIA Library, <https://www.ice.gov/foia/library> (accessed June 6, 2018).

Background

This report updates a May 2017 report by Human Rights Watch and Freedom for Immigrants (formerly known as Community Initiatives for Visiting Immigrants in Confinement (CIVIC)) titled “Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention” and a February 2016 report by the National Immigrant Justice Center (NIJC), the American Civil Liberties Union (ACLU), and the Detention Watch Network (DWN) titled “Fatal Neglect: How ICE Inspections Ignore Deaths in Detention.” Both reports analyzed government records known as Detainee Death Reviews (“death reviews”)⁵ relating to deaths in immigration detention from 2012 to 2015 (for the Human Rights Watch and CIVIC report) and from 2010 to 2012 (for the NIJC/DWN/ACLU report).

The 2016 report by NIJC, DWN, and the ACLU analyzed 18 ICE death reviews concerning deaths in immigration detention from January 2010 to May 2012 received by the ACLU through a Freedom of Information Act (FOIA) request.⁶ In eight of the cases, ICE investigators had found in their death reviews that detention centers were noncompliant with ICE detention standards.⁷ In those cases, medical experts contracted by the government concluded that substandard medical care contributed to the deaths. They found four of the deaths to be clearly preventable. NIJC, DWN, and the ACLU also found that ICE facility inspections conducted before and after the deaths failed to acknowledge—or sometimes dismissed—the critical flaws in care identified in the death reviews.

The 2017 report by Human Rights Watch and CIVIC (now Freedom for Immigrants) examined 18 death reviews of people who died in immigration custody from May 2012 to June 2015.⁸ Based on the opinions of two independent medical experts who examined the files,

⁵ These reviews began as a component of 2009 detention reforms adopted by the Obama administration after multiple media and civil society investigations revealing failure to address fatal flaws at detention centers. In the period covered by the NIJC, DWN, and ACLU report, ICE reported 24 deaths in detention but completed and released via a FOIA request only 17 death reviews, failing to complete or release reviews for the remaining seven deaths.

⁶ American Civil Liberties Union, Detention Watch Network, and National Immigrant Justice Center, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 2016, <https://www.aclu.org/report/fatal-neglect-how-ice-ignores-death-detention> (accessed May 5, 2018) [hereinafter *Fatal Neglect*].

⁷ For one of these cases, the report’s discussion is based on a summary of the death review findings included in a facility inspection report for the Adelanto Detention Facility. The actual Detainee Death Review was not released by ICE.

⁸ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, <https://www.hrw.org/report/2017/05/08/systemic-indifference/dangerous-substandard-medical-care-us-immigration-detention#6c7be7> [hereinafter *Systemic Indifference*]. ICE reported that 21 people died during the period covered by *Systemic Indifference* but completed and released only 18 death reviews.

Human Rights Watch concluded that inadequate care contributed to seven of the 18 deaths. Human Rights Watch and Freedom for Immigrants also interviewed more than 90 people who were held in immigration detention, family members, and attorneys, and drew conclusions from expert medical analyses of the medical records of 12 people held in 10 different ICE detention centers in 2015 and 2016.

In both reports, medical experts identified several instances in which patients died after unreasonable delays in the provision of care, poor quality care by facility and medical staff, and botched emergency responses. Both reports concluded that these errors occurred in a system characterized by the absence of independent external monitoring and the failure of internal investigations and monitoring to identify problems or take corrective action after problems were identified, relying on preannounced and cursory visits to detention centers.

The Insufficiency of the Detainee Death Review Process

In many cases Detainee Death Reviews are the only available window into the events leading to the deaths of individuals in ICE custody. Unfortunately, the reviews themselves evidence flawed investigatory practices, including delays, an overriding focus on checklists and standards that fail to evaluate the quality of care, and omission of key information or analysis.

The reviews we analyzed for this report began an average of 38 days after the death under review, with the longest delay being 65 days. Long delays in investigations mean that key witnesses, including both staff and other detained people, have less reliable recollections or are no longer available.

While the quality of the death reviews vary, many are incomplete or cursory. For example, the death review for Mr. Igor Zyazin, who died at Otay Mesa Detention Center (OMDC) in 2016, states that the doctor at OMDC “failed to appreciate the acuity of [Mr. Zyazin’s] symptoms.”⁹ However, in analyzing the death review, an independent medical expert found it “impossible to determine” if this was “the result of failure of

⁹ Immigration and Customs Enforcement, “Detainee Death Review – Igor Zyazin, JICMS 201606226,” <https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf> (accessed May 5, 2018).

the previous facility to provide the information, failure of the patient to report it, failure of the physician to communicate well with the patient or failure of the physician to elicit an adequate history.” Each of these scenarios would point to a different corrective action needed to prevent that same situation in the future. In order for death reviews to serve the purpose of improving medical care, increased specificity is crucial.

The death reviews prioritize discussion of whether the facility has complied with protocols, such as documentation of medical care encounters, while giving short shrift to standard of care issues. For example, ICE’s review of Mr. Rafael Barcenás’ death emphasizes problems with paperwork, rather than the glaring problems with medical care, including nurses’ failure to “consistently document assessment findings on which they based their conclusion” that they did not need to call a doctor. One of the independent medical experts who reviewed the ICE investigation report called it akin to a “military parody novel.” All of the reviews we analyzed in this report appear to lack a care-focused mortality review, a widespread health care practice in which practitioners review the death to find opportunities to improve clinical care processes.

ICE facility inspectors responsible for completing global reviews of its detention centers do not appear to consistently take the information contained in the death reviews into account. In only two of the 23 deaths experts linked to inadequate medical care since 2010 did ICE facility inspectors give the facility anything less than “acceptable” inspection ratings either before or after the death. Indeed, ICE has only rated four facilities out of over 200 nationwide “deficient” or “does not meet standard” in any of its inspections since 2010.¹⁰

The government’s own reports provide additional documentation of deficient medical care in ICE facilities. In 2016, the Department of Homeland Security’s Office of Inspector General (OIG) began making unannounced inspections of ICE and Customs and Border Patrol detention centers.¹¹ In December 2017, the OIG reported that the results of visits to

¹⁰ We calculated this number using the information contained in the ICE ERO Facility List current as of July 10, 2017 (on file with Human Rights Watch).

¹¹ US Department of Homeland Security, Office of Inspector General, “DHS OIG to Periodically Inspect CBP and ICE Detention Facilities,” March 15, 2016, <https://www.oig.dhs.gov/assets/pr/2016/oigpr-031516b.pdf> (accessed January 5, 2017).

five detention centers had raised concerns that the treatment and care of ICE detainees at four facilities undermined “the protection of detainees’ rights, their humane treatment, and the provision of a safe and healthy environment.”¹² The inspections revealed delayed and improperly documented medical care including “instances of detainees with painful conditions, such as infected teeth and a knee injury waiting days for a medical intervention.” While the OIG report documented extensive abuses, its sole recommendation was that ICE field offices review the problems. Given the problems that we and others have documented with ICE’s internal review processes,¹³ this recommendation is insufficient at best.

This report comes as the Trump administration moves to detain a record number of immigrants and significantly decrease standards at the overwhelming majority of detention facilities.¹⁴ The administration’s fiscal year 2019 budget proposal includes a plan to sign contracts with county jails for long-term “non-dedicated” detention space using cursory checklist-style standards to govern conditions of detention.¹⁵ This would be a significant step backward from the current standards that immigration detention facilities are expected to meet.

The administration is also moving to detain more vulnerable people. An ICE directive—issued on December 14, 2017, and made public on March 29, 2018—eliminates the presumption that ICE should not detain pregnant individuals except in extraordinary circumstances and removes critical reporting requirements regarding the treatment of pregnant individuals.¹⁶ In early April, President Trump signed a memo ordering an end to the practice of allowing children and families to be released from detention while a judge

¹² Department of Homeland Security, Office of Inspector General, “Concerns about ICE Detainee Treatment and Care at Detention Facilities,” December 11, 2017, <https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf> (accessed May 5, 2018).

¹³ See ACLU, “Fatal Neglect,” and Human Rights Watch, *Systemic Indifference*; see also National Immigrant Justice Center, “Lives in Peril: How Ineffective Inspections Make ICE Complicit in Detention Center Abuse,” October 2015, <http://immigrantjustice.org/research-items/report-lives-peril-how-ineffective-inspections-make-ice-licit-detention-center> (access May 5, 2018).

¹⁴ Department of Homeland Security, Congressional Budget Justification FY 19, US Immigration and Customs Enforcement, <https://www.dhs.gov/sites/default/files/publications/U.S.%20Immigration%20and%20Customs%20Enforcement.pdf> (access May 5, 2018) [hereinafter “ICE Budget Request”].

¹⁵ “ICE Budget Request,” Operations and Support p. 118.

¹⁶ Immigration and Customs Enforcement, “Directive: Identification and Monitoring of Pregnant Detainees,” December 14, 2017, <https://www.ice.gov/directive-identification-and-monitoring-pregnant-detainees> (accessed May 5, 2018).

decides if they qualify for asylum.¹⁷ On the same day, Attorney General Sessions issued a “zero-tolerance” policy directing federal prosecutors along the southern border to prosecute all people crossing the border.¹⁸ In late May, a DHS official testified to Congress that 658 children had been separately detained from their parents at the border from May 6 to May 19, in pursuance of this policy.¹⁹

ICE detention operations are also notoriously lacking in transparency. Recent steps by the agency to request the destruction of records related to serious issues in detention including sexual assault, solitary confinement, and deaths are further evidence of unwillingness to be exposed to public scrutiny or held accountable.²⁰ Many of the documents that ICE is seeking to destroy have been used in reports documenting the conditions of immigration detention, including the kind of records used in our analysis for this report. The National Archives and Records Administration is currently considering the request.²¹

¹⁷ Presidential Memorandum for the Secretary of State, the Secretary of Defense, the Attorney General, the Secretary of Health and Human Services, and the Secretary of Homeland Security, April 6, 2016, <https://www.whitehouse.gov/presidential-actions/presidential-memorandum-secretary-state-secretary-defense-attorney-general-secretary-health-human-services-secretary-homeland-security/>.

¹⁸ Office of the Attorney General, Memorandum for Federal Prosecutors Along the Southwest Border, Zero Tolerance for Offenses under 8 U.S.C. § 1325(a), April 6, 2018, <https://www.justice.gov/opa/press-release/file/1049751/download> (accessed June 6, 2018).

¹⁹ Testimony of the Honorable Richard Hudson, Deputy Chief of the Operations Program, Law Enforcement Operations Directorate, United States Customs and Border Protection before the Senate Committee on the Judiciary, May 23, 2018.

²⁰ American Civil Liberties Union, Victoria Lopez, “ICE Plans to Start Destroying Records of Immigrant Abuse, Including Sexual Assault and Deaths in Custody,” August 28, 2017, <https://www.aclu.org/blog/immigrants-rights/ice-and-border-patrol-abuses/ice-plans-start-destroying-records-immigrant> (accessed May 5, 2018).

²¹ John Washington, “ICE Wants to Destroy Its Records of In-Custody Deaths, Sexual Assault, and Other Detainee Files,” *The Nation*, September 13, 2017, <https://www.thenation.com/article/ice-wants-to-destroy-its-records-of-in-custody-deaths-sexual-assault-and-other-detainee-files/> (accessed May 5, 2018).

Deaths in Detention

Evidence that Substandard Care Contributed to 8 of 15 Deaths, 2015-2017

The independent medical experts who agreed to review cases for this report analyzed the 15 ICE Detainee Death Reviews posted by ICE on its website, addressing all but one of the deaths in detention believed to have taken place from December 2015 through April 2017.²² They found evidence of substandard care in nearly all of the cases, and concluded that medical lapses likely led or contributed to eight of the deaths.

1. Jose Manuel Azurdia Hernandez: Acute symptoms of a heart attack ignored by a nurse who “did not want to get sick”

Jose Manuel Azurdia Hernandez was 54 years old when he died in detention at the Adelanto Detention Facility operated by the GEO Group in San Bernardino, California, on December 23, 2015. Mr. Azurdia spent six months detained at Adelanto prior to his death.

On the morning of December 19 around 9 a.m. another person detained in the same housing unit at Adelanto informed an officer that Mr. Azurdia was sick and wanted to see a medical caregiver. The officer told ICE investigators he went to Mr. Azurdia’s cell and that he appeared to be normal but that he later heard vomiting. He told investigators that he did not return to check on Mr. Azurdia when he heard vomiting.

At 9:30 a.m. a licensed vocational nurse (LVN) entered Mr. Azurdia’s unit to distribute medication. The officer told the nurse that Mr. Azurdia was sick and vomiting. According to the officer, the nurse responded “by saying she did not want to see Azurdia because she did not want to get sick.”²³ This began a series of delays in Mr. Azurdia receiving attention for what turned out to be a fatal heart attack.

A second officer told investigators that at some time between 9:30 a.m. and 10:14 a.m. she told another officer to call the medical unit about Mr. Azurdia but that she did not go to check on his welfare. There was no answer, according to the officer who called, and neither

²² ICE did not release a death review for Roger Rayson, a Jamaican citizen who passed away while detained at the Jena, Louisiana LaSalle Detention Center in March 2017.

²³ Immigration and Customs Enforcement, “Detainee Death Review – Jose Manuel Azurdia Hernandez, JICMS 201602241,” <https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.pdf> (accessed May 5, 2018). This nurse was later put on administrative leave, according to the review.

followed up. Government investigators reviewed surveillance footage of the unit that showed Mr. Azurdia being helped to the guard desk by another detained person at 10:14 a.m. He is seen speaking to the officer and pointing to his chest area.

During this time, one of the guard posts in Mr. Azurdia's unit was left unattended and officers had difficulty reaching the medical unit to alert them about Mr. Azurdia's condition. One officer told government investigators that she did not call a "Code Blue" or medical emergency because she thought the individual needed to be unconscious or severely injured before a Code Blue could be called.

At 10:29 a.m. surveillance footage shows Mr. Azurdia leaving the unit in a wheelchair. Officers told government investigators that Mr. Azurdia had thrown up several times, his left arm was numb, he was having trouble breathing, and he had pain in his shoulder and neck. One described Mr. Azurdia's speech as slurred.

At the medical unit, a registered nurse gave Mr. Azurdia oxygen and asked the doctor to evaluate him. It took nine minutes for the doctor to see Mr. Azurdia. Fourteen minutes after Mr. Azurdia's arrival in the unit the doctor told facility staff to call 911. It took nine more minutes for the ambulance to arrive at the gate of the facility. Because no officer was in position to let the ambulance in, a further two-minute delay accrued. Mr. Azurdia arrived at the hospital at 11:32 a.m., two hours after others in the housing unit first tried to alert facility staff to his condition. By that point, Mr. Azurdia's heart was too damaged to benefit from procedures aimed at increasing the capacity of his heart. He was given supportive care until his death in the late evening of December 23.

Expert comments: Three expert physicians reviewing this case agreed that the death was likely preventable. They all noted that valuable time was lost at multiple points in getting Mr. Azurdia the care he needed, the most egregious of which was a nurse simply ignoring the patient when she was told he was ill. The experts also raised concerns about the delays in care due to confusion about when to call a medical emergency and staff missing from a key post. "This was an egregious nursing decision," said Dr. Cohen, speaking of the LVN refusal to see Mr. Azurdia when she learned he was ill during medication distribution.

“The whole point of the emergency treatment of chest pain is to get someone care immediately. He was critically ill and they needed to get him care.”²⁴

“During a heart attack, every minute counts,” Dr. Stern said. “A common phrase amongst cardiologists during medical emergencies involving heart complications is ‘Time is Muscle.’ Every minute is vital to preventing the loss of life, and thus delays by medical and detention staff likely turned a survivable event into a fatal one.”²⁵

“Time is absolutely critical,” said Dr. Babaria. “If they could have stented him [or inserted a device to increase blood flow through his heart] when he had symptoms he could have been saved.”²⁶

A spokesperson for the GEO Group told Human Rights Watch the company was “unable to comment on specific medical cases/files and would refer you to U.S. Immigration and Customs Enforcement.”²⁷ ICE did not respond to repeated and detailed requests for comment.

2. Thongchay Saengsiri: Mismanaged and misdiagnosed congestive heart failure and an acute crisis ignored

Thongchay Saengsiri, age 65, had been detained at the GEO Group’s LaSalle Detention Facility in Louisiana for 15 months prior to his death in March 2016. On May 18, 2015, he visited the medical facility because of pain in his legs, which were swollen. He complained of shortness of breath at night and when he exercised, and of having an occasional non-productive cough. Swelling, shortness of breath, and cough are all textbook symptoms of congestive heart failure. His examining nurse practitioner was concerned about this possibility but did not investigate further or send him to a hospital, instead prescribing a diuretic. He was not seen for any follow-up, meaning that despite the nurse practitioner’s suspicions, his symptoms of new onset heart failure went essentially ignored.²⁸

²⁴ Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018.

²⁵ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

²⁶ Email and telephone correspondence from Dr. Palav Babaria to Human Rights Watch, February 27, 2018.

²⁷ Email from Pablo Paez to Human Rights Watch, May 10, 2018.

²⁸ Immigration and Customs Enforcement, “Detainee Death Review – Thongchay Saengsiri JICMS #201604767,” pp. 5-6, <https://www.ice.gov/doclib/foia/reports/ddr-Saengsiri.pdf>.

Over the next 10 months, Mr. Saengsiri continued to exhibit signs of worsening health, which were largely ignored by medical staff. In August, a nurse recommended he increase his fluid intake after a low blood pressure reading. In November, he was diagnosed with anemia. Later that month, he had lightheadedness severe enough to cause a fall. In January 2016, an EKG scan showed possible inferior wall myocardial infarction and other rhythm abnormalities.²⁹

In February 2016, he visited a nurse practitioner with a cough, shortness of breath, wheezing, and a dangerously high respiratory rate of 24 breaths per minute. The nurse practitioner planned to send him to the hospital, but told investigators that Mr. Saengsiri refused, saying he felt better. The nurse practitioner did not have him sign a refusal form, nor did she refer him to a doctor. The day before his death, Mr. Saengsiri again reported having difficulty breathing. After an inhaler treatment, he was allowed to return to his dorm.³⁰

On March 17, 2016, Mr. Saengsiri again reported coughing, shortness of breath, wheezing, and difficulty breathing. The nurses and nurse practitioners attending him nevertheless treated the wheezing as if it were asthma and evaluated him as fit enough for van transport to the hospital. He was handcuffed, leg-cuffed, and belly-chained to a chair for nearly half an hour while his paperwork was found and processed. It wasn't until he had what an officer called a panic attack, where he was hunched over and unable to breathe, that 911 was called — over two hours after he first exhibited symptoms. Mr. Saengsiri went into cardiac arrest in the ambulance on his way to the hospital, and was pronounced dead soon after arriving.³¹

Expert Comments: The two physicians reviewing Mr. Saengsiri's Detainee Death Review found that his death likely could have been prevented with appropriate care both in terms of managing his symptoms over the duration of his detention and the emergency care on the day of his death. "Mr. Saengsiri demonstrated very clear symptoms of new onset of congestive heart failure" from the early days of his detention, Dr. Stern said. He required "aggressive cardiac management, most likely including admission to the hospital, or at least active expert management on an outpatient basis. This was not done." Despite

²⁹ Ibid., pp. 7-11.

³⁰ Ibid., p. 11.

³¹ Ibid., pp. 12-17.

“continuing and obvious” symptoms and signs of congestive heart failure, “medical staff continued to alternately miss the diagnosis and grossly mismanage it.”³²

His low blood pressure was a reflection of his heart failure, and the nurse’s recommendation of increasing his fluid intake “had a high risk of making his heart failure worse,” Dr. Stern said. New onset anemia in a 65-year-old man is unusual, and “should have set off alarm bells.” The anemia “may have been the trigger that brought out the heart failure.” No action was taken after his fall from lightheadedness or abnormal EKG readings. “The nurse practitioner clearly needed help in the management of Mr. Saengsiri’s low blood pressure in the presence of heart failure and anemia,” Dr. Cohen said. But Mr. Saengsiri was never referred to a physician who could have appropriately assessed his symptoms.³³

On the day of Mr. Saengsiri’s death, both experts agreed that a two-hour delay in appropriate emergency response could have been definitive. “He was in an acute emergency situation and it took them two-and-a-half hours to get him to the hospital when he was in trouble,” Dr. Cohen said.³⁴

A spokesperson for the GEO Group told Human Rights Watch the company was “unable to comment on specific medical cases/files and would refer you to U.S. Immigration and Customs Enforcement.”³⁵ ICE did not respond to repeated and detailed requests for comment.

3. Rafael Barcenas-Padilla: Three-day delay in transfer to a hospital despite dangerously low oxygen

Rafael Barcenas-Padilla, 51, died from bronchopneumonia in April 2016.³⁶ He had been detained for a month and a half at the Otero County Processing Center (OCPC) in New Mexico, operated by the Management and Training Corporation (MTC).³⁷

³² Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

³³ Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018.

³⁴ Ibid.

³⁵ Email from Pablo Paez to Human Rights Watch, May 10, 2018.

³⁶ US Department of Homeland Security, Immigration and Customs Enforcement, “Detainee Death Review – Rafael Barcenas Padilla JICMS #201605426” <https://www.ice.gov/doclib/foia/reports/ddr-Barcenas.pdf> (accessed May 5, 2018).

³⁷ Ibid.

Mr. Barcenas was apprehended by the Border Patrol and sent to OCPC on March 2, 2016. He requested a medical visit on March 7, and was seen on March 8th for fever, runny nose, sore throat, sneezing, and flu. The examining nurse noted that he had a long history of smoking and a slightly high temperature, prescribed Tylenol and an antihistamine and told him to come back if his condition worsened.³⁸

On March 13, Mr. Barcenas submitted a written request in Spanish to see a doctor, stating that six days had passed and that his symptoms had not improved. A nurse who spoke only “minimal” Spanish attempted to read the request without translation in the morning and determined he did not need to be seen.³⁹

Around 8 p.m. a nurse distributing medication in Mr. Barcenas’ unit told the registered nurse on duty that Mr. Barcenas “looked ill and appeared to have a fever.” On this basis, Mr. Barcenas was taken to the medical unit where the registered nurse documented that he had a fever of 104 degrees, a high pulse, and diminished oxygen saturation, or amount of oxygen in his blood. The review does not state whether the nurse recorded exactly how diminished at that time. This nurse called a physician who, the review says, issued orders for medications to treat fever related to an upper respiratory infection of bacterial origin. Mr. Barcenas did not receive a key medication, Albuterol, because the facility did not have the required nebulizer to administer it. MTC’s policy at the time was to reorder medical supplies every two months, regardless of when the existing supply was depleted. The nurse requested the missing equipment, and the MTC Health Services Administrator told her he would find supplies the next morning, but did not.⁴⁰

Over the next three days, Mr. Barcenas continued to be held in the medical housing unit at the OCPC.⁴¹ His oxygen saturation remained dangerously low, hovering between 80 and 90 percent despite being supplied with oxygen.⁴² On the 14th and the 15th, Mr. Barcenas requested to see a doctor, according to the nurse’s notes, but was not seen. On the evening of the 16th, Mr. Barcenas was seen by a doctor who decided, after recording an oxygen saturation level of 78 percent, to send Mr. Barcenas to the hospital. Instead of

³⁸ Ibid., pp. 2-3.

³⁹ Ibid., p. 4.

⁴⁰ Ibid.

⁴¹ Ibid., p. 5.

⁴² Ibid., pp. 5-8.

being sent by ambulance, Mr. Barcenas waited for two hours to be transferred by correctional van. He was hospitalized and ultimately diagnosed with Acute Respiratory Distress Syndrome. His condition declined until he died on April 7, 2016.

Expert Comments: Three independent medical experts who reviewed ICE’s Detainee Death Review about Mr. Barcenas found fundamental errors in his medical treatment and concluded that proper care may well have saved his life.

“He had a serious infection,” but beginning intensive treatment earlier “could have had [a] major impact on outcome,” said Dr. Stern.⁴³ All three experts agreed that the oxygen levels recorded in the facility between March 14 and March 16 were dangerously low and should have prompted immediate evacuation to a hospital. “Normal oxygen saturation levels for healthy individuals are usually 98-100 percent,” said Dr. Babaria. “Levels are almost always maintained at greater than 88 percent even in sick patients with chronic illness, with oxygen if needed.”⁴⁴

“With an oxygenation of 80 percent it was ridiculous not to send him to the hospital,” Dr. Cohen said. “You have to get an X-ray and see what’s going on. He had to go to the hospital at that point.”⁴⁵

All of the reviewers also raised concerns that someone with a 78 percent oxygen level was not sent to the hospital in an ambulance, instead of a van.

“The failure of the medical staff to appreciate how sick he was and arrange for his immediate evacuation to a hospital added a three-day delay to his receiving appropriate medical care,” said Dr. Stern. “Such care may well have saved his life.”⁴⁶

The Management and Training Corporation told Human Rights Watch, “MTC is committed to providing prompt, quality medical care to those we serve. Our clients have access to 24-hour medical services provided by doctors, nurses, and other medical professionals.” In the case of Mr. Barcenas, an MTC spokesperson said, “our medical team immediately attended to this individual’s needs and placed him on 24-hour observation. When his

⁴³ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

⁴⁴ Email and telephone correspondence from Dr. Palav Babaria to Human Rights Watch, February 27, 2018.

⁴⁵ Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018.

⁴⁶ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

condition did not improve, he was transferred to a local hospital where he was treated for three weeks prior to his passing.”⁴⁷

When asked to respond directly to the assertion that Mr. Barcenas’ low oxygen levels should have prompted evacuation to a hospital, the spokesperson added that Mr. Barcenas “was closely monitored during his stay at the prison’s medical facility and was provided with treatments to improve his condition. An independent audit of this case by Immigration and Customs Enforcement did not indicate a delay in care, failure to act, or an unacceptable standard of care. The patient was seen approximately 150 times during his 14-day tenure at the prison and was transferred to the hospital when medical professionals deemed additional medical treatment, outside of the prison’s capabilities, was needed.”

ICE did not respond to repeated and detailed requests for comment.

4. José Leonardo Lemus Rajo: Complications of initially untreated alcohol withdrawal

José Leonardo Lemus Rajo, 23, died from the complications of alcohol withdrawal soon after being detained at the Krome North Service Processing Center in Miami, Florida. Mr. Lemus arrived at the facility on April 25, 2016 around 5:30 p.m. and his medical screening was completed around 6 p.m.⁴⁸

During his medical screening, Mr. Lemus told a registered nurse that he had an “alcohol problem” and that he consumed “17 beers and hard liquor every day for the past year.” He had most recently had alcohol that morning. According to the medical record, he told the nurse that he was experiencing tremors during the screening, but the nurse also documented that he “did not observe tremors, agitation, excessive sweating, bizarre or unusual behavior, or disorientation during the encounter.” ICE investigators noted that Lemus checked “yes” on the intake form in response to the question on whether he was experiencing withdrawal and that his handwritten signature on the consent form appears shaky.⁴⁹ The RN called a facility doctor about Mr. Lemus’ intake around 7 p.m., who recommended that Mr. Lemus be placed in the medical observation unit and ordered that

⁴⁷ Email from Issa Arnita, director of Corporate Communications at the Management and Training Corporation, to Human Rights Watch, May 15, 2018

⁴⁸ US Department of Homeland Security, Immigration and Customs Enforcement, “Detainee Death Review – José Leonardo Lemus Rajo, JICMS 201606268,” <https://www.ice.gov/doclib/foia/reports/ddr-Lemus.pdf> (accessed May 5, 2018).

⁴⁹ *Ibid.*, p. 8.

he be given a number of vitamins used to prevent additional complications of alcohol abuse and the anti-anxiety drug Ativan, which helps to wean the brain off the depressant effects of constant exposure to alcohol.

During the next five hours, Mr. Lemus was kept in a holding cell and given neither the vitamins nor the Ativan. A doctor told ICE investigators that these vitamins and medications are “on occasion” not available in the night cabinet and must be obtained from the facility pharmacy the following day. Creative Corrections, the contractor that completed a medical and security compliance analysis for ICE investigators, noted “that ensuring timely supplementation of vitamins to counteract the effects of malnutrition common in alcoholism can help prevent severe withdrawal symptoms.”⁵⁰

Mr. Lemus’ symptoms of withdrawal, according to ICE investigators, “progressed rapidly.” At nearly midnight, six hours after his arrival and intake, he was moved to the medical unit where a nurse applied for the first time since his arrival the standard Clinical Institute for Alcohol Withdrawal Assessment (CIWA), an assessment tool used to measure the severity of alcohol withdrawal, and documented that Mr. Lemus was experiencing “severe tremors, moderate agitation, moderate anxiety, and moderately severe hallucinations.” ICE notes that National Commission on Correctional Health Care standards say that this assessment should be given to everyone who screens positive for possible alcohol withdrawal at intake and then be repeated at a minimum every four hours thereafter.

Based on this CIWA, Mr. Lemus was sent to the hospital via facility van at around 1 a.m. Had the facility doctor known the extent of his symptoms at that point, she told investigators, she would have ordered him to be taken in an ambulance. However, the facility nurse failed to consult with the physician. Detention officers contracted through Akima Global Services (AGS) accompanied Mr. Lemus to the hospital and kept him shackled in his bed “with one leg cuff around his ankle and the adjoining cuff secured to the bed rail throughout the day.” Over the next several days, Mr. Lemus became increasingly agitated and angry, and at around 1 p.m. on April 28 officers also cuffed his hand to the top of the bed. The officers told ICE investigators that these restraints “caused significant abrasions and bleeding to his wrists and ankles from pulling hard.” The records from Kendall Regional Medical Center (KRMC) where Mr. Lemus was being treated are

⁵⁰ Ibid.

incomplete, but our medical experts raised serious concerns that KRMC staff treated Mr. Lemus with infrequent and inadequate doses of vital medications and potentially inappropriate doses of benzodiazepene drugs required to treat delirium tremens, a potentially fatal manifestation of alcohol withdrawal.

Around 6 p.m. on April 28, the ICE investigation states, a new AGS officer assumed watch of Mr. Lemus. He told ICE investigators that when he entered the room Mr. Lemus was “extremely agitated, screaming, pulling at his restraints, ‘foaming at the mouth,’ and appeared to be hallucinating.” Both of Mr. Lemus’ wrists were shackled to the bed as well as his right ankle. The officer asked a nurse if the hospital could give him something to calm him down and hospital records show he was given an antipsychotic and anti-anxiety medication at 6:11 p.m. At 6:25 p.m. he stopped breathing and at 7:25 p.m. he was pronounced dead.

Expert comments: Two independent medical experts who reviewed the ICE investigation report said it raised serious unresolved concerns about the quality of care given to Mr. Lemus at the hospital, and both agreed that prompt treatment at the Krome North Service Processing Center might have prevented his death.

“Alcohol withdrawal is a really serious problem,” said Dr. Cohen. “They had hours and hours to treat him. He was not treated until he got to the hospital. Delaying treatment for over seven hours with someone with serious alcohol withdrawal is a problem.”⁵¹

“Mr. Lemus reported very heavy alcohol use which—very predictably—led to alcohol withdrawal. The failure of the facility to administer medications to him promptly was significant,” said Dr. Stern.⁵²

Both doctors also questioned the use of restraints in the hospital despite their causing significant injury. “I would imagine that the shackling made him more agitated,” said Dr. Cohen.⁵³ Dr. Stern noted medical restraints designed to minimize injury can sometimes be necessary.⁵⁴ However, the use of extra and damaging restraints here was driven by

⁵¹ Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018.

⁵² Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

⁵³ Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018.

⁵⁴ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

inadequate medical treatment, according to Dr. Stern. “In properly treated alcohol withdrawal, there should have been little, if any, need for restraining the patient.”⁵⁵

ICE did not respond to repeated and detailed requests for comment.

5. Igor Zyazin: A cardiac emergency ignored

Igor Zyazin, 46, died in ICE custody at CoreCivic’s Otay Mesa Detention Center (OMDC) in San Diego, California, on May 1, 2016.⁵⁶ Prior to being transferred to OMD, he was held at a short-term detention facility, the Emerald Correctional Management San Luis Regional Detention Center (SLRDC) in San Luis, Arizona from April 24 to 29, 2016 while he awaited transfer to a long-term facility.⁵⁷ Originally from Russia, Mr. Zyazin was taken into custody after he appeared before US Customs and Border Protection Officers at the Port of Entry at San Ysidro, California, and said that he was seeking asylum.⁵⁸

While detained at SLRDC, Mr. Zyazin informed a nurse practitioner that he took heart medications and had a pre-existing heart condition.⁵⁹ He attempted to explain to the facility’s nurse that he had medical records from Russia in the contents of his backpack including electrocardiograms (EKGs), but security personnel never inventoried the backpack or its contents.⁶⁰

On April 29, Zyazin asked an officer to be seen by medical staff because he felt unwell, was dizzy, and had pain in his chest.⁶¹ Instead of immediately calling for emergency medical assistance, the officer asked him to pack his belongings and escorted him to the medical unit.⁶² Once Mr. Zyazin arrived at the medical unit, the registered nurse there administered two doses of nitroglycerin, a treatment for chest pain caused by coronary artery disease. Mr. Zyazin advised the nurse that he had a significant medical history of heart disease and was being treated with medications for this condition.⁶³

⁵⁵ Email correspondence from Dr. Marc Stern to Human Rights Watch, May 26, 2018.

⁵⁶ Immigration and Customs Enforcement, “Detainee Death Review – Igor Zyazin, JICMS 201606226,” <https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf> (accessed May 5, 2018).

⁵⁷ *Ibid.*

⁵⁸ *Ibid.*, p. 2.

⁵⁹ *Ibid.*, p. 6.

⁶⁰ *Ibid.*, pp. 4-6.

⁶¹ *Ibid.*, p. 7.

⁶² *Ibid.*

⁶³ *Ibid.*, pp. 7-8.

Later that day, Mr. Zyazin was transferred to the medical housing unit for continued monitoring. Instead of sending him to a hospital emergency room for his chest pain and dizziness, an ICE deportation officer at SLRDC decided to transfer him to OMDC, three to four hours away, “to ensure proper care of his cardiac issues.”⁶⁴ The ICE Detainee Death Review notes that Mr. Zyazin complained of chest pains twice before his transfer to OMDC. Persistent chest pain, reported use of heart medication, and Mr. Zyazin’s communication that he had medical records in his belongings documenting his heart problems should have triggered emergency evaluation. However, the nurse completed a medical transfer summary, noting he was diagnosed with cardiomyopathy, a heart disease that can lead to heart failure, and was provided nitroglycerin.⁶⁵ He was transported the same day, leaving SLRDC at 11:17 a.m. for OMDC.⁶⁶

Upon arrival at OMDC at 3:25 p.m., when asked by a nurse how he felt, he held his chest and again reported that his chest hurt, but no follow-up occurred. On April 30, he was examined by a doctor who noted that he’d had a heart attack in 2015, but did not understand that he had had an event that may have been a heart attack a mere 24 hours earlier.⁶⁷ The doctor ordered an EKG for Mr. Zyazin, and scheduled another appointment for him in three weeks.⁶⁸ Mr. Zyazin had the EKG performed the next morning, which was later interpreted as “unremarkable” given his history.⁶⁹ That evening another detained person found him unresponsive, and attempts to resuscitate him failed.⁷⁰ He died at OMDC.⁷¹

Expert Comments: Two medical experts who reviewed Mr. Zyazin’s case found that his death was likely preventable. On April 29, the SLRDC nurse’s management of Mr. Zyazin at each step was severely deficient and dangerous, the experts agreed.⁷² Having Mr. Zyazin pack his belongings and walk to the medical unit was “a dangerous instruction” because

⁶⁴ Ibid.

⁶⁵ Ibid.

⁶⁶ Ibid.

⁶⁷ Ibid., p. 14.

⁶⁸ Ibid., p. 15.

⁶⁹ Ibid.

⁷⁰ Ibid., pp. 16-17.

⁷¹ Ibid., p. 19.

⁷² Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018; Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

“he might have needed care on the spot.”⁷³ Administering nitroglycerin without a doctor’s order, and not informing a doctor or calling 911 was dangerous. “For the nurse to have managed acute chest pain requiring nitroglycerin by herself was a major breach of her scope of license and one which requires reporting to the state board,” Dr. Stern said.⁷⁴ Further, “by filling out the transfer note, the nurse was stating that the patient was stable for transfer to another ICE facility, which he was not.” Assuming that the ODO’s death review was complete, “[Mr. Zyazin] was having a serious acute event at this point—very likely a heart attack—and sending him to the hospital for appropriate care likely would have saved his life.”⁷⁵ The ICE contractor Creative Corrections noted that SLRDC does not have a supervising physician who can be called on to consult with nurses or other practitioners.⁷⁶

“Persistent chest pain in a patient with known cardiomyopathy with abnormal vital signs should be treated as a medical emergency,” Dr. Cohen said.⁷⁷ The symptoms and signs recorded by medical staff at SLRDC in the presence of an extremely abnormal cardiac history “required emergency room evaluation, diagnostic tests, and treatment, which were not provided.”⁷⁸ An emergency room, Dr. Cohen noted, could have performed a diagnostic evaluation and intervention which could have prevented the terminal event.⁷⁹

CoreCivic told Human Rights Watch that the company “adheres strictly to ICE’s Performance-Based National Detention Standards (PBNDs), and there are onsite ICE contract monitors at all of our detention facilities who have unfettered daily access to our operations and the detainees housed at these facilities.”⁸⁰ Emerald Correctional Management and ICE did not respond to requests for comment.

Gerardo Cruz-Sanchez

⁷³ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

⁷⁴ Ibid.

⁷⁵ Ibid.

⁷⁶ Immigration and Customs Enforcement, “Detainee Death Review – Igor Zyazin, JICMS 201606226,” <https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf> (accessed May 5, 2018).

⁷⁷ Email and telephone correspondence from Dr. Robert Cohen to Human Rights Watch, March 30, 2018.

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ Letter from Steve Owen, Managing Director of Communications, CoreCivic, May 21, 2018 (on file with Human Rights Watch).

Two-and-a-half months before Mr. Zyazin’s death, another person detained at OMDC became critically ill and died. Gerardo Cruz-Sanchez was a migrant who had recently crossed the border and was being held in the ICE detention facility as a material witness for the US Marshal Service. According to a wrongful death suit filed by Mr. Cruz-Sanchez’s family, his cellmate told his cellmate’s wife that Mr. Cruz-Sanchez had not been getting medical care, could not eat for at least a week, and vomited anything he did eat. Another detainee said that despite detainees in his unit begging the officers to help Mr. Cruz-Sanchez, they did nothing, saying that they only take detainees to the hospital when they are dying. According to the family’s complaint, an officer screamed at Mr. Cruz-Sanchez, angry that he stained a table when he spat up blood in the cafeteria. It was not until later, when an officer happened upon him after he had coughed up so much blood that his bedsheets were soaked, that he was taken to a hospital.⁸¹

CoreCivic told Human Rights Watch that “these allegations are a matter of active litigation and as such have not been established as fact by the court.” A company spokesperson also noted that ICE’s Health Service Corps (IHSC) is “solely responsible for providing, contracting, staffing and oversight of any medical or mental health services at Otay Mesa.” CoreCivic staff, the company said, “are trained to refer all detainee health or medical concerns, whether routine or acute, to facility medical staff.”⁸²

6. Moises Tino Lopez: Anoxic brain injury after failure to respond to previous seizures

Moises Tino Lopez, a 23-year-old from Guatemala, died after a seizure while in ICE custody at the Hall County Department of Corrections (HCDC) in Grand Island, Nebraska, on September 27, 2016.⁸³ Mr. Tino had been arrested by ICE a month earlier as he

⁸¹ *Cruz-Sanchez v. CCA*, United States District Court, Southern District of California, Case 3:17-cv-00569-AJB-NLS, April 30, 2018, Transcript of 12 audio filed from CCA between Chavez and his wife, Maribel.

⁸² Letter from Steve Owen, Managing Director of Communications, CoreCivic, May 21, 2018 (on file with Human Rights Watch).

⁸³ Immigration and Customs Enforcement, “Detainee Death Review of Moises Tino Lopez, JICMS Number 201404156,” <https://www.ice.gov/doclib/foia/reports/ddr-Tino.pdf> (accessed January 23, 2018).

accompanied his wife to a routine appointment to update her address with the ICE office in St. Paul, Minnesota.⁸⁴

ICE inspectors, who interviewed jail and hospital staff, found that Mr. Tino, whose first language was K'iche, spoke no English and limited Spanish. But the Hall County Jail did not even use qualified Spanish interpreters. Instead they relied on another Guatemalan person detained in the facility and even Google Translate to communicate about sensitive medical issues.⁸⁵ Dr. Stern called this practice “in violation of ICE detention standards, HIPAA [the medical privacy law]” and “just wrong.”⁸⁶

Language barriers were especially pertinent when Mr. Tino refused critical seizure medication he believed was causing him headaches without apparently being informed of the risks and consequences of doing so.

On September 6, an officer on duty in Mr. Tino's unit noticed that he appeared to be having a seizure. Instead of moving him to the medical unit, officers picked up Mr. Tino's mattress with him on it, moved it to a lower bunk, and placed an extra mattress on the floor next to that bunk as he lay unresponsive.

On September 15, a licensed practical nurse (LPN) recorded that Mr. Tino said the seizure medication he was taking was causing headaches, and he was prescribed a different medication. Later that day, Mr. Tino told an officer that another person in the housing unit pushed him as he was entering the shower, threw his personal items on the floor and told him to leave the area. Although the alleged aggressor did not claim that Mr. Tino had laid hands on him, Mr. Tino was charged with assault and obstruction of correction operations and placed in isolation. Facility staff told ICE investigators that it is standard practice to charge everyone involved in a physical altercation with potential disciplinary infractions and place them in isolation. ICE investigators noted “concern” that this practice “may deter reporting of assaultive incidents of all types, including sexual.”⁸⁷

⁸⁴ Ibid., p. 1.

⁸⁵ Ibid.

⁸⁶ Robin Urevich, “Deadly Detention: the Lonely Death of Moises Tino Lopez,” *Capital and Maine*, December 20, 2017, <https://capitalandmaine.com/deadly-detention-the-lonely-death-of-moises-tino-lopez-1220> (accessed June 7, 2018).

⁸⁷ Immigration and Customs Enforcement, “Detainee Death Review of Moises Tino Lopez, JICMS Number 201404156,” <https://www.ice.gov/doclib/foia/reports/ddr-Tino.pdf> (accessed January 23, 2018), p. 18.

Starting the next day, while Mr. Tino was still in isolation, he refused his prescribed seizure medication. No one documented the reason for his refusal and there is no evidence that a qualified practitioner had a conversation with him to be sure he understood the reason he was being given the medication and the risks he undertook by refusing it. On September 19, around noon, he suffered a second seizure, this time in his isolation cell. Officers found him “lying on his bunk, rigid, and shaking slightly with his eyes rolled back.”⁸⁸ An off-site nurse practitioner prescribed Ativan, a seizure medication, but facility medical staff did not administer it. Instead of being seen by a medical practitioner or provided emergency medical treatment following his seizure, officers carried Mr. Tino to a new cell and placed a mattress on the floor.

At no point after the onset of his first or second seizure was he medically evaluated or sent to the hospital to determine the underlying cause of his seizures. There were numerous deficiencies in HCDC’s compliance with ICE’s National Detention Standards (NDS 2000), including a severe lack of medical personnel (“the facility’s physician...provides no on-site services”) and unavailability of ordered, prescribed medication for seizures.⁸⁹ Further, ODO found that HCDC had no written or formalized seizure protocol in place during the duration of Mr. Tino’s detention.

Later that day, at 4:15 p.m., Mr. Tino was again found unresponsive by officers – the Detainee Death Review states the officer who discovered Mr. Tino saw that his “lips were blue” and a responding officer described his appearance as “bluish in color.”⁹⁰ HCDC security personnel initiated cardiopulmonary resuscitation (CPR), called for an ambulance via radio, and attempted to use an automated external defibrillator to resuscitate him, but the defibrillator did not detect a viable signal from his heart.⁹¹ He was transferred to the hospital in an ambulance and never regained consciousness. On September 27, 2016, his family agreed to discontinue his life support and he was pronounced dead.⁹²

Expert comments: The two medical experts who reviewed ICE’s investigation concluded that serious medical failures likely contributed to Mr. Tino’s death. “The first [seizure] should have prompted a high level of concern and attention,” said Dr. Stern. “And if the

⁸⁸ Ibid., p. 9.

⁸⁹ Ibid., pp. 14-18.

⁹⁰ Ibid., p. 11.

⁹¹ Ibid., p. 12.

⁹² Ibid.

first one didn't, the second one should have.”⁹³ Dr. Stern said that HCDC staff should not have accepted Mr. Tino's refusal of seizure medications without obtaining true informed consent. Informed consent cannot be obtained without ensuring that provider and patient are communicating, something HCDC staff consistently failed to do.

“The language barrier likely contributed to an inability to collect an accurate history,” said another medical expert.⁹⁴ “Having him in a setting where he could be evaluated via EEG [electroencephalogram, a test that detects electrical activity in the brain] would mean they could see what the profile of the seizure is and treat it more effectively,” the expert added.

Both experts raised concerns that a LPN was charged with assessing Mr. Tino, something LPNs are not trained to do. “Having a system in which your primary on the ground health care is an LPN is very risky,” said the second medical expert.⁹⁵ “If someone has a first-time seizure they should be evaluated by a practitioner immediately. Seeing a provider two days later is to me substandard.”⁹⁶

7. Olubunmi Toyin Joshua: Poorly-managed hypertensive cardiovascular disease

Olubunmi Toyin Joshua died while in ICE custody at the Emerald Correctional Management operated Rolling Plains Detention Center (RPDC) in Haskell, Texas, on October 24, 2016, due to hypertensive cardiovascular disease.⁹⁷ She was 54, and had been detained for nearly nine months before her death.⁹⁸

During her detention at RPDC, Ms. Joshua dealt with several significant health problems that first became apparent during her initial health evaluations and, taken together, should have alerted medical staff that she was at risk for heart failure.

From the very beginning of her time at RPDC in late January, Ms. Joshua reported and nursing staff documented hypertension, which is a known risk factor for cardiovascular damage,

⁹³ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

⁹⁴ Email and telephone correspondence from a physician in public service with expertise in correctional health to Human Rights Watch, April 15, 2018.

⁹⁵ Ibid.

⁹⁶ Ibid.

⁹⁷ US Immigration and Customs Enforcement, “Detainee Death Review of Olubunmi Toyin Joshua, JICMS Number 201700751,” <https://www.ice.gov/doclib/foia/reports/ddr-Joshua.pdf> (accessed January 24, 2018).

⁹⁸ Ibid., p. 1.

such as stroke and heart attack. The facility’s nursing protocol for hypertension requires health care service provider notification for blood pressure readings over 160/100, and on 10 occasions Ms. Joshua’s blood pressure exceeded that threshold, but a provider was never notified.⁹⁹ She had anemia, which increases the risk of a heart attack in someone with cardiovascular damage, but medical staff did not provide her iron supplements until more than three months after the condition was documented in a blood test.¹⁰⁰

In February, Ms. Joshua was diagnosed with anxiety by a RPDC psychologist, a stressor which increases the chances of a heart attack in someone with cardiovascular damage, and which the RPDC doctor chose not to treat in part because of an arbitrary decision that anxiolytic (anti-anxiety) medications would not be used at the jail.¹⁰¹

In October 2016, Ms. Joshua began experiencing persistent tooth and gum pain. She submitted her first request for medical care on October 6, a second on October 11 insisting that the pain was becoming progressively severe, and a third on October 18 stating that the pain was ongoing.¹⁰² On October 20, two weeks from her first sick call request, she received a dental exam.¹⁰³ The dentist documented a gum abscess on the upper right and left quadrants and broken teeth in the upper right quadrant for which he prescribed Keflex, an antibiotic used to treat infections caused by bacteria, for 10 days and then re-evaluation in 10 days.¹⁰⁴

On October 24, 2016, Ms. Joshua experienced a sudden loss of consciousness at around 9:40 p.m.¹⁰⁵ The review notes that she “fell backward into an open cell door and landed on the floor face up.”¹⁰⁶ Soon after she fell, an officer observed her appearing to have a seizure.¹⁰⁷ RPDC staff initiated cardiopulmonary resuscitation (CPR) and a nurse retrieved a medical bag that should have contained an automated external defibrillator (AED). The

⁹⁹ Ibid.

¹⁰⁰ US Immigration and Customs Enforcement, “Detainee Death Review of Olubunmi Toyin Joshua, JICMS Number 201700751,” <https://www.ice.gov/doclib/foia/reports/ddr-Joshua.pdf> (accessed January 24, 2018).

¹⁰¹ Ibid.

¹⁰² Ibid., p. 13.

¹⁰³ Ibid.

¹⁰⁴ Ibid.

¹⁰⁵ Ibid., p. 14.

¹⁰⁶ Ibid.

¹⁰⁷ Ibid., p. 15.

defibrillator was missing from the bag, however, so staff moved Ms. Joshua to the medical unit.¹⁰⁸

Due to delays in obtaining and using the defibrillator, Ms. Joshua did not reach the medical unit until 10:14 p.m.¹⁰⁹ Staff continued their attempts to resuscitate her until an ambulance arrived and departed for Haskell Memorial Hospital (HMH) at 10:40 p.m., an hour after her fall. Ms. Joshua was pronounced dead at 11:18 p.m.¹¹⁰

Expert comments: Two medical experts found that inadequate medical care likely contributed to Ms. Joshua’s death. “The care for the hypertension was quite poor,” said Dr. Stern, “including failure to treat and failure to follow up.” Both doctors also noted the failure to treat her pain from double dental abscesses, as well as anemia and anxiety, all of which are risk factors or stressors that increase the risk of a cardiovascular event. “It is difficult to imagine how the poor care provided to her during her detention did not materially contribute to her death,” said Dr. Stern.¹¹¹

A doctor in public service with expertise in correctional health who wished to remain anonymous agreed that her risk factors were not taken as seriously as they should have been. Both experts also noted that a delay in getting a defibrillator matters. “Emergency response is stressful,” the doctor said, “but having devices that are not up to date or broken is a major problem. Having a faulty device is a systems failure.”¹¹²

Neither Emerald Correctional Management nor ICE responded to requests for comment.

8. Wenceslau Esmerio Campos: Delays in responding to symptoms of heart attack after an officer refused to call for emergency help on his radio

Wenceslau Esmerio Campos died at the age of 49 on November 25, 2016, due to complications of myocardial infarction with atherosclerotic cardiovascular disease.¹¹³ He

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ Ibid., p. 16.

¹¹¹ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

¹¹² Email and telephone correspondence from a physician in public service with expertise in correctional health to Human Rights Watch, April 15, 2018.

¹¹³ US Immigration and Customs Enforcement, “Detainee Death Review of Wenceslau Esmerio Campos, JICMS Number 201701894,” <https://www.ice.gov/doclib/foia/reports/ddr-Campos.pdf> (accessed January 24, 2018).

had entered ICE custody on October 27, 2016, when he was booked into the South Texas Detention Complex (STDC) operated by GEO in Pearsall, Texas.¹¹⁴

On October 28, a licensed vocational nurse (LVN) documented that Mr. Campos said he had undergone varicose vein surgery to both of his legs in June 2016 and that doctors ordered him to wear compression stockings, which place mild static pressure on the legs.¹¹⁵ Later that day, Mr. Campos had another medical appointment for his initial health appraisal and physical examination.¹¹⁶ Again, he stated that he was told to wear compression stockings, but no longer had them on his person as they were placed with his personal property.¹¹⁷ The facility's commander provided him with new thromboembolic deterrent (TED) hose which were thigh-high, even though the pair that had been taken from Mr. Campos were waist-high.¹¹⁸ The Detainee Death Review notes that ICE investigators were unable to determine why or by whom Mr. Campos' personal stockings were confiscated.¹¹⁹

On November 16, Mr. Campos submitted an urgent sick call request asking that he either retrieve his personal stockings or receive a new pair of facility-issued stockings.¹²⁰ He was seen by a nurse at 10:42 a.m.¹²¹ The RN documented that he displayed non-pitting edema, or swelling, in both of his legs.¹²² Mr. Campos informed the nurse that the compression stockings issued to him by STDC were not sufficiently tight, which he said was resulting in lower extremity swelling as well as tingling in his left leg.¹²³ In addition, he showed the nurse that his facility-issued TED hose contained runs and holes and became bunched up below the knees.¹²⁴ The nurse informed the ICE supervisory detention and deportation officer at the facility that Mr. Campos needed to retrieve his stockings and the officer agreed to assist.¹²⁵ When interviewed after Mr. Campos' death, the nurse stated that she

¹¹⁴ *Ibid.*, p. 2.

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.*, p. 5.

¹¹⁷ *Ibid.*

¹¹⁸ *Ibid.*

¹¹⁹ *Ibid.*, pp. 5-6.

¹²⁰ *Ibid.*, p. 7.

¹²¹ *Ibid.*

¹²² *Ibid.*

¹²³ *Ibid.*

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

did not schedule a follow-up appointment with a doctor or qualified health care provider regarding Mr. Campos' edema because she thought that once he retrieved his personal stockings his issue would be resolved.¹²⁶ Mr. Campos was never taken to retrieve his personal stockings and on November 17, a lieutenant commander denied his request to wear his personal stockings considering them a "safety" concern.¹²⁷

Mr. Campos' death occurred after a medical emergency on November 23, 2016, at around 5:40 p.m. when officers were informed by another person in the detention center that Mr. Campos was ill. Mr. Campos was found vomiting, pale, sweating, experiencing bad chest pains, and holding his hands to his chest.¹²⁸ The death review describes the initial response on behalf of STDC security personnel:

Officer [REDACTED] approached CAMPOS in his bunk, located towards the front of the dorm near the officer's station, and observed he was pale and sweating, and held his hands to his chest. Officer [REDACTED] immediately asked Officer [REDACTED] to call a medical emergency on his radio, telling him CAMPOS was having a heart attack, but Officer [REDACTED] refused, stating the detainee was fine because he could walk around. Officer [REDACTED] asked a second time, and Officer [REDACTED] again refused, so Officer [REDACTED] asked for the radio to call the emergency herself, but Officer [REDACTED] refused to give it to her. Officer [REDACTED] completed two incident reports following CAMPOS' death, wherein he stated he did not call a medical emergency, or provide the radio to Officer [REDACTED] because he did not believe CAMPOS required emergency attention.¹²⁹

Due to the officer's refusal to recognize Mr. Campos' medical emergency, an hour elapsed between the time his medical emergency began and his transport by ambulance to Frio Regional Hospital (FRH) in Pearsall, Texas.¹³⁰ Mr. Campos fell into cardiac arrest during

¹²⁶ Ibid.

¹²⁷ Ibid., pp. 9-10.

¹²⁸ Ibid., p. 9.

¹²⁹ Ibid.

¹³⁰ Ibid., p. 12.

transport and CPR was initiated.¹³¹ Despite attempts to revive him and an emergency surgery, two days later, on November 25, 2016, Mr. Campos was pronounced dead.¹³²

Expert comments: Our medical experts agreed that the multiple delays between when Mr. Campos first manifested clear symptoms of a serious problem (chest pain) and when the ambulance departed for the hospital may have significantly decreased any chances the hospital doctors had of saving his life and contributed to the fatal outcome.

As described above in the case of Mr. Azurdía, during a heart attack, every minute counts (“Time is Muscle”), so the hour-long delay between the onset of Mr. Campos’ chest pain and his hospital transport “was critical and may have significantly decreased any chances the hospital doctors had of saving his life,” said Dr. Stern.¹³³ “Vomiting and chest pain equals heart attack until proven otherwise,” said Dr. Babaria. “There were delays that definitely could have cost him his life.”¹³⁴

A spokesperson for the GEO Group told Human Rights Watch the company was “unable to comment on specific medical cases/files and would refer you to U.S. Immigration and Customs Enforcement.”¹³⁵ ICE did not respond to repeated and detailed requests for comment.

Raquel Calderon de Hidalgo

On November 27, 2016, Raquel Calderon de Hidalgo became the fifteenth person to die in custody at the CoreCivic Eloy Detention Center in Arizona. Ms. Hidalgo was awaiting deportation to Guatemala when she suffered seizures and was taken to a hospital, where she soon passed away. An autopsy later found her cause of death to

¹³¹ Ibid.

¹³² Ibid., p. 14.

¹³³ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

¹³⁴ Email and telephone correspondence from Dr. Palav Babaria to Human Rights Watch, February 27, 2018.

¹³⁵ Email from Pablo Paez to Human Rights Watch, May 10, 2018.

be a blood clot, which developed from a leg injury she suffered in the desert weeks earlier after crossing the southern border.¹³⁶

The Pima County medical examiner who conducted the autopsy appeared to have had access to Ms. Hidalgo's medical records showing she had sought medical attention for the injury before she was apprehended by Border Patrol, and at that time also complained of diarrhea from drinking dirty water. He told a local public radio station that both conditions "would certainly be risk factors for potential development of a blood clot."¹³⁷

Dr. Babaria noted that the Eloy nurse practitioner had failed to see Ms. Calderon when she was referred as a high priority patient under the facility triage system and that there was a subsequent delay in responding to Ms. Calderon's complaints of increasing pain in her leg, delays that could have been definitive. If a doctor had actually seen her when she requested a visit, three days before her death, "they might have been worried about a pulmonary embolism ... and a different outcome might have happened," said Dr. Babaria.¹³⁸ Dr. Stern did not know whether Ms. Calderon's death could have been prevented but said the failure of the nurse practitioner to see Ms. Calderon when she was referred as a high priority patient was a dangerous medical care practice that could result in deaths.¹³⁹

CoreCivic noted that it "does not provide medical or mental healthcare services or staffing at the Eloy Detention Center" and that the federal government is "solely responsible for providing, contracting, staffing and oversight of any medical and mental health services at Eloy." A spokesperson directed all questions regarding medical or mental health services at Eloy to ICE officials.¹⁴⁰ ICE did not respond to repeated and detailed requests for comments.

¹³⁶ US Immigration and Customs Enforcement, "Detainee Death Review of Raquel Calderon de Hidalgo, JICMS Number 201701893," <https://www.ice.gov/doclib/foia/reports/ddr-Calderon.pdf> (accessed May 5, 2018).

¹³⁷ Michel Marizco, "Autopsy: Guatemalan Detainee Who Died in Arizona Died From Blood Clot," December 20, 2016, Fronteras Desk, <http://fronterasdesk.org/content/10529/autopsy-guatemalan-detainee-who-died-arizona-died-blood-clot> (accessed May 5, 2018).

¹³⁸ Email and telephone correspondence from Dr. Palav Babaria to Human Rights Watch, February 27, 2018.

¹³⁹ Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

¹⁴⁰ Letter from Steve Owen, Managing Director of Communications, CoreCivic, May 21, 2018 (on file with Human Rights Watch).

Deaths in 2017 and 2018

Although few Detainee Death Reports are publicly available yet for 2017 and 2018, ICE has reported that 12 people died in ICE custody in fiscal year 2017—more than in any other fiscal year since 2009—and five more people died in fiscal year 2018 to date. As of May 2018, ICE had released reviews for only six of the deaths in fiscal year 2017 and beyond. However, community organizers’ and families’ efforts to obtain information and an increase in media scrutiny during the Trump administration has meant that more information is available on the final days of many of these individuals than on those who died in ICE custody earlier.

Deaths in ICE Custody by Fiscal Year¹⁴¹

Fiscal Year	Number of Deaths
2009	14
2010	8
2011	10
2012	8
2013	9
2014	6
2015	7
2016	10
2017	12

Several of those who died had been living in the United States for years; some were receiving treatment for serious medical or mental health conditions before they were detained by ICE. One person died from suicide. The circumstances surrounding these deaths deserve scrutiny and should be clarified through prompt and effective investigations.

¹⁴¹ We calculated these values from ICE’s list of deaths in immigration detention from 2003 to mid-2017 combined with a tally of deaths the agency has announced publicly since mid-2017. See Immigration and Customs Enforcement, List of Deaths in ICE Custody, Data from 10/1/2003 to 6/5/2017, <https://www.ice.gov/doclib/foia/reports/detaineedeaths-2003-2017.pdf> (accessed June 5, 2018); the American Immigration Lawyers Association, List of deaths in ICE adult detention centers, updated May 25, 2018, http://www.aila.org/infonet/deaths-at-adult-detention-centers?utm_source=Recent%20Postings%20Alert&utm_medium=Email&utm_campaign=RP%20Daily (accessed June 7, 2018)

- A year after the death of Thongchay Saengsiri (discussed above), there was another death at the GEO Group’s LaSalle Detention Center in Louisiana. On March 13, 2017 Roger Rayson, a 47-year-old Jamaican immigrant, died approximately two months after being taken into ICE custody and a month after being transferred to a hospital for nausea, vomiting, and pain. At the hospital, Mr. Rayson was diagnosed with Burkitt Lymphoma, a fast-growing but treatable form of non-Hodgkin’s Lymphoma, and died nine days later, according to ICE’s press release announcing his death.¹⁴²
- JeanCarlo Jimenez-Joseph, a 27-year-old who had lived most of his life in the United States, died by suicide at the CoreCivic Stewart Detention Center (SDC) in Georgia on May 15, 2017. The *Atlanta Journal-Constitution* reported that Mr. Jimenez-Joseph had a known history of schizophrenia when he was ordered to 20 days in solitary confinement at SDC.¹⁴³ He died after 19 days in isolation. The Georgia Bureau of Investigation reviewed his death and, according to *Capital & Main*, found that Mr. Jimenez-Joseph “repeatedly displayed suicidal behavior, but never got the mental health care he needed. He was also placed in a cell that contained a known suicide hazard, a ceiling sprinkler head, upon which he affixed his makeshift noose.”¹⁴⁴ The investigation found that Mr. Jimenez-Joseph had been prescribed medication at a mental health facility before he was detained by ICE, but SDC staff did not give him the full dosage. An agent who probed Mr. Jimenez-Joseph’s death told the *Atlanta Journal-Constitution* that Mr. Jimenez-Joseph had been put in solitary because he was “always clowning around.”¹⁴⁵ A December 2017 report by the DHS Office of Inspector General raised concerns about SDC’s overly punitive use of solitary confinement.¹⁴⁶ A spokesperson for CoreCivic told Human Rights Watch “it does not provide medical or mental healthcare services or staffing at the Stewart Detention Center” and that the federal government is “solely responsible for

¹⁴² Immigration and Customs Enforcement, “ICE detainee passes away in local hospital,” March 14, 2017, <http://www.aila.org/File/Related/16050900n.pdf> (accessed on June 5, 2018).

¹⁴³ Jeremy Redmon, “ICE Detainee Who Hanged Himself Had History of Mental Health Problems,” *AJC*, July 13, 2017, <https://www.ajc.com/news/breaking-news/ice-detainee-who-hanged-himself-had-history-mental-health-problems/ZuLyxfRD7oEUvOOL86q7lK/> (accessed May 5, 2018).

¹⁴⁴ Robin Urevich, “Deadly Detention: Self-Portrait of a Tragedy,” *Capital & Main*, co-published by *International Business Times*, March 14, 2018, <https://capitalandmain.com/deadly-detention-self-portrait-of-a-tragedy-0314> (accessed May 5, 2018).

¹⁴⁵ Jeremy Redmon, “GBI: ICE Detainee Who Died in Georgia was Isolated for 19 Days,” *AJC*, May 17, 2017, <https://www.ajc.com/news/breaking-news/gbi-ice-detainee-who-died-georgia-was-isolated-for-days/DcGHSwotmwlU5oi8yGJqWM/>.

¹⁴⁶ US Department of Homeland Security, Office of Inspector General, “Concerns About ICE Detainee Treatment and Care at Detention Facilities,” December 11, 2017, <https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf>.

providing, contracting, staffing and oversight of any medical and mental health services at Stewart.”¹⁴⁷ Regarding the use of isolation in the facility, a CoreCivic spokesperson wrote that “facility staff and management are required to adhere to the applicable Performance-Based National Detention Standards ...[and] ICE maintains full-time monitoring staff onsite at the facility” to ensure compliance.¹⁴⁸ ICE did not respond to repeated and detailed requests for comments.

- Attkumar Babubhai Patel of India was detained by ICE at the Atlanta City Detention Center in Georgia, where he was diagnosed with high blood pressure and diabetes and transferred to a hospital with shortness of breath. He died on May 16, 2017 with congestive heart failure as the reported cause of death.¹⁴⁹
- On May 31, 2017, Vicente Caceres-Maradiaga, a 46-year-old Honduran man, collapsed while playing soccer at the Adelanto Detention Center in California.¹⁵⁰ Mr. Caceres-Maradiaga reportedly died of acute coronary syndrome and was being treated for hypertension.¹⁵¹
- The family and lawyer of Rolando Meza-Espinoza, who died in ICE custody on June 10, 2017, have raised a number of questions about the medical care he received after ICE arrested him at his construction job, in what might have been a case of mistaken identity. Mr. Meza-Espinoza, a Honduran father of three, had serious medical conditions when he was detained at the Hudson County Correctional Center in New Jersey, including cirrhosis of the liver, anemia, and diabetes. Mr. Meza-Espinoza’s family told the *New York Daily News* that during his two months in detention he repeatedly asked for his prescribed medications but only received treatment for diabetes.¹⁵² Mr. Meza-Espinoza was taken to a hospital with severe internal bleeding on June 8 and died two days later.

¹⁴⁷ Letter from Steve Owen, Managing Director of Communications, CoreCivic, May 21, 2018 (on file with Human Rights Watch).

¹⁴⁸ The company also provided a table of comparing “restrictive housing” at the Stewart Detention Facility to the general population in terms of meals, sick call, medical and mental health services, among other factors. The full letter is available on our website.

¹⁴⁹ Immigration and Customs Enforcement, “Ice Detainee Passes Away at Atlanta Hospital,” May 17, 2017, <https://www.ice.gov/news/releases/ice-detainee-passes-away-atlanta-hospital>.

¹⁵⁰ Immigration and Customs Enforcement, “ICE detainee passes away en route to Victorville hospital,” June 1, 2017, <https://www.ice.gov/news/releases/ice-detainee-passes-away-en-route-victorville-hospital>.

¹⁵¹ Adolfo Flores, “Another Immigrant Has Died in ICE Custody and Critics Worry It’s Just the Beginning,” *Buzzfeed*, June 2, 2017, https://www.buzzfeed.com/adolfoflores/another-immigrant-has-died-in-ice-custody-and-critics-worry?utm_term=.fvVWL92Ok#.gx3P2oXg1.

¹⁵² Catherina Gioino and Victoria Bekiempis, “Widow Recounts her ‘Hardworking’ Honduran Immigrant Husband who Died in ICE Custody as ‘Good Father’ of Three,” *Daily News*, June 22, 2017, <http://www.nydailynews.com/new-york/widow-recalls-husband-died-ice-custody-good-father-3-article-1.3270644>.

- Osvadis Montesino-Cabrera, 37, was admitted to a hospital near Krome Detention Center in Florida in August 2017 for issues related to urinary retention and died by suicide in the hospital a week later on September 1, 2017, still under ICE custody.¹⁵³
- Felipe Almazan-Ruiz died on September 17, 2017, at a hospital near the Management and Training Corporation IAH Adult Detention Facility in Texas after being evacuated from Glades County (Florida) Detention Center in advance of Hurricane Irma.¹⁵⁴ Kamyar Samimi of Iran died at a hospital on December 2, 2017, after being transferred from GEO Group Denver Contract Detention Facility in Colorado.¹⁵⁵ ICE stated the preliminary cause of death for both Mr. Samimi and Mr. Almazan-Ruiz was cardiac arrest.
- The death of a Cuban man, Yulio Castro Garrido, brought CoreCivic Stewart Detention Center (SDC) back into the spotlight in early 2018. Mr. Castro Garrido was diagnosed with pneumonia and transferred from SDC to a hospital, where he died about three weeks later, on January 30, 2018. Mr. Castro Garrido’s brother told the *Atlanta Journal-Constitution* that the man was healthy before he was taken into ICE custody. In its press release announcing Mr. Castro Garrido’s death, ICE initially stated that he had resisted treatment, but later revised the statement to say he “didn’t respond well to medically administered treatments, which caused his condition to worsen.”¹⁵⁶ A spokesperson for CoreCivic told Human Rights Watch “it does not provide medical or mental healthcare services or staffing at the Stewart Detention Center” and that the federal government is “solely responsible for providing, contracting, staffing and oversight of any medical and mental health services at Stewart.”¹⁵⁷

¹⁵³ Arek Sarkissian, “Nursing Home Deaths: Police Investigate Detainee Death at Hospital Owned by Same Doctor,” *Naples Daily News*, September 29, 2017, <https://www.naplesnews.com/story/weather/hurricanes/2017/09/29/nursing-home-deaths-police-investigate-inmate-death-hospital-owned-same-doctor/709899001/> (accessed May 5, 2018). ICE’s Detainee Death Review on Mr. Montesino was released prior to this report’s publication but we were not able to gather independent medical opinions on the care he received. See US Immigration and Customs Enforcement, “Detainee Death Review of Osvadis Montesino Cabrera, JICMS Number 201710563,” <https://www.ice.gov/doclib/foia/reports/ddr-Montesino.pdf> (accessed June 5, 2018).

¹⁵⁴ Immigration and Customs Enforcement, “Houston-Area Detainee Passes Away at Local Hospital,” September 18, 2017, <https://www.ice.gov/news/releases/houston-area-detainee-passes-away-local-hospital>.

¹⁵⁵ Immigration and Customs Enforcement, “Denver-Area Detainee Passes Away at Local Hospital,” December 4, 2017, <https://www.ice.gov/news/releases/denver-area-ice-detainee-passes-away-local-hospital>.

¹⁵⁶ Jeremy Redmon, “Brother: Cuban was Healthy Before Dying of Pneumonia in ICE Custody,” *Politically Georgia*, February 20, 2018, <https://politics.myajc.com/news/state--regional-govt--politics/brother-cuban-was-healthy-before-dying-pneumonia-ice-custody/9TNpil95CYQPyiGPoSyzm/>.

¹⁵⁷ Letter from Steve Owen, Managing Director of Communications, CoreCivic, May 21, 2018 (on file with Human Rights Watch).

- Luis Ramirez-Marcano, who was detained at Krome Detention Center, died on February 19, 2018, about a month after being taken into ICE custody and two days after being admitted to a nearby hospital.¹⁵⁸ Gourgen Mirimanian, who was detained for two months at the Prairieland Detention Center in Texas, was found unresponsive on his bunk on April 10, 2018, according to ICE.¹⁵⁹ The causes of death for both men have not been reported as of the end of May 2018.
- Ronal Francisco Romero, a 39-year-old Honduran national, died on May 16, 2018, a week after he came into US custody after crossing the border into South Texas. ICE identified a preliminary cause of death as cardiac arrest.¹⁶⁰ A secondary autopsy performed at the request of Mr. Romero’s family concluded that he had a form of bacterial meningitis that began as an infection of the right middle ear and subsequently spread to the brain.¹⁶¹ The autopsy report concluded that Mr. Romero would have been intensely, visibly ill and in severe pain for several days prior to his transfer to the hospital from Port Isabel Detention Center on the afternoon of May 15, 2018. Mr. Romero’s mother filed a legal action to compel the government to release more information about his death.¹⁶²
- Roxana Hernandez, 33, a Honduran woman, entered the US seeking asylum via the San Ysidro Port of Entry in California on May 9, 2018.¹⁶³ She was transferred to ICE custody on May 13 and then between different holding facilities until May 16 when she arrived at the Cibola County Correctional Center in Milan, New Mexico. There she was jailed in the transgender unit. The next day she was admitted to the hospital with symptoms of “pneumonia, dehydration and complications associated with HIV,” according to ICE.¹⁶⁴ Later that day she was sent to the Intensive Care Unit

¹⁵⁸ Immigration and Customs Enforcement, “ICE Detainee Passes Away at Kendall Regional Medical Center in Miami,” February 21, 2018, <https://www.ice.gov/news/releases/ice-detainee-passes-away-kendall-regional-medical-center-miami>.

¹⁵⁹ Immigration and Customs Enforcement, “Dallas-Area Detainee Passes Away at Local Hospital,” April 12, 2018, <https://www.ice.gov/news/releases/dallas-area-ice-detainee-passes-away-local-hospital>.

¹⁶⁰ Immigration and Customs Enforcement, “South Texas ICE detainee from Honduras passes away in local hospital,” May 21, 2018, <https://www.ice.gov/news/releases/south-texas-ice-detainee-honduras-passes-away-local-hospital>. Mr. Romero was known to immigration authorities as Ronald Cruz, according to his family’s attorney.

¹⁶¹ Autopsy Report (preliminary), Ronal Francisco Romero, Kris Sperry, M.D., Forensic Pathologist, May 29, 2018 (on file with Human Rights Watch).

¹⁶² Verified petition to perpetuate testimony in the matter of Martina Blasina Romero, United States District Court Southern District of Texas, McAllen Division, June 4, 2018, Case 7:18-mc-01084.

¹⁶³ Susan Montoya Brian and Anita Snow, Transgender migrant dies while in US custody, *Associated Press*, May 31, 2018, <https://www.apnews.com/a3edef6853dd4b3aabe476fbc49959f7> (accessed June 7, 2018).

¹⁶⁴ Immigration and Customs Enforcement, “South Texas ICE detainee from Honduras passes away in local hospital,” May 25, 2018, <https://www.ice.gov/news/releases/ice-detainee-honduras-passes-away-new-mexico-hospital>. Ms. Hernandez’s first name was identified as Jeffrey in ICE’s press release but advocates identified her preferred name as Roxana.

where she remained until she passed away a week later. Ms. Hernandez was part of a caravan of Central American migrants that arrived at the US border in early May. Organizers with Pueblo Sin Fronteras, an advocacy group working with the migrants in the caravan, said Ms. Hernandez “spent five days freezing in the “hieleras”—or cells with very cold temperatures—in the custody of Customs and Border Protection without adequate food or medical attention, being guarded and without a way to rest in the cold under 24-hour lighting.”¹⁶⁵

The appendix to this report lists all of the deaths in ICE detention facilities since our first report in 2010, noting which have been analyzed by medical experts and with what result.¹⁶⁶

¹⁶⁵ Press release of Pueblo Sin Fronteras, Al Otro Lado and Diversity Sin Fronteras on the institutional assassination of Roxana Hernandez, May 29, 2018, <https://www.facebook.com/PuebloSF/posts/2184986174861405> (accessed June 1, 2018).

¹⁶⁶ ICE’s count of reported deaths from 2003 to mid-2017 can be found here: <https://www.ice.gov/doclib/foia/reports/detaineddeaths-2003-2017.pdf>; the American Immigration Lawyers Association maintains a list of deaths in ICE detention here: http://www.aila.org/infonet/deaths-at-adult-detention-centers?utm_source=Recent%20Postings%20Alert&utm_medium=Email&utm_campaign=RP%20Daily.

Lack of Effective Oversight Leads to Repeated Deadly Failures

As noted above, ICE has released a total of 52 Detainee Death Reviews since March 2010. Analysis of those reviews in this and the two prior reports of our organizations shows that the same defects in oversight are leading to the same deadly failures. Three failings stand out: (1) unreasonable delays in providing care, (2) poor practitioner and nursing care, and (3) botched emergency responses. There is also a troubling pattern of suicides by people with psychosocial disabilities who have been held in isolation.

Unreasonable Delays

The unreasonable delays in providing medical care that contributed to some of the detainee deaths documented above were not new to the system or even in some cases to the facility involved. Three cases at the Adelanto Detention Facility starkly illustrate the problem:

- As described above, a nurse declined to examine Jose Azurdiá Hernandez during a morning visit to his unit at the Adelanto Detention Facility because “she did not want to get sick,” kicking off a series of delays in Mr. Azurdiá getting care for his ultimately fatal heart attack in December 2015.¹⁶⁷
- Raul Ernesto Morales Ramos, who died while detained at Adelanto Detention Facility in April 2015, suffered a series of long delays for a referral to a specialist as was clinically indicated by his severe symptoms of gastrointestinal cancer. For two years, he suffered from symptoms of undiagnosed cancer including weight loss, body aches, diarrhea, and rectal bleeding, and he was not seen by a specialist until a month before his death, when it was too late. The doctor, who was certified in medical oncology, told ICE investigators that when she finally saw Mr. Morales-Ramos on March 6, 2015, he had “the largest [abdominal mass] she had ever seen in her practice,” which was “notably visible through the abdominal wall.”¹⁶⁸

¹⁶⁷ Immigration and Customs Enforcement, “Detainee Death Review – Jose Manuel Azurdiá Hernandez, JICMS 2016041,” <https://www.ice.gov/doclib/foia/reports/ddr-Azurdiá.pdf> (accessed May 5, 2018).

¹⁶⁸ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, p.38, https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_o.pdf (accessed June 7, 2018).

- Delays also contributed to the death of Fernando Dominguez Valdivia, who was detained in Adelanto in 2012. According to the ODO summary of the investigation into his death, Adelanto staff failed to “facilitate timely and appropriate access to off-site treatment” for pneumonia that went undiagnosed for three months prior to his death.¹⁶⁹

Unreasonable delays also likely contributed to deaths at other detention facilities.

- As described above, Rafael Barcenas Padilla was not transferred to the hospital in 2016 from the Otero County Processing Center for three days, despite dangerously low oxygen saturation readings and the absence at the facility of a key medication to help his breathing.¹⁷⁰
- Marjorie Annmarie Bell, who had a known history of heart attacks, informed nurses at the San Diego County Detention Facility on six separate occasions in early 2014 that she was having chest pain. On none of those occasions did a nurse contact a physician or call an ambulance. She ultimately died of a heart attack.¹⁷¹
- Mauro Rivera Romero did not receive medical attention over a 24-hour period despite voicing complaints of feeling progressively worse to a barracks officer at the El Paso County Processing Center in late 2011. Ultimately, a physician contracted by ICE concluded his death “may have possibly been preventable,” calling it “imperative” that “the barracks officer notify a medical provider in a timely manner of detainees’ medical complaints, and that medical staff take necessary and appropriate action to determine if treatment is necessary.”¹⁷²

Poor Practitioner and Nursing Care

Another contributing factor is poor practitioner and nursing care. The death reviews we analyzed from 2010 to 2017 included evidence of practitioners or nurses failing to act on

¹⁶⁹ ACLU, DWN, NIJC, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 24, 2016, p. 16-17, https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf (accessed June 7, 2018).

¹⁷⁰ Immigration and Customs Enforcement, “Detainee Death Review – Rafael Barcenas Padilla JICMS #201605426” <https://www.ice.gov/doclib/foia/reports/ddr-Barcenas.pdf> (accessed May 5, 2018).

¹⁷¹ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, p.35-36, https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_o.pdf (accessed June 7, 2018).

¹⁷² ACLU, DWN, NIJC, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 24, 2016, p. 20-21, https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf (accessed June 7, 2018).

abnormal vital signs or test results, failing to ensure patients made informed decisions to refuse care, practicing beyond the scope of their licenses, and failing to respond to requests for care. In some cases, these failures caused delays in patients accessing care; in others practitioners or nurses made decisions that may have contributed or did contribute to worse outcomes. These poor practices point collectively to the absence of an effective system for reviewing practitioner or nursing decisions and implementing improvements.

Relevant cases include the following:

- Nurses and practitioners alternately missed the diagnosis and mismanaged Thongchay Saengsiri's new onset congestive heart failure in La Salle Detention Facility prior to his death in March 2016, as described above.¹⁷³
- Health care providers treating Peter George Carlisle Rockwell knew he had high blood pressure but failed to respond to his complaints of blurry vision, a telltale sign of an intracranial bleed. He died at CoreCivic's Houston Contract Detention Facility in 2014.¹⁷⁴
- Tiombe Carlos, who died from suicide, had repeatedly shown suicidal symptoms and had previously attempted to kill herself in the months leading up to her death at York County Prison in 2013. Medical staff failed to provide her any counseling, and while they did treat her with a psychotropic medication, they failed to properly manage that medication treatment by making adjustments to dosages or medication when she failed to respond to treatment. Ms. Carlos was repeatedly placed in isolation, further harming her mental health.¹⁷⁵
- Lelis Rodriguez exhibited extremely high blood pressure and a headache at the Rio Grande Valley Staging Facility in 2013 but medical staff took no action to transport him to a hospital until hours later when he collapsed.¹⁷⁶

¹⁷³ Immigration and Customs Enforcement, "Detainee Death Review – Thongchay Saengsiri JICMS #201604767," <https://www.ice.gov/doclib/foia/reports/ddr-Saengsiri.pdf> (accessed June 7, 2018).

¹⁷⁴ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, pp. 36-37, https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_o.pdf (accessed June 7, 2018).

¹⁷⁵ *Ibid.*, pp. 33-35.

¹⁷⁶ *Ibid.*, pp. 31-33.

- The medical staff who examined Manuel Cota-Domingo missed signs of diabetes and pneumonia, leading to his death at CoreCivic’s Eloy Detention Center in 2012.¹⁷⁷
- Amra Miletic died of complications of chronic bowel inflammation and heart arrhythmia in 2011 after nearly two months of substandard care in the Weber County Correctional Facility that failed to address Ms. Miletic’s rectal bleeding, vomiting, abdominal pain, and nausea.¹⁷⁸
- Irene Bamenga was detained at the Albany Country Jail in New York in 2011. In the days before she died she was given incorrect higher and inconsistent dosages of medication for congestive heart failure. Although the death certificate indicates that cardiomyopathy was the immediate cause of death, a doctor reviewing Ms. Bamenga’s death questioned this conclusion and concluded that her death could have been prevented had her congestive heart failure been treated appropriately or due to toxicity from the incorrect medicine dosages.¹⁷⁹
- In the weeks before Victor Ramirez Reyes died in 2011 at CoreCivic’s Elizabeth Detention Center in New Jersey, he received double doses of his medications on a daily basis because medical staff did not follow proper protocols. A sick call slip submitted by Mr. Ramirez was not forwarded to medical staff scheduled to see him. Consequently, medical staff failed to address the symptoms documented on the slip, including trouble breathing. He ultimately died of heart disease.¹⁸⁰

Botched Emergency Responses

Flawed emergency response is also a recurring theme in the cases. Across several different detention centers, facility and medical staff lacked appropriate medical equipment, failed to properly monitor for and respond to emergencies, or inappropriately decided to send desperately ill patients by van to the hospital instead of by ambulance.

¹⁷⁷ Ibid., pp. 39-40.

¹⁷⁸ ACLU, DWN, NIJC, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 24, 2016, pp. 8-10, https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf (accessed June 7, 2018).

¹⁷⁹ Ibid., pp. 15-16.

¹⁸⁰ Ibid., p. 18.

- As described above, Thongchay Saengsiri waited for over two hours before medical staff called an ambulance in response to his acute coughing, shortness of breath, wheezing, and difficulty breathing when he died in 2016.¹⁸¹
- Although Rafael Barcenas exhibited dangerously low oxygen saturation levels which should have required immediate medical emergency action, nurses at the Otero County Processing Center delayed his transfer to the hospital for three days in 2016, as described above.¹⁸²
- Several days prior to his death in 2016, Igor Zyazin alerted officers at SLRDC that his chest hurt, a symptom of a heart attack. Instead of calling a medical emergency, facility staff initiated a transfer to Otay Mesa Detention Center “an estimated three to four hours” away—he died there of a heart attack a day after the transfer, as described above.¹⁸³
- When Olunbinmi Joshua collapsed at the Rolling Plains Detention Center in 2016 staff were unable to obtain a functioning defibrillator, which led to delays in appropriate emergency care, as described above.¹⁸⁴
- Delays in emergency medical care to Wenceslau Campos, who suffered a heart attack at the South Texas Detention Complex in 2016, occurred after an officer refused to call for emergency help on his radio even though Campos was vomiting and reporting chest pains. As a result, over four hours passed before Mr. Campos made it to the hospital where he later died.¹⁸⁵
- As described above, Jose Manuel Azurdia died in 2015 after a 90-minute delay at the Adelanto Detention Facility in responding appropriately to symptoms of a heart attack.¹⁸⁶
- Peter Rockwell collapsed with a hemorrhagic stroke in full view of a correctional officer at the Houston Contract Detention Facility (HCDF) in 2014 and it took staff

¹⁸¹ Immigration and Customs Enforcement, “Detainee Death Review – Thongchay Saengsiri JICMS #201604767,” pp 9-15, <https://www.ice.gov/doclib/foia/reports/ddr-Saengsiri.pdf> (accessed June 7, 2018).

¹⁸² Immigration and Customs Enforcement, “Detainee Death Review – Rafael Barcenas Padilla JICMS #201605426.” pp. 4-9 <https://www.ice.gov/doclib/foia/reports/ddr-Barcenas.pdf> (accessed May 5, 2018).

¹⁸³ Immigration and Customs Enforcement, “Detainee Death Review – Igor Zyazin, JICMS 201606226,” p. 7, <https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf> (accessed May 5, 2018).

¹⁸⁴ Immigration and Customs Enforcement, “Detainee Death Review of Olunbinmi Toyin Joshua, JICMS Number 201700751,” <https://www.ice.gov/doclib/foia/reports/ddr-Joshua.pdf> (accessed January 24, 2018).

¹⁸⁵ Immigration and Customs Enforcement, “Detainee Death Review of Wenceslau Esmerio Campos, JICMS Number 201701894,” <https://www.ice.gov/doclib/foia/reports/ddr-Campos.pdf> (accessed January 24, 2018).

¹⁸⁶ Immigration and Customs Enforcement, “Detainee Death Review – Jose Manuel Azurdia Hernandez, JICMS 201602241,” <https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.pdf> (accessed May 5, 2018).

- eight minutes to call 911. Facility staff did not immediately respond to the severity of the emergency nor bring required emergency equipment as per facility policy.¹⁸⁷
- Manuel Cota-Domingo, who died while detained at Eloy Detention Center in 2012, was forced to wait for emergency treatment because of unnecessary administrative delays including being sent to the hospital in a van rather than an ambulance, meaning he did not arrive at the emergency room until eight hours after he first began to have trouble breathing.¹⁸⁸
 - It took nearly half an hour for Evalin Ali Mandza to be seen by a doctor at the Denver Contract Detention Facility in 2012 after other detained individuals informed an officer that he was experiencing chest pain. The doctor determined that Mr. Mandza needed to be treated in an emergency room – but nearly one hour passed before 911 was called. The call to 911 was delayed because staff prioritized filling out transfer paperwork instead of placing the call.¹⁸⁹
 - Anibal Ramirez-Ramirez, who died from liver failure while in custody at the Farmville Immigration Centers of America in 2011, faced substantial delays in receiving emergency care. Corrections staff at the facility refused to follow a recommendation from a nurse who found that he had a “perilously high” heart rate requiring emergency care, insisting that the nurse wait for Mr. Ramirez-Ramirez to be seen by a doctor at an appointment scheduled some fifteen hours later. He never made it to the appointment: nurses found him three hours later lying on the ground with blood coming out of his mouth.¹⁹⁰
 - On the day of Victor Ramirez-Reyes’ death in 2011, following a collapse, medical staff at the Elizabeth Detention Center did not initiate CPR or use a defibrillator, but rather waited 10 minutes for emergency medical technicians to arrive.¹⁹¹

¹⁸⁷ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, pp. 36-37, https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_o.pdf (accessed June 7, 2018).

¹⁸⁸ *Ibid.*, pp. 30-31.

¹⁸⁹ ACLU, DWN, NIJC, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 24, 2016, pp. 7-8, https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf (accessed June 7, 2018).

¹⁹⁰ *Ibid.*, pp. 13-14.

¹⁹¹ *Ibid.*, pp. 18-19.

Dangerous Use of Isolation for People with Psychosocial Disabilities

The UN Special Rapporteur on Torture considers placement of people with psychosocial disabilities in solitary confinement to be “cruel, inhuman or degrading treatment.”¹⁹² This makes it a violation of US obligations under the Convention Against Torture.¹⁹³ ICE detainees with psychosocial disabilities have often been subjected to prolonged and repeated solitary confinement.

One of the Detainee Death Reviews we analyzed for this report involved a man who committed suicide after being placed in isolation despite a recent off-site hospitalization for psychosis.¹⁹⁴ Osmar Epifanio Gonzalez-Gadba, 32, had been detained for three months at the GEO Group’s Adelanto Detention Facility (ADF) and was waiting to be deported to Nicaragua when he died at a hospital on March 28, 2017, of injuries he sustained when he attempted suicide six days earlier in a solitary confinement cell.¹⁹⁵

After several months of battling infections, beginning on March 6, 2017, Mr. Gonzalez refused meals and told staff that he “would not eat until he was deported.”¹⁹⁶ ICE was notified that Mr. Gonzalez had refused meals the following day.¹⁹⁷ Thereafter, an assistant warden visited him. Mr. Gonzalez informed the assistant warden that he “stopped eating because he was sexually assaulted while housed in general population.”¹⁹⁸ The Detainee Death Review notes that upon being told about the assault, the assistant warden went directly to ADF’s Prison Rape Elimination Act (PREA) administrator and directed that PREA staff immediately interview Gonzalez regarding his allegation. Later that same day, a facility doctor met with Mr. Gonzalez, who reported to them that he was raped and that he would rather die from hunger than from a sexually transmitted infection. The doctor

¹⁹² UN General Assembly, “Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment,” A/66/268, August 5, 2011, <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf> (accessed May 18, 2018).

¹⁹³ Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Convention Against Torture), adopted December 10, 1984, G.A. res. 39/46, annex 39 U.N. GAOR Supp. (No. 51) at 197, U.N. Doc. A/39/51 (1984), entered into force June 26, 1987, ratified by the United States on November 20, 1994.

¹⁹⁴ Immigration and Customs Enforcement, “Detainee Death Review of Osmar Esifanio Gonzalez-Gadba, JICMS Number 201705550, <https://www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf>, (accessed May 24, 2018).

¹⁹⁵ Peter Holley, “An Undocumented Immigrant Hanged Himself After 3 Months in an ICE Detention Center,” *The Washington Post*, March 29, 2017, https://www.washingtonpost.com/news/post-nation/wp/2017/03/29/an-illegal-immigrant-hanged-himself-after-three-months-in-an-ice-detention-center/?utm_term=.bc236e0b8f4c.

¹⁹⁶ Immigration and Customs Enforcement, “Detainee Death Review of Osmar Esifanio Gonzalez-Gadba, JICMS Number 201705550, p. 8. <https://www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf>, (accessed May 24, 2018).

¹⁹⁷ *Ibid.*, p. 9.

¹⁹⁸ *Ibid.*

documented that he appeared psychotic and delusional.¹⁹⁹ Subsequently, the facility doctor ordered that Mr. Gonzalez be transported to the Alvarado Parkway Institute (API), a behavioral health hospital in La Mesa, California.²⁰⁰ The death review notes that no medical and mental health assessment was conducted in response to Mr. Gonzalez's allegation of rape nor was a PREA validation tool completed prior to his transfer to API as required by DHS PREA regulation.²⁰¹

From March 7 to March 15, Mr. Gonzalez was treated at API and placed on several psychotropic medications.²⁰² Discharge instructions indicated primary diagnoses were paranoid schizophrenia, asthma, and dysuria, and recommended continued medication and laboratory studies. The Detainee Death Review notes that ADF medical staff did not conduct any lab testing, did not have Mr. Gonzalez sign consent forms for psychiatric medications, and never reviewed the API summary or recommendations.²⁰³

When back at ADF, Mr. Gonzalez was housed initially in medical observation and then in isolation on psychiatric observation status, which required 30-minute checks by security staff.²⁰⁴ During the period between his return to ADF and his death, Mr. Gonzalez refused medication on several occasions – the Detainee Death Review explains that nurses failed to follow the facility's medication administration policy by not notifying a medical provider after he missed three doses of any medication in the days preceding his suicide.²⁰⁵

Further, the review found that despite Mr. Gonzalez's diagnosed psychosocial disabilities, his medication refusals, and his psychiatric observation status, there were numerous instances of security rounds failing to check in on him every 30 minutes as required, including on the day of the medical emergency that led to his death. Video surveillance footage of officers completing security rounds showed that officers did not look directly into cells to ensure individuals' well-being.²⁰⁶

¹⁹⁹ Ibid.

²⁰⁰ Ibid.

²⁰¹ Ibid., p. 9.

²⁰² Ibid., pp. 10-11.

²⁰³ Ibid., p. 11.

²⁰⁴ Ibid., pp. 11-12.

²⁰⁵ Ibid., p. 14.

²⁰⁶ Ibid., pp. 21-23.

On the evening of March 22, Mr. Gonzalez hanged himself by attaching his bedsheet to the ladder of his bunk bed. After transport to the hospital, he was pronounced dead on March 28, 2017.²⁰⁷

Two independent experts who reviewed Mr. Gonzalez's Detainee Death Review agreed that facility staff were on notice that he had a serious mental health condition and had stopped taking his medicine. This combination is "problematic," said Dr. Cohen, especially for someone being held in isolation. "He shouldn't have been put in solitary even if he requested it," said Dr. Cohen. "The reason you don't put mentally ill people in solitary is because they are likely to decompensate."²⁰⁸ In psychiatry, decompensation is the failure to generate effective psychological coping mechanisms in response to stress, resulting in personality disturbance or disintegration.

As described above, JeanCarlo Alfonso Jimenez Joseph, a 27-year-old DACA recipient, died by suicide while in solitary confinement in ICE custody at CoreCivic's Stewart Detention Center in Lumpkin, Georgia.²⁰⁹ A Georgia Bureau of Investigations probe into Mr. Jimenez' death found he had been in solitary confinement for 19 days as punishment for jumping from the top tier of his housing unit, which he described as an effort to harm himself. Despite being identified by ICE and SDC as a suicide risk early on, he was never put on suicide watch nor provided the upward adjustment on his anti-psychotic medication he begged for days before his death. On the night of his death, Mr. Jimenez Joseph was seen jumping rope with his bedsheets and had written "Hallelujah The Grave Cometh" in large dark letters on his cell wall.²¹⁰

Three other cases of people with psychosocial disabilities who committed suicide after being placed in isolation are detailed in Human Rights Watch's 2017 report, *Systemic Indifference*:

- Tiombe Kimana Carlos, 34, died by suicide in October 2013, after being held in prolonged isolation at the York County Prison. Both independent experts who

²⁰⁷ Ibid., pp. 16-18.

²⁰⁸ Telephone correspondence from Dr. Robert Cohen to Human Rights Watch, April 4, 2018.

²⁰⁹ Jeremy Redmon, "GBI: ICE Detainee Who Died in Georgia was Isolated for 19 Days," *AJC*, May 17, 2017, <https://www.ajc.com/news/breaking-news/gbi-ice-detainee-who-died-georgia-was-isolated-for-days/DcGHSwotmwlu5oi8yGJqWM/>.

²¹⁰ Robin Urevich, "Deadly Detention: Self Portrait of a Tragedy," *International Business Times*, March 14, 2018, <http://www.ibtimes.com/political-capital/deadly-detention-self-portrait-tragedy-2662749> (accessed June 7, 2018).

reviewed that case for Human Rights Watch found that subpar mental health care likely contributed to Ms. Carlos’s death.²¹¹

- For eight months of his 15-month detention at CoreCivic’s Houston Contract Detention Facility in 2013, Clemente Mponda was in isolation, including administrative segregation, disciplinary segregation and three days on suicide watch. Dr. Stern said that the treatment of Mr. Mponda “might be the poster child for misuse of isolation for mental health patients.”²¹²
- Jose de Jesus Deniz-Sahagun, 31, died of suicide on May 20, 2015 in CoreCivic’s Eloy Detention Center. Facility staff were on notice that he was unstable. He had been taken to the hospital after a suicide attempt days before and was placed on suicide watch at Eloy. Based on one report of him claiming he was not suicidal he was downgraded off of suicide watch and given his property in an isolation cell. Mr. Deniz ultimately used an item from his property—a sock—to end his life. Independent experts found that medical staff failed to adequately elevate the level of Mr. Deniz’s treatment based on his symptoms.²¹³

Systemic Deficits in Medical Care

The overwhelming majority of the Detainee Death Reviews—not solely those in which the evidence suggests that medical failures likely led or contributed to deaths—include evidence of serious deficits in medical care. Of the 33 reviews for which we have sought independent medical reviews (those discussed in *Systemic Indifference* and the present report) our experts said that only three described what appeared to be adequate care.²¹⁴ As emphasized by our experts, the other 30 contain evidence of substandard medical practices and faulty systems that, if typical of the facilities, would put many other people detained in the facilities at risk.

²¹¹ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, pp.40 https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_o.pdf (accessed June 7, 2018).

²¹² *Ibid.*, pp. 41-42.

²¹³ *Ibid.*, pp. 42-44.

²¹⁴ These three cases are: Saul Enrique Banegas-Guzman, who died on January 22, 2016 while detained at LaSalle Detention Center; Jose Javier Hernandez-Valencia, who died on April 12, 2014 at Houston Contract Detention Facility; and Jorge Umana-Martinez, who died on October 30, 2014 at South Texas Detention Center. It is possible that they were exposed to subpar medical care or dangerous detention practices, but our experts did not find evidence of such practices in these three reviews. Whether this is due to adequate care or inadequate investigation of the death by ICE is not clear.

Some of the dangerous practices evidenced throughout the death review summaries include:

- Medical staff at the Hudson County Correctional Facility and the Orange County Jail failed to follow up on Santo Carela’s abnormal vital signs and ignored his complaints of severe pain prior to his death in 2016.²¹⁵
- Nurses at the Essex County Correctional Facility accepted over 100 refusals of insulin from Luis Alonso Fino Martinez—a known diabetic—without notifying anyone and failed to assess lower extremity swelling he developed. Such swelling is a sign of heart failure, the ailment from which he ultimately died in 2016.²¹⁶
- Medical staff noted Juan Luis Boch Paniagua’s allergy to acetaminophen while he was detained at the GEO Group’s LaSalle Detention Facility in 2016 but then administered the drug to him anyway, a practice that one of our independent medical reviewers called potentially “life-threatening” in another case.²¹⁷
- The review of Pablo Ortiz-Matamoros’ death from metastatic cancer in Joe Corley Detention Center in 2013 contains evidence that licensed vocational nurses at the GEO facility were regularly conducting clinical visits and clinically assessing patients for any danger that might follow from placing them in isolation, practices outside of their scope of practice as defined by their license to practice nursing.²¹⁸
- Jorge Garcia-Maldonado and Elsa Guadalupe-Gonzalez hanged themselves within days of each other in the Eloy Detention Center in 2013. In reviews of these deaths, ICE found that “confusion as to who has the authority to call for local emergency medical assistance” led to three-minute and five-minute delays in calling 911, respectively. The reviews of their deaths indicate that Eloy Detention Center policy did allow security personnel to call 911 under CoreCivic/CCA Policy 8-1A on medical emergencies, but not before alerting others within the facility, and that security

²¹⁵ Immigration and Customs Enforcement, “Detainee Death Review Santo Carela, JICMS 201609553,” <https://www.ice.gov/doclib/foia/reports/ddr-Carela.pdf>; Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

²¹⁶ Immigration and Customs Enforcement, “Detainee Death Review --Luis Alonso Fino Martinez,” <https://www.ice.gov/doclib/foia/reports/ddr-Martinez.pdf>; Email and telephone correspondence from Dr. Marc Stern to Human Rights Watch, February 2, 2018.

²¹⁷ Immigration and Customs Enforcement, Detainee Death Review – Juan Luis Boch Paniagua,” <https://www.ice.gov/doclib/foia/reports/ddr-Boch.pdf>; Email and telephone correspondence from Dr. Palav Babaria to Human Rights Watch, February 27, 2018.

²¹⁸ Human Rights Watch, *Systemic Indifference: Dangerous and Substandard Medical Care in US Immigration Detention*, May 8, 2017, https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_o.pdf (accessed June 7, 2018).

staff believed they had no authority to call 911 without an assessment from medical staff.²¹⁹

- During the two weeks leading up to his death from a rabies infection while detained at the Brooks County Detention Center in 2013, Federico Mendez-Hernandez showed symptoms of a serious medical condition, including difficulty breathing, anxiety and loss of consciousness, but was not referred to see a doctor.²²⁰
- Two days before Welmer Alberto Garcia-Huezo collapsed without a pulse at the Rio Grande Detention Center in 2014 he put in a written request for medical care which was not triaged by a licensed vocational nurse until five days later. Our medical experts raised concerns about this delay and also noted concern that the facility used licensed vocational nurses, who are not trained to assess symptoms, to triage requests for care.²²¹
- The review conducted of Evalin Ali Mandza’s 2012 death in the GEO Group’s Denver Contract Detention Facility found that facility medical staff were unfamiliar with the institution’s Chest Pain Protocol, that appropriate cardiac medication was not administered, and that there was a delay in transporting him to a higher-level care facility, “all of which may have been contributing factors to Mr. Mandza’s death.”²²²
- The review of Mauro Rivera Romero’s death in 2011 at the El Paso Processing Center found that medical personnel failed to review information in Mr. Rivera’s medical record and should have referred Mr. Rivera to a higher-level medical care provider after documenting that he had an elevated pulse.²²³
- The review of Anibal Ramirez Ramirez’s 2011 death in the Farmville Immigration Centers of America documents allegations that non-medical facility staff interfered with medical recommendations from nurses, violating standards which require clinical decisions to be the sole province of the clinical medical authority and never made by non-clinicians. In the case of Mr. Ramirez, this involved forcing a nurse to

²¹⁹ Ibid., p. 45.

²²⁰ Ibid. p. 46.

²²¹ Immigration and Customs Enforcement, “Detainee Death Review – Welmer Alberto Garcia-Huezo JICMS #201410359,” <https://www.ice.gov/doclib/foia/reports/ddr-garciahuezo.pdf> (accessed June 8, 2018).; Human Rights Watch telephone interviews with Dr. Allen Keller, July 1-6, 2017; Human Rights Watch email and telephone correspondence with Dr. Stern, June 8, 26, 30, and July 1-6, 2017.

²²² ACLU, DWN, NIJC, “Fatal Neglect: How ICE Ignores Deaths in Detention,” February 24, 2016, p. 7-8, https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf (accessed June 7, 2018).

²²³ Ibid. pp. 20-21.

take vital signs through the slot in a solitary confinement door and ignoring her recommendation that he be transferred to emergency care based on his “perilously high” heart rate.²²⁴

²²⁴ *Ibid.* pp. 13-14.

US and International Legal Standards

Right to Reasonable Medical Care and Health

Right to Reasonable Medical Care Under US Law

The Eighth Amendment to the US Constitution protects all convicted prisoners from “cruel and unusual punishment” and requires corrections officials to provide a “safe and humane environment.”²²⁵ Prisoners have a right to health care that is not shared by the general population. As Justice Marshall explained in the Supreme Court decision, *Estelle v. Gamble*:

These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical torture or lingering death, the evils of most concern to the drafters of the Amendment.²²⁶

In *Estelle*, the Supreme Court established a narrow interpretation of the Eighth Amendment, requiring prisoners to demonstrate that officials were “deliberately indifferent to serious medical needs.”²²⁷

People held in immigration detention, however, are not convicted prisoners. Rather, they are in civil detention, held under administrative provisions. Their constitutional protection derives from the Fifth Amendment, which prohibits the imposition of punishment upon any person in the custody of the United States without due process of law.²²⁸

Few courts have considered the precise scope of the right to health care for individuals in immigration detention, as distinct from people in other civil or pretrial detention. Many federal courts adjudicating claims of inadequate medical care brought by people in pretrial and civil detention have applied the same “deliberate indifference” standard developed

²²⁵ *Estelle v. Gamble*, 429 U.S. 97 (1976).

²²⁶ *Ibid.*, p. 100.

²²⁷ *Ibid.*, p. 104.

²²⁸ *Wing Wong v. United States*, 163 U.S. 228 (1896).

under Eighth Amendment jurisprudence to these claims.²²⁹ Others have argued that a distinct, and perhaps more stringent, standard should apply.²³⁰

Right to Health Under International Law

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

The United States is a party to the International Covenant on Civil and Political Rights (ICCPR).²³¹ Under the ICCPR, governments should provide “adequate medical care during detention.”²³²

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

Not only may persons deprived of their liberty not be subjected to torture, or other cruel, inhuman or degrading treatment or punishment, including medical or scientific experimentation, but neither may they be subjected to any hardship or restraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as that of free persons. Persons deprived of their

²²⁹ See *Cuoco v. Moritsugu*, 222 F.3d 99, 106 (2nd Cir. 2000) (“We have often applied the Eighth Amendment deliberate indifference test to pre-trial detainees bringing actions under the Due Process Clause of the Fourteenth Amendment.... We see no reason why the analysis should be different under the Due Process Clause of the Fifth Amendment.”).

²³⁰ See *Cupit v. Jones*, 835 F.2d 82, 85 (5th Cir 1987) (“Today, we conclude that pretrial detainees are entitled to reasonable medical care unless the failure to supply that care is reasonably related to a legitimate governmental objective... In so holding, we recognize that the distinction as to medical care due a pretrial detainee, as opposed to a convicted inmate, may indeed be a distinction without a difference, for if a prison official acted with deliberate indifference to a convicted inmate's medical needs, that same conduct would certainly violate a pretrial detainee's constitutional rights to medical care. However, we believe it is a distinction which must be firmly and clearly established to guide district courts in their evaluation of future cases involving the constitutionality of all conditions imposed upon pretrial detainees.”).

²³¹ International Covenant on Civil and Political Rights (ICCPR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, entered into force March 23, 1976, ratified by the US on June 8, 1992, arts. 6,7, 10(1).

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

liberty enjoy all the rights set forth in the ICCPR, subject to the restrictions that are unavoidable in a closed environment.²³³

The Human Rights Committee has also urged states to specify in their reports whether individuals in detention “have access to such information and have effective legal means enabling them to ensure that those rules are respected, to complain if the rules are ignored and to obtain adequate compensation in the event of a violation.”²³⁴ The Human Rights Committee also recently recommended that the US “impose strict limits on the use of solitary confinement” and prohibit its use against juveniles and individuals with serious mental disabilities.²³⁵

The United States is also a party to the Convention Against Torture. The Committee Against Torture—the monitoring body of the Convention Against Torture—has found that failure to provide adequate medical care can violate the CAT’s prohibition of cruel, inhuman or degrading treatment.²³⁶ The Committee has also explicitly addressed the situation in the US and recommended that the United States review its use of prolonged isolation on detainees given the “effect such treatment has on their mental health, and that its purpose may be retribution, in which case it would constitute cruel, inhuman or degrading treatment or punishment.”²³⁷ As noted above, the UN Special Rapporteur on Torture has also maintained that the placement of individuals with psychosocial disabilities into solitary confinement is prohibited under the CAT.²³⁸

²³³ United Nations Committee on Human Rights, General Comment No. 21, Article 10, Humane Treatment of Prisoners Deprived of their Liberty, U.N. Doc. HRI/Gen/1/Rev.1 at 33 (1994), para. 3.

²³⁴ United Nations Human Rights Committee, “Replaces general comment 9 concerning humane treatment of persons deprived of liberty,” General Comment No. 21, U.N. Doc. A/47/40 (1992), para. 7.

²³⁵ UN Human Rights Committee, “Concluding observations on the fourth periodic report of the United States of America,” April 23, 2014, para. 20, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CCPR%2fC%2fUSA%2fCO%2f4&Lang=en.

²³⁶ United Nations Committee Against Torture, “Concluding Observations: New Zealand,” 1998, U.N. Doc. A/53/44, para. 175.

²³⁷ UN Committee against Torture, Conclusions and Recommendations of the Committee against Torture: United States of America, CAT/C/USA/CO/2, July 25, 2006, para. 16, <http://www.refworld.org/publisher,CAT,CONCOBSERVATIONS,USA,453776c60,o.html> (access June 12, 2018).

²³⁸ UN General Assembly, “Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment,” A/66/268, August 5, 2011, <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf> (accessed May 18, 2018). The UN Special Rapporteur on Torture has opined that any detention regime that exposes migrants to conditions of detention “grossly inconsistent with universally recognized standards...is incompatible with the prohibition of torture and ill-treatment.” The threshold of prohibited ill-treatment, in the view of the Special Rapporteur, “will be reached sooner with regard to migrants with an irregular status or other vulnerabilities.” Human Rights Council, Report of the Special Rapporteur on torture and other cruel,

Other standards provide non-binding, but authoritative, interpretation of fundamental human rights standards for all persons in detention. The Standard Minimum Rules for the Treatment of Prisoners, the Basic Principles for the Treatment of Prisoners and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment articulate a consensus that individuals in detention are entitled to a standard of medical care equivalent to that available in the general community, without discrimination based on their legal status.²³⁹ International standards support the confinement of individuals in administrative and pre-trial detention in non-punitive conditions.²⁴⁰ The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment further provides that a proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary.²⁴¹

In its Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention, UNHCR (the UN's refugee agency), states that appropriate medical treatment must be provided where needed, including psychological counselling. Detained individuals needing medical attention should be transferred to appropriate facilities or treated on site where such facilities exist.²⁴²

In some cases, state obligations to protect prisoners' fundamental rights, in particular the rights to be free from ill-treatment, the right to health, and ultimately the right to life, may require states to ensure a higher standard of care than is available to people outside prison who are not wholly dependent upon the state for protection of those rights.²⁴³ In prison, where most material conditions of incarceration are directly attributable to the

inhuman or degrading treatment or punishment, Advance Unedited Version, A/HRC/37/50, February 26, 2018, para. 20, https://www.ohchr.org/Documents/Issues/Torture/A_HRC_37_50_EN.pdf (accessed June 12, 2018).

²³⁹ United Nations Standard Minimum Rules for the Treatment of Prisoners, United Nations General Assembly Resolution 70/175 (2015); "Basic Principles for the Treatment of Prisoners," United Nations General Assembly Resolution 45/111 (1990); "Body of Principles for the Protection of All Persons Under any form of Detention or Imprisonment," United Nations General Assembly Resolution 43/173 (1988).

²⁴⁰ UN "Standard Minimum Rules," supra note 215, para.8.

²⁴¹ UN "Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment," supra, principle 24.

²⁴² United Nations High Commissioner for Refugees (UNHCR), UNHCR Detention Guidelines, "Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention," 2012, para. 48.

²⁴³ See, Rick Lines, "From Equivalence of Standards to Equivalence of Objectives: The Entitlement of Prisoners to Standards of Health Higher than those Outside Prisons," *International Journal of Prisoner Health*, vol. 2 (2006), p. 269.

state, and inmates have been deprived of their liberty and means of self-protection, the requirement to protect individuals from risk of torture or ill treatment can give rise to a positive duty of care, which has been interpreted to include effective methods of screening, prevention and treatment of life-threatening diseases.²⁴⁴

The right to health is most explicitly expressed in the International Covenant on Economic, Social and Cultural Rights (ICESCR) which states that every person has a “right to the highest attainable standard of health.”²⁴⁵ The United States has signed, but not ratified, the ICESCR; its provisions remain a useful and authoritative guide to the steps the US government should take to protect and realize the right to health, among others.²⁴⁶

Rights of Persons with Psychosocial Disabilities

The Convention on the Rights of Persons with Disabilities (CRPD) seeks to “promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities.”²⁴⁷ The UN Special Rapporteur on Torture has pointed out that persons with disabilities are often segregated from society in prisons as well as in other institutions. Inside these institutions, persons with disabilities “are frequently subjected to unspeakable indignities, neglect, severe forms of restraint and seclusion, as well as physical, mental and sexual violence.”²⁴⁸ The United States has signed but not ratified the CRPD. The Convention is nonetheless a useful and authoritative guide to steps the US government should take to protect and respect the rights of people with disabilities.

Further, the authorities should ensure protection of the person’s integrity, including mental health. Without due regard to their condition, some of the rules of detention

²⁴⁴ See, e.g., European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), CPT Standards, CPT/IN/E, 2002, para. 31.

²⁴⁵ International Covenant on Economic, Social, and Cultural Rights (ICESCR), adopted December 16, 1966, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 49, U.N. Doc. A/6316 (1966), 993 U.N.T.S. 3, entered into force January 3, 1976, *supra*, Article 12.

²⁴⁶ Vienna Convention on the Law of Treaties (VCLT), adopted May 23, 1969, entered into force January 27, 1980, Article 18. The US signed the ICESCR on October 5, 1977.

²⁴⁷ Convention on the Rights of Persons with Disabilities (CRPD), adopted January 24, 2007, G.A. Res. 61/106, U.N. Doc. A/61/106 (2007), entered into force May 3, 2008, signed by the United States on July 30, 2009. The US has not yet ratified the convention, but as a signatory, may not take actions inconsistent with it.

²⁴⁸ UN General Assembly, “Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Note by the Secretary-General,” A/63/175, July 28, 2008, <http://www.refworld.org/docid/48db99e82.html> (accessed September 27, 2016).

centers could be unreasonably harsh if applied to people with mental health conditions and may constitute ill-treatment, or even torture. Isolation should be prohibited for persons with disabilities because of its potential harm to their health.

Limits on the Use of Detention for the Control of Immigration

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

Article 9 of the International Covenant on Civil and Political Rights states, "Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law."²⁴⁹ With regard to immigration, the Human Rights Committee has noted that "detention must be justified as reasonable, necessary and proportionate in the light of the circumstances and reassessed as it extends in time."²⁵⁰ The United Nations Working Group on Arbitrary Detention has argued that "immigration detention should gradually be abolished.... If there has to be administrative detention, the principle of proportionality requires it to be a last resort."²⁵¹

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

The Human Rights Committee has noted with regard to medical care, "Decisions regarding the detention of migrants must also take into account the effect of the detention on their physical or mental health."²⁵² The US detention system regularly detains individuals with serious medical and mental health conditions, sometimes for prolonged periods of time, in

²⁴⁹ ICCPR, *supra* note 209, Art. 9.

²⁵⁰ UN Human Rights Committee, General Comment No. 35, Article 9 (Liberty and Security of Person), CCPR/C/GC/35 (2014), para. 18.

²⁵¹ UN Commission on Human Rights, Report of the Working Group on Arbitrary Detention, A/HRC/13/30, January 18, 2010, para. 59.

²⁵² UN Human Rights Committee, General Comment No. 35, Article 9 (Liberty and Security of Person), para. 18.

facilities ill-equipped to provide appropriate care, without sufficient consideration of the impact of detention on these individuals' health, leading to sometimes fatal consequences.

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This report is dedicated to the families who have lost loved ones in immigration detention in the hope that additional families can be spared their pain.



Appendix: Deaths in Immigration Detention March 2010 – May 2018

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
1	Ernesto Gomez-Vasquez	M	30	Guatemala	3/5/2010	Mira Loma Detention Center, CA	No	N/a	N/a
2	Evelyn Obey	F	36	Liberia	3/12/2010	York County Prison, PA	No	N/a	N/a
3	Arnulfo Rodriguez-Solis	M	62	Guatemala	3/13/2010	Oakdale Federal Detention Center, LA	No	N/a	N/a
4	Julian Cogle-Del Pino	M	72	Cuba	5/7/2010	Butner Federal Correctional Institute, NC	No	N/a	N/a
5	Kazimierz Holowienko	M	54	Poland	6/16/2010	Columbia Care Center, SC	Yes	Undetermined	Undetermined
6	Jose Nelson Reyes-Zalaya	M	28	El Salvador	7/17/2010	Orleans Parish Prison, LA	No	N/a	N/a
7	Jose Antonio Hernandez-Gomez	M	66	Mexico	11/5/2010	Broadview Service Staging, IL	Yes	Undetermined	Undetermined

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
8	John Sterling	M	54	Jamaica	11/6/2010	Oakdale Federal Detention Center, LA	Yes	Undetermined	Undetermined
9	Jose Manuel Segundo	M	41	Panama	12/23/2010	Krome North Service Processing Center, FL	Yes	Undetermined	Undetermined
10	Juan Palomo-Rodriguez	M	30	Mexico	1/13/2011	Houston Contract Detention Facility, TX	Yes	Undetermined	Undetermined
11	Jose Aguilar-Espinoza	M	55	Honduras	1/31/2011	Theo Lacy Facility, CA	Yes	Undetermined	Undetermined
12	Qi Gen Guo	M	47	China	2/23/2011	Clinton County Correctional Facility, PA	Yes	Undetermined	Undetermined
13	Amra Militec	F	47	Bosnia	3/20/2011	Weber County Jail, UT	Yes	Yes	Yes
14	Miguel Angel Hernandez	M	54	El Salvador	4/28/2011	North Georgia Detention Center, GA	Yes	No	Undetermined
15	Irene Bamenga	F	29	Angola	7/27/2011	Albany County Jail, NY	Yes	Yes	Yes
16	Victor Ramirez-Reyes	M	56	Ecuador	9/26/2011	Elizabeth Contract Detention Facility, NJ	Yes	Yes	Yes
17	Anibal Ramirez-Ramirez	M	35	El Salvador	10/2/2011	Immigration Centers of America Farmville, VA	Yes	Yes	Yes

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
18	Mauro Rivera-Romero	M	43	El Salvador	10/5/2011	El Paso County Criminal Justice Center, CO	Yes	Yes	Yes
19	Pablo Gracida-Conte	M	54	Mexico	10/30/2011	Eloy Federal Contract Facility, AZ	Yes	Yes	Yes
20	Ricardo Rojas-Martinez	M	53	Mexico	12/19/2011	Houston Contract Detention Facility, TX	Yes	Undetermined	Undetermined
21	Miguel Angel Sarabia-Ortega	M	36	Mexico	1/17/2012	Las Vegas Hold Room, NV	Yes	Undetermined	Undetermined
22	Fernando Dominguez-Valivia	M	58	Mexico	3/4/2012	Adelanto Correctional Facility, CA	Yes	Yes	Yes
23	Evalin-Ali Mandza	M	46	Gabon	4/12/2012	Denver Contract Detention Facility, CO	Yes	Yes	Yes
24	Juan Pablo Flores-Segura	M	32	Mexico	5/30/2012	Adelanto ICE Processing Center, CA	Yes	No	Yes
25	Manuel Cota-Domingo	M	34	Guatemala	12/23/2012	Eloy Federal Contract Facility, AZ	Yes	Yes	Yes
26	Pablo Ortiz-Matamoros	M	25	Honduras	2/8/2013	Joe Corley Detention Facility, TX	Yes	No	Yes
27	Glaston Smith	M	41	British Virgin Islands	4/4/2013	Guaynabo Metropolitan Detention Center, PR	No	N/a	N/a
28	Oldrich Tomanek	M	51	Czech Republic	4/25/2013	Rolling Plains Detention Center, TX	No	N/a	N/a

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
29	Elsa Guadalupe-Gonzales	F	24	Guatemala	4/28/2013	Eloy Federal Contract Facility, AZ	Yes	No	Yes
30	Jorge Garcia-Maldonado	M	40	Guatemala	4/30/2013	Eloy Federal Contract Facility, AZ	Yes	No	Yes
31	Federico Mendez-Hernandez	M	28	Guatemala	6/11/2013	Brooks County Detention Center, TX	Yes	No	Yes
32	Leslis Rodriguez	M	50	Honduras	7/31/2013	Port Isabel Detention Center, TX	Yes	Yes	Yes
33	Clemente Ntangola Mponda	M	27	Mozambique	9/2/2013	Houston Contract Detention Facility, TX	Yes	No ²⁵³	Yes
34	Tiombe Kimana Carlos	F	34	Antigua-Barbuda	10/23/2013	York County Prison, PA	Yes	Yes	Yes
35	Marjorie Annmarie Bell	F	48	Jamaica	2/13/2014	Otay Mesa Detention Center, CA	Yes	Yes	Yes
36	Peter George Carlisle Rockwell	M	46	Canada	2/22/2014	Houston Contract Detention Facility, TX	Yes	Yes	Yes
37	Jose Javier Hernandez Valencia	M	44	Mexico	4/12/2014	Houston Contract Detention Facility, TX	Yes	No	Yes
38	Santiago Sierra-Sanchez	M	38	Mexico	7/12/2014	Utah County Jail, UT	Yes	Yes	Yes

²⁵³ Medical experts concluded, however, that inadequate mental health care and the use of isolation may have significantly exacerbated Mr. Mponda's mental health problems.

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
39	Welmer Alberto Garcia-Huezo	M	24	El Salvador	8/3/2014	Rio Grande Detention Center, TX	Yes	No	Yes
40	Jorge Alberto Umana-Martinez	M	47	El Salvador	10/30/2014	South Texas Detention Complex, TX	Yes	No	No
41	Raul Ernesto Morales Ramos	M	44	El Salvador	4/6/2015	Adelanto Correctional Facility, CA	Yes	Yes	Yes
42	Carlos Funez Ochoa	M	30	Honduras	4/23/2015	Port Isabel Detention Center, TX	No	N/a	N/a
43	Jose de Jesus Deniz-Sahagun	M	31	Mexico	5/20/2015	Eloy Federal Contract Facility, AZ	Yes	No ²⁵⁴	Yes
44	Marcos, Navarrette-Quontana	M	37	Mexico	6/18/2015	El Paso County Criminal Justice Center, CO	Yes	No	Yes
45	Nho Thi Nguyen	F	61	Vietnam	7/2/2015	Houston Contract Detention Facility, TX	No	N/a	N/a
46	Juan Garcia-Hernandez	M	39	Mexico	9/14/2015	Florence Servicing Processing Center, AZ	No	N/a	N/a
47	Jose Manuel Azurdia Hernandez	M	54	Guatemala	12/23/2015	Adelanto Correctional Facility, CA	Yes	Yes	Yes
48	Saul Enrique Banegas-Guzman	M	46	Honduras	1/22/2016	Jena/LaSalle Detention Facility, LA	Yes	No	No

²⁵⁴ Medical experts concluded, however, that inadequate mental health care and the use of isolation may have significantly exacerbated Mr. Deniz's mental health problems.

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
49	Thongchay Saengsiri	M	65	Laos	3/17/2016	Jena/LaSalle Detention Facility, LA	Yes	Yes	Yes
50	Rafael Barcnas Padilla	M	50	Mexico	4/7/2016	Otero County Processing Center, NM	Yes	Yes	Yes
51	José Leonardo Lemus Rajo	M	23	El Salvador	4/28/2016	Krome Detention Center, FL	Yes	Yes	Yes
52	Igor Zyazin	M	46	Russia	5/1/2016	Otay Mesa Detention Center, CA	Yes	Yes	Yes
53	Juan Luis Boch-Paniagua	M	36	Guatemala	6/1/2016	Jena/LaSalle Detention Facility, LA	Yes	No	Yes
54	Luis Alonso Fino Martinez	M	54	Honduras	6/13/2016	Essex County Correctional Facility, NJ	Yes	No	Yes
55	Santo Carela	M	60	Dominican Republic	7/28/2016	Orange County Jail, NY	Yes	No	Yes
56	Moises Tino-Lopez	M	23	Guatemala	9/27/2016	Hall County Department of Corrections, NE	Yes	Yes	Yes
57	Olubunmi Toyin Joshua	F	54	United Kingdom	10/24/2016	Rolling Plains Detention Center, TX	Yes	Yes	Yes
58	Wenceslau Esmerio Campos	M	49	Brazil	11/25/2016	South Texas Detention Complex, TX	Yes	Yes	Yes
59	Raquel Calderon de Hildago	F	36	Guatemala	11/27/2016	Eloy Federal Contract Facility, AZ	Yes	No	Yes
60	Roger Rayson	M	47	Jamaica	3/13/2017	Jena/LaSalle Detention Facility, LA	No	N/a	N/a

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
61	Osmar Epifanio Gonzalez-Gadba	M	32	Nicaragua	3/28/2017	Adelanto Correctional Facility, CA	Yes	No ²⁵⁵	Yes
62	Sergio Alonso Lopez	M	55	Mexico	4/13/2017	Adelanto Correctional Facility, CA	Yes	No	Yes
63	Jean Carlos Alfonso Jimenez-Joseph	M	27	Panama	5/15/2017	Stewart Detention Center, GA	No	N/a	N/a
64	Atulkumar Babubhai Patel	M	58	India	5/16/2017	Atlanta City Detention Center, GA	No	N/a	N/a
65	Vicente Caceres-Maradiaga	M	46	Honduras	5/31/2017	Adelanto Correctional Facility, CA	No	N/a	N/a
66	Rolando Mesa-Espinoza (Identified by ICE as Carlos Mejia-Bonilla)	M	44	El Salvador	6/12/2017	Hudson County Correctional Facility, NJ	No	N/a	N/a
67	Osvadis Montesino-Cabrera	M	37	Cuba	9/1/2017	Krome North Service Processing Center, FL	Yes	Undetermined	Undetermined
68	Kamyar Samimi	M	64	Iran	9/17/17	Denver Contract Detention Facility, CO	No	N/a	N/a
69	Felipe Almazan-Ruiz	M	51	Mexico	9/17/2017	IAH Secure Adult Detention Center, TX	No	N/a	N/a

²⁵⁵ Medical experts concluded, however, that inadequate mental health care and the use of isolation may have significantly exacerbated Mr. Gonzalez's mental health problems.

	Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee Death Review published	Poor Care Contributed or Led to Death, per Medical Experts	Dangerous Practices or Serious Violations of Detention Standards Documented in Review
70	Yulio Castro-Garrido	M	33	Cuba	1/18/18	Stewart Detention Center, GA	No	N/a	N/a
71	Luis Ramirez-Marcano	M	59	Cuba	2/19/18	Krome Detention Center, FL	No	N/a	N/a
72	Gourgen Mirimanian	M	54	Armenia	4/10/18	Prairieland Detention Center, TX	No	N/a	N/a
73	Ronal Francisco Romero (Identified by ICE as Ronald Cruz)	M	39	Honduras	5/21/18	Port Isabel Detention Center, TX	No	N/a	N/a
74	Roxana Hernandez (Identified by ICE as Jeffrey Hernandez)	F	33	Honduras	5/25/18	Cibola County Correctional Center, NM	No	N/a	N/a

CODE RED

The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention

A dozen people died in immigration detention in fiscal year 2017, more than any year since 2009. *Code Red*, a joint effort of four organizations that have long worked to advance the rights of detained immigrants, is the third report in three years showing that significant numbers of deaths in immigration detention are linked to dangerously inadequate medical care.

Code Red examines 15 recent deaths in depth, scrutinizing the reports of government investigations known as Detainee Death Reviews of deaths in immigration detention that occurred between December 2015 and April 2017. At least two independent physicians with expertise in correctional health separately reviewed each file for us and agreed that substandard medical care contributed or led to eight of the 15 deaths.

The Trump administration has asked Congress to allocate \$2.8 billion for FY2019 for immigration detention, and has proposed to lock up a daily average of 52,000 immigrants in such facilities, a record number representing a nearly 30 percent expansion over the previous year. This expansion means that more people, the majority of whom the government itself says pose “no threat,” are being needlessly put at risk in immigration detention.

Congress should immediately act to curtail the abuses. It should press ICE to decrease rather than expand detention; demand that all types of immigration detention facilities meet robust health, safety, and human rights standards; and exercise strong oversight through frequent information requests, hearings, and investigations. States and localities should refuse to assist federal efforts to expand detention in their jurisdictions, monitor and expose detention abuses, and hold ICE, facilities and healthcare providers accountable for abuses or substandard care.



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