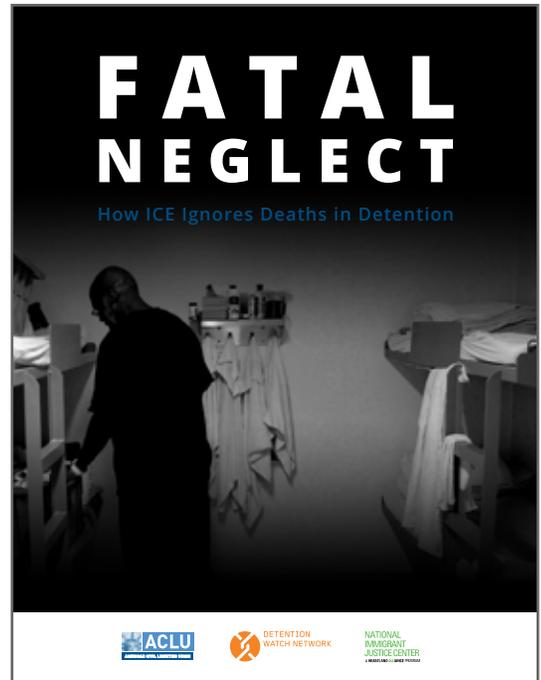


# Executive summary

The Obama administration announced immigration detention reforms in 2009, primarily in response to sustained criticism over medical neglect and unnecessary deaths of immigrants in detention. This report analyzes government death reviews and inspection documents, which show that problems persist, inadequate medical care continues to contribute to the death of immigrants in federal immigration custody and U.S. Immigration and Customs Enforcement's (ICE) ineffective inspection process has not improved the quality of medical care.

Egregious violations of ICE medical care standards played a prominent role in eight in-custody deaths from 2010 to 2012. *Fatal Neglect: How ICE Ignores Deaths in Detention*, a report jointly produced by the American Civil Liberties Union (ACLU), Detention Watch Network (DWN), and National Immigrant Justice Center (NIJC), examines these deaths and the agency's response to them. Our research shows that even though ICE conducted reviews that identified violations of medical standards as contributing factors in these deaths, routine ICE detention facility inspections before and after the deaths failed to acknowledge—or at times dismissed—these violations. Instead of forcing changes in culture, systems, and processes that could reduce future deaths, ICE's deficient inspections system essentially swept the agency's own death review findings under the rug.

In the case of Pablo Gracida-Conte, who was detained at Arizona's Eloy Detention Center, ICE's death review concluded that his death "might have been prevented" if he had received "the appropriate medical treatment in a timely manner." The ICE death review also found that Eloy had been operating without a clinical director for years, the medical clinic was understaffed, and Eloy's doctor reported that she "badly needs help." Nevertheless, routine ICE inspections both before and after Mr. Gracida's death concluded that medical staffing was adequate. Indeed, an inspection after Mr. Gracida's death claimed that his was the first "to ever occur" at Eloy when, in fact, it was the facility's 10th death.<sup>1</sup> The findings in *Fatal Neglect: How ICE Ignores Deaths in Detention* underscore how ICE's deficient inspections system, first exposed by DWN and NIJC in the October 2015 report *Lives in Peril*, exacts a tragic human toll.<sup>2</sup>



## Detention Deaths

- **Fernando Dominguez-Valdivia**  
*Adelanto Detention Facility (CA)*
- **Irene Bamenga**  
*Albany County Corrections Facility (NY)*
- **Evalin-Ali Mandza**  
*Denver Contract Detention Facility (CO)*
- **Mauro Rivera Romero**  
*El Paso Processing Center (TX)*
- **Victor Ramirez-Reyes**  
*Elizabeth Detention Center (NJ)*
- **Pablo Gracida-Conte**  
*Eloy Detention Facility (AZ)*
- **Anibal Ramirez-Ramirez**  
*Immigration Centers of America – Farmville (VA)*
- **Amra Miletic**  
*Weber County Correctional Facility (UT)*



# Key findings

This report focuses on the eight deaths for which ICE death reviews identified non-compliance with its own medical standards as contributing causes of death; ICE identified four of these deaths as preventable. Overall, the ICE documents reveal a failure to:

- 1. Meet health care needs in a timely manner**
- 2. Refer individuals to higher-level medical care providers, including transfer to external services such as emergency services**
- 3. Provide adequate levels of medical staff**
- 4. Communicate critically important information about individuals' medical conditions among staff, especially during transfers**
- 5. Adequately screen individuals for illnesses**
- 6. Proactively identify and rectify concerns about medical care during facility inspections**

ICE's routine facility inspections before and after the deaths should have detected the same gaps and flawed protocols. Instead, for all but one of the eight deaths, ICE inspectors gave facilities passing ratings prior to and following the deaths we examined.

Overall, the systems and the individuals responsible for providing health care failed these eight individuals, and may have cost them their lives.

# Recommendations

The ACLU, DWN, and NIJC call on the Department of Homeland Security (DHS) and ICE to immediately:

- 1. Immediately reduce immigration detention.**
  - a. Release people with serious medical and mental health needs, particularly when individuals require higher-level care.
  - b. Immediately terminate contracts for facilities with repeated preventable deaths, such as the Eloy Detention Center in Arizona.
  - c. Shift current funding for detention to community-based alternatives, which will allow people to seek medical attention and receive support from family, legal counsel, and community.
  - d. Apply current ICE detention standards to all facilities used by ICE and discontinue contracts where current standards are not being met.
- 2. Improve delivery of medical care in detention**
  - a. Revise Performance-Based National Detention Standards (PBNDS 2011) to require that medical care providers be held responsible for meeting the health care needs of individuals in ICE custody as opposed to simply providing "access" to health care.
  - b. Revise PBNDS 2011 medical care standards to meet or exceed all analogous National Commission on Correctional Health Care standards for prison and jail health care.



- c. End the use of private for-profit detention facilities and for-profit medical care sub-contractors. Instead, ensure that ICE Health Service Corp (IHSC) is the direct health care provider at all immigration detention facilities.
- d. Remove IHSC from ICE supervision to maintain clinical independence and independent oversight.
- e. Ensure all detention facilities have appropriate clinical staffing plans, and include whether or not positions are filled as a compliance component during facility inspections.

### 3. Ensure inspections provide meaningful oversight

- a. Improve the inspections process by ensuring that inspections are more effectively used to hold facilities accountable, as set forth in the appendix.
- b. Require ICE inspectors to read the death review documents for all deaths that have occurred at a given facility under inspection, and report on whether the issues raised in the death reviews have been addressed.
- c. In response to each death where an ICE death review identifies violations of ICE standards, concludes the death was preventable, or identifies other areas of concern, require ICE and IHSC to develop a corrective action plan with clear deadlines to reduce the risk of future deaths or other significant events, and to provide those corrective action plans to all offices conducting inspections and death reviews.

### 4. Increase transparency of inspections, deaths, and serious medical incidents in detention

- a. Make the inspections process more transparent by making facility inspections and death reviews available to the public within three months of being finalized, and by providing regular public and congressional reporting on the frequency and circumstances of sentinel events (as defined by the Joint Commission<sup>3</sup>) in detention.
- b. Require ICE to publish all death reviews that occur, including by the DHS Office of Inspector General and Office for Civil Rights and Civil Liberties.
- c. Create an independent medical advisory committee to investigate deaths that occur in detention.

## Endnotes

1. 2012 Eloy ODO Inspection, available at: <https://www.documentcloud.org/documents/2644422-Eloy.html#document/p3/a266239>.
2. Detention Watch Network and National Immigrant Justice Center, *Lives in Peril: How Ineffective Inspections Make ICE Complicit in Immigration Detention Abuse*, Oct. 2015, available at: <http://immigrantjustice.org/sites/immigrantjustice.org/files/THR-Inspections-FOIA-Report-October-2015-FINAL.pdf> [hereinafter “*Lives in Peril*”].
3. See The Joint Commission, Sentinel Events Policy, available at: [http://www.jointcommission.org/assets/1/6/CAMH\\_24\\_SE\\_all\\_CURRENT.pdf](http://www.jointcommission.org/assets/1/6/CAMH_24_SE_all_CURRENT.pdf) (defining a sentinel event as a patient safety event, not primarily related to the natural course of the patient’s illness or underlying condition, that reaches a patient and results in death, permanent harm, severe temporary harm, or certain other specified harms).

