CODE RED

The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention

HUMAN RIGHTS WATCH

ACLU

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Detention Watch Network (DWN) is a national coalition of organizations and individuals working to expose and challenge the injustices of the United States' immigration detention and deportation system and advocate for profound change that promotes the rights and dignity of all persons. Founded in 1997 by immigrant rights groups, DWN brings together advocates to unify strategy and build partnerships on a local and national level to end immigration detention. For more information, please visit our website: http://www.detentionwatchnetwork.org

The National Immigrant Justice Center (NIJC) is a nongovernmental organization dedicated to ensuring human rights protections and access to justice for all immigrants, refugees, and asylum seekers through a unique combination of direct services, policy reform, impact litigation and public education. For more information, please visit our website: http://www.immigrantjustice.org

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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

To the US Congress:

1. Immediately reduce the number of people who are needlessly held in immigration detention and ensure accountability for abuses by

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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.

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

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.

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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,

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[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-deaths-detention

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

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]

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 unwillngness 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]

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

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 co

"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 undiagnosed 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]

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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.

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

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, 23 — 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 fortatCld the roul-1.66(om)-oSr-5.5<nfor c.5(and Cus5(adic-oSunusuaeadic

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."

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 OMDC, 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 attemp2.0007 [n7E8 1 TfrT*

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

"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.g

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]

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,

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 attack6.1vicswi t0

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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 facilty 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

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[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.

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.

- 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

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[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/ZuLyxfRD70EUvOOL86q7IK/ (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.

- Atlkumar 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.

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[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#.gx3P20Xg1.

[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,

- 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

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[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

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/detaineedeaths-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-

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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 nusing 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 Azurdia 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. Azurdia 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 Azurdia Hernandez, JICMS 2016041," https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.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_0.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

- € 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 inflamation 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.

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[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

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 puni

documented that he appeared psychotic and delusional.[199] Subsequently, the facility doctor ordered that Mr. Gonzalez be transported to the Alvarado Parkaway Institute (API), a

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'

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

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

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[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, , May 8, 2017, https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_0.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

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.

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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

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[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.

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

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]

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This report was written and researched by Clara Long, senior US researcher at Human Rights Watch (HRW). Some sections were drafted by Tara Tidwell Cullen, director of communications at the National Immigrant Justice Center (NIJC); Thomas Rachko, US program associate at HRW; and Rie Ohta, US intern at HRW.The report was reviewed and edited by Tara Tidwell Cullen; Heidi Altman, NIJC policy director; Silky Shah, executive director of the Detention Watch Network (DWN); Mary Small, DWN policy director; David Fathi, director of the National Prison Project of the American Civil Liberties Union; Victoria Lopez, senior staff attorney at the National Prison Project of the American Civil Liberties Union; Michael Tan, ACLU senior staff attorney; and Madhuri Grewal, federal immigration policy counsel. Katherine Montanez Montes, DWN policy associate, provided analysis and support.

At Human Rights Watch, the report was reviewed and edited by Alison Parker, US Program managing director; Chris Albin-Lackey, senior legal advisor; Joe Saunders, deputy program director; Megan McLemore, senior health and human rights researcher; Shantha Rau Barriga, disability rights director; and Amanda Klasing, senior women's rights researcher. Thomas Rachko, US associate, contributed to editing. Fitzroy Hepkins, administrative manager, Jose Martinez, administrative senior coordinator.

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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.

2010 2018

Name	Gender	

Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Detainee

Name	Gender	Age at Death	Country ofy

	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

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	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 Barcenas 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
		M	36	Guatemala	6/1/2016	Jena/LaSalle Detention Facility, LA	Yes	No	Yes
		M	54	Honduras	6/13/2016	Essex County Correctional Facility, NJ	Yes	No	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
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 æ 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 us3e 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

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