



ACLU, AMERICAN OVERSIGHT, AND PHR RESEARCH REPORT

Deadly Failures

Preventable Deaths in U.S. Immigration Detention

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Physicians for
Human Rights

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Physicians for
Human Rights

Acknowledgements

This report is dedicated to the memory of people who have perished after enduring immigration detention.

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Executive Summary

Since January 1, 2017, Immigration and Customs Enforcement (ICE) has reported that 70 people have died in its custody. This number does not include detained people who ICE released immediately prior to their deaths, which ICE has admitted reduces the number of reported deaths, and allows the agency to avoid accountability requirements.¹ These deaths raise serious concern about continued, systemic problems with medical and mental health care provided in immigration detention facilities, and

between January 1, 2017 and December 31, 2021. Our analysis is based on a review of over 14,500 pages of documents obtained from the Department of Homeland Security (DHS) and ICE through Freedom of Information Act (FOIA) requests; from local government agencies through state public record act requests; and from civil litigation. Report analysis also incorporates the review of ICE's own investigatory reports into deaths in custody by independent medical experts, as well as interviews with two family members of people who died in ICE detention during the studied period.

Deadly Failures exposes the ways in which the Department of Homeland Security's (DHS) internal oversight mechanisms have failed to conduct rigorous investigations, impose meaningful consequences, or improve conditions that cause immigrants to die in ICE detention. Based on independent medical expert reviews of deaths, the report further examines the ways in which systemic failures in medical and mental health care in ICE detention have caused otherwise preventable deaths.

Summary of Findings

Key findings from our study include:

ICE's current oversight and accountability mechanisms regarding death in detention are critically flawed and do little to prevent future deaths.

- **ICE's detention death investigations have allowed the destruction of evidence, have**

ICE currently detains, on average, approximately 38,000 people each day in a network of approximately 130 detention facilities nationwide.

the absence of accountability or consequences faced by facilities where detained people have died. ICE currently detains, on average, approximately 38,000 people each day in a network of approximately 130 detention facilities nationwide.² Congress, however, recently increased ICE's budget to detain 41,500 people on a daily basis for FY 2024, at a cost of \$3.4 billion.³

This report, a joint project of the American Civil Liberties Union (ACLU), Physicians for Human Rights (PHR), and American Oversight, provides a comprehensive examination of the deaths of 52 people whom ICE reported to have died in its custody

failed to interview key witnesses, and have omitted key inculpatory facts.

- In at least two different cases, ICE released key detained eyewitnesses from custody immediately before investigators could speak to them, and investigators did not further attempt to make contact with these eyewitnesses. For example, ICE released detained eyewitnesses from custody mere hours before—and even during—investigator facility visits regarding the deaths of **Ben Owen** and **Efrain de la Rosa**.
- In at least two cases, ICE allowed detention facilities to destroy or overwrite video evidence critical to its investigations into detention deaths. Detention facilities destroyed video evidence highly relevant to investigations into the deaths of **Roxsana Hernandez** and **Gourgen Mirimanian**.
- ICE’s investigatory reports omit critical facts that may embarrass, or suggest fault by, detention facilities or ICE in cases of detainee death. For example, *ICE investigatory reports failed to disclose that internal oversight staff had ignored reports of dangerous conditions in the death of Efrain de la Rosa*. ICE investigators also chose to omit evidence that the Kay County Detention Center failed to accurately translate **Maria Celeste Ochoa de Yoc**’s requests for medical attention. Because Kay County staff did not speak Spanish, they interpreted Ochoa’s statement that “she felt like she was dying” as suicidal ideation, placing her in solitary confinement under suicide watch, instead of providing her proper treatment for liver failure. Ochoa died soon after.
- **ICE lacks standardized criteria for autopsies and autopsy reports in cases of detention deaths, leading to inconsistent and potentially unreliable results.**
- **DHS and ICE investigations into detention deaths exclude analysis of key structural**

factors that have led to the deaths of detained people, and fail to require systemic changes that would prevent future deaths in custody.

- Detention death investigations typically focus on and assign blame to the lowest-level employees involved, but fail to address facility-wide policies and practices, and do not consider those who have the most authority to address these factors. Investigators also frequently fail to make recommendations for policy changes that would prevent similar deaths in the future.
- **ICE’s oversight process has failed to result in meaningful consequences for detention facilities, including those whose conditions have caused the greatest number of deaths.**
 - Although Congress has legislated that ICE cannot expend funds on detention facilities that have failed two consecutive agency inspections, ICE has not terminated any detention contract and no facility has failed an ICE inspection in the period covered by this report, even where ICE’s death reviews have found multiple violations of detention standards.
 - To the authors’ knowledge, ICE has issued financial penalties against detention facilities on only three occasions out of the 70 deaths that have taken place between 2017 and June 2024, the date of this report’s publication. These financial penalties, however, had little impact on contractors’ bottom line, as ICE soon after *expanded* the scope of its detention contacts at the facilities in question.

Systemic failures in medical and mental health care have caused preventable deaths in ICE detention.

- **The overwhelming majority of deaths likely could have been prevented if ICE had provided clinically appropriate medical care.** Medical experts concluded that of the 52 deaths reported by ICE between January 1,

2017 and December 31, 2021, that 49 deaths (95 percent) were preventable or possibly preventable if appropriate medical care had been provided. Only three deaths were deemed not preventable.

- Medical experts considered a death to be preventable where the person's life could have been saved or the outcome could have been different with appropriate medical care; a death was considered possibly preventable where there was a reasonable possibility that the person's life could have been saved or the outcome could have been different with appropriate medical care.
- **ICE detention medical staff made incorrect or incomplete diagnoses in the overwhelming majority of cases of death.** In 88 percent of the 52 death cases reviewed, ICE detention medical staff made incorrect, inappropriate, or incomplete diagnoses. For example:
 - **Jesse Jerome Dean, Jr.** died in ICE custody from an undiagnosed gastrointestinal hemorrhage after his detention at the Calhoun County Jail in Michigan. Although Dean was unable to eat, lost almost 20 pounds in three weeks, and suffered from severe nausea, the detention facility's medical staff never even referred Dean to be seen by a physician. The night before Dean's death, medical staff moved him to the medical observation unit after he had collapsed to the floor. But no one checked on him that night: surveillance footage showed that "for at least 2 hours and 45 minutes throughout her shift, [the nurse] was reclining in the nursing station chair with her feet propped up, texting on her cell phone."⁴
 - **Emigdio Abel Reyes Clemente** died of undiagnosed and untreated bacterial pneumonia, after the detention facility medical staff assumed, without testing, that he had influenza. The detention facility never prescribed antibiotics, provided oxygen,

or took a chest x-ray. Two days later, Reyes Clemente died in a medical isolation cell.

- **ICE detention medical staff provided incomplete, inappropriate, or delayed treatment and medication.** In 79 percent of the 52 death cases reviewed, ICE detention medical staff provided treatment that did not meet evidence-based medical standards, was inadequate to resolve the medical issue, or was unreasonably delayed. Medical staff also failed to appropriately manage necessary medication, and prescribed contraindicated medications. For example:
 - **Carlos Mejia-Bonilla** struggled to receive his prescribed medication for cirrhosis while detained at the Hudson County Department of Corrections and Rehabilitation in New Jersey. Ultimately, the facility's careless approach to medication management may have proved fatal. Mejia-Bonilla died of gastrointestinal bleeding four days after the detention facility prescribed him with naproxen, which is contraindicated for patients with cirrhosis.
 - **Wilfredo Padron** died of a heart attack at the Monroe County Detention Center in Florida after detention facility medical staff failed on multiple occasions to conduct an EKG test or refer him to a doctor when he complained of radiating chest pain and elevated blood pressure.
 - Medical staff at the Aurora Detention Center in Colorado discontinued medication assisted treatment for opioid use disorder that **Kamyar Samimi** had been prescribed and had used for over two decades, putting him into withdrawal. Samimi deteriorated rapidly, experiencing nausea, repeated vomiting to the point of vomiting blood, and seizures, until he passed away sixteen days later.
- **ICE detention facilities failed to provide timely and appropriate emergency care.**

In 40 percent of the 52 death cases reviewed, ICE detention facilities failed to provide timely emergency health care or operable emergency equipment.

- **Henry Missick (a/k/a Anthony Alexander Jones)** died alone of a heart attack at the Adams County Detention Center in Mississippi, after medical staff failed to check on him in the medical unit waiting room. Medical staff did not discover him until 45 minutes after his heart attack and waited another 10 minutes before they initiated CPR. An ambulance did not arrive until 42 minutes after first being called.
- After staff discovered that **Nebane Abienwi** had suffered a stroke at the Otay Mesa Detention Center, it took 50 more minutes for emergency medical services to arrive and provide the required higher-level care, because the on-call medical provider at the detention facility did not respond to a nurse's request for authorization to call an ambulance.
- After **Huy Chi Tran** was found unresponsive in his cell due to cardiac arrest at the Eloy Detention Center, medical staff failed to place automated external defibrillator pads in the correct position on his chest, and had no backup pads when the equipment failed to properly adhere to his body.
- Confusion over who was responsible for calling an ambulance among staff at the El Valle Detention Facility in Texas caused a half-hour delay in calling an ambulance for **Elba Maria Centeno Briones** after her oxygen levels dropped dangerously low.
- **ICE detention facilities have faced repeated and increased deaths by suicide due to their failure to provide adequate mental health care, manage psychiatric medication, and ensure sufficient staff.**
 - **Efrain de la Rosa** deteriorated for weeks and ultimately died by suicide at the Stewart

Detention Center in Georgia after medical staff failed to ensure that he receive his prescribed antipsychotic medication used to treat his schizophrenia. After he died by suicide, nursing staff falsely recorded their administration of psychiatric medication.

- **Mergansana Amar** died by suicide at the Northwest Detention Center in Washington within hours after ICE officers told him that the Board of Immigration Appeals had denied his case and that ICE had scheduled his deportation to Russia. Although Amar had exhibited several warning signs of suicidal ideation the previous days, ICE failed to provide him mental health support upon providing him news of his impending deportation. Moreover, had ICE officers fully informed Amar of his rights while providing him news of his deportation, he might have known that he could have further appealed his case and requested a stay of removal to prevent deportation during his appeal.
- **ICE detention facilities have failed to provide necessary interpretation and translation to detained people who do not speak English.**
 - The nurse on duty at the La Paz County Adult Detention Facility in Arizona confirmed that the only words **Simratpal Singh** seemed to know in English were "court" and "lawyer," but decided that he did not exhibit any suicidal ideations based on her observation of his appearance alone. The facility provided no security rounds of Singh's cell to ensure suicide prevention. Three days after he was detained at the facility, Singh died by suicide.
- **ICE detention facilities failed to take basic precautions during the COVID-19 pandemic,** depriving detained immigrants of basic protections such as soap and masks during a time where no vaccine or antiviral treatment existed. ICE transferred detained people from facilities with COVID-19 outbreaks across the country, further spreading the virus, and delayed or failed

to release medically vulnerable people from custody in time for them to avoid the virus.

- **James Thomas Hill**, a 72-year-old man, died of COVID-19 after contracting the virus at the Immigration Centers of America Farmville in Virginia, during a time when no vaccine or antiviral medications for the virus were available. Although an immigration judge had ordered Hill removed in May 2020, ICE did not set his deportation flight back to Canada until two months later. This delay proved fatal: Hill soon contracted COVID-19 after ICE transferred dozens of people from detention facilities in Florida and Arizona that had recently experienced COVID-19 outbreaks.
- **ICE detention facilities have consistently failed to provide adequate medical and mental health staff who are trained and licensed to ensure patient health and safety.** Health care providers in detention facilities frequently provide care outside their licensed scope of practice. ICE detention facilities rely heavily on the lowest-level providers, and often prevent detained patients from receiving care from doctors. In 44 percent of the 52 detainee death cases reviewed, records indicated serious staffing issues, including shortages, improper training, or care outside the scope of practice.
 - **Kamyar Samimi** died after medical staff at the Aurora Detention Center in Colorado discontinued medication assisted treatment for opioid disorder. At the time of his death, the facility had only one doctor responsible for the entire facility and left multiple medical positions vacant. *Samimi never received a health appraisal by either a physician or registered nurse during his detention.* ICE’s own investigation concluded that “clinical supervision was inadequate to assure adherence to provider orders and necessary and appropriate care.”⁵
 - **Jean Jimenez** died by suicide at the Stewart Detention Center in Georgia after failing to

receive timely mental health care treatment. At the time of Jimenez’s death, Stewart provided tele-psychiatry to detained people for six hours a week—a level of less than 20 percent of required staffing, with *backlogs of 10-12 weeks for mental health services.*

- **ICE detention staff falsified or made improper or insufficient documentation of patient checks and provision of medical care in 61 percent of detainee death cases.**
 - Detention center officers at the Baker County Detention Center in Florida falsified records to show that they had conducted wellness checks of **Ben Owen** in the hours before he was discovered to have died by suicide. The officers, moreover, reported that their method of logging security rounds without making visual contact of detained people was consistent with their training and an accepted practice at the facility.

Key Recommendations

To the Department of Homeland Security:

ICE’s reliance on immigration detention is unnecessary, expensive, and deeply harmful. **We strongly urge that ICE dismantle the mass immigration detention machine. ICE should phase out the immigration detention system, invest in community-based social services instead of placing people in detention, and avoid surveillance of immigrants as an alternative to detention.** As ICE shifts from a detention-based system, ICE should adopt the following recommendations to reduce the number of people held in detention and prevent deaths of people in detention:

- **Issue a directive ensuring the prompt release from ICE detention of people with medical and mental health vulnerabilities.** It should include a presumption of release for people with medical and mental health

vulnerabilities, ensure prompt medical screening of detained immigrants to identify those who face increased medical and/or mental health risk in detention, and set forth procedures to ensure the prompt release of these individuals from custody.

- **Immediately release from ICE detention people who have prevailed in their immigration cases before an Immigration Judge, instead of continuing detention upon ICE’s administrative appeal.**
 - **Require the release of people from and prohibition of the use of ICE detention facilities upon a finding by DHS’s Office of Civil Rights and Civil Liberties that health and safety standards are not being met, or cannot be met.**
 - **Prohibit solitary confinement.** Until it is fully prohibited, issue and implement a directive barring solitary confinement for anyone who has a disability, has a diagnosed mental health condition, is pregnant, postpartum, or caring for a child, or has identified or is known or perceived to be LGBTQ+ or gender non-conforming.
 - **Ensure meaningful consequences for detention facilities that have caused deaths of detained people.** Promptly terminate ICE detention contracts for facilities with any death resulting from substandard medical and mental health care, including deaths that occur within 30 days of release from custody.
 - **Undertake full, comprehensive, and unbiased investigation of deaths in detention.** Ensure preservation of all relevant evidence, and ensure that interviews of detainee witnesses are conducted and included in death investigations and ensure protection from retaliation and deportation of detainee witnesses. Require that all detention facilities provide investigators unimpeded access to staff and contractors, and require full physical autopsies and full-spectrum forensic toxicology screen for all people who die in custody, and psychological autopsies for any apparent suicides.
- **Provide timely, quality medical and mental care to all in ICE detention,** with the caveat that increased funding for detention has not resulted in improvement of health conditions for those in detention.
 - Ensure that all detention facilities, whether care is provided by ICE Health Service Corps (IHSC) or another entity, are bound by IHSC directives and standards for the provision of medical and mental health care through contract modifications or uniform updates to all detention standards. Violations of these directives and standards shall be immediately remedied.
 - Ensure that all detention facilities are bound by, and in compliance with, the 2016 Performance Based National Detention Standards.
 - Ensure routine collection and reporting on the number of individuals in detention with medical vulnerabilities, including chronic conditions, communicable and non-communicable diseases, and severe mental illness.
 - Ensure that all detention facilities provide sufficient and adequate levels of health care staffing by tracking and publishing vacancy rates for medical and mental health staff at each facility.
 - Require that detention population levels do not exceed medical and mental health staffing levels for the facility at any time.
 - Ensure that all ICE detention facilities strictly prohibit medical and mental health professionals from practicing outside the scope of licensed practice, and improve access of those in detention to physicians, nurse practitioners, and physicians’ assistants.
 - Ensure that all healthcare and detention staff are trained in and routinely participate in emergency (code) drills.

- Ensure that all facilities are required to provide medical interpretation at all encounters, and that metrics of rates of medical interpretation use are publicly reported.
- Create and enforce protocols for strict documentation and reporting of acute medical situations.
- Create and enforce protocols for immediate consultations 24/7 with physicians on call.
- Ensure that all ICE detention facilities provide translation and interpretation for all medical encounters, including the ability to request medical care, in accordance with Performance-Based National Detention Standards (PBNDS) standards.
- Ensure that all ICE detention facility medical staff are trained in and utilize screening tools for the Clinical Institute of Withdrawal Assessment (CIWA) and Clinical Opiate Withdrawal Symptoms (COWS).
- Create, enforce, and audit protocols and implementation of regular wellness checks, every 15 minutes, to engage with the person in custody, evaluate and treat any urgent health needs, and attempt de-escalation if needed.
- Create and enforce protocols for routine and frequent inspection of medical equipment.
- Perform regular quality audits of medical documentation and create mechanisms to identify gaps in management, errors, and other practice failures.
- **Comply with Requests for Public Records Under the Freedom of Information Act.**
Comply with FOIA requests more expeditiously, apply a “presumption of openness” at the outset when evaluating records, and share with the requester information about the scope of the agency’s search.

To the Department of Justice:

- Ensure full implementation of the Death in Custody Reporting Act (DCRA). Ensure that DHS fully complies with its reporting obligations under the DCRA, and releases annual reports on key data trends of deaths in DHS custody.

To Congress:

- **Substantially reduce funding for immigration detention.** Increase funding for community-based social support and legal representation programs as alternatives to detention that are far more effective and humane.
- **Conduct rigorous oversight of detention conditions, including through hearings with senior government officials.** Request a GAO investigation into ICE's failure to prevent the deaths of detained people, including those who have died in custody and those who have died, while hospitalized, within 30 days of release from ICE custody.
- **Require that ICE track, publicly report, and investigate the death of any detained person who died while hospitalized or within 30 days of release from ICE custody.**
- **Require that ICE make publicly available on its website,** as a matter of course, detainee death reviews, Healthcare and Security Compliance Analyses, Mortality Reviews, Root Cause Analyses, autopsy reports, and psychological autopsy reports, regarding all individuals who have died in ICE custody or those who have died while hospitalized, or within 30 days of release from ICE custody. Ensure disclosure of cause of death. Make only those redactions necessary to comply with federal privacy laws.
- **Require monthly publication of all medical and mental health vacancies by facility,** as well as average length of time for detained patients to be seen by a physician, physician's assistant, or nurse practitioner.

- **Require that ICE make publicly available within 30 days any corrective actions taken to enforce contract terms** for the provision of medical or mental health care in ICE detention facilities or any other contract violations that may have contributed to a death in custody, as well as ODO inspection reports, OPR detainee death reviews, and IHSC mortality reviews.
- **Hold ICE accountable for meeting specific standards with regard to provision of care and data reporting.**
- Pass the **Dignity for Detained Immigrants Act** (H.R. 2760/S. 1208), and the **End Solitary Confinement Act** (H.R. 4972/S. 3409).

To State and Local Governments:

- **Pass legislation to prohibit intergovernmental services agreements** between state or local agencies and the federal government for civil immigration detention, and to prevent contract modifications to expand detention.
- **Pass local ordinances or legislation to prohibit the physical expansion of detention facilities** that would allow increased capacity for detention.
- **Pass legislation that provides causes of action against for-profit detention facilities that deviate from contractually binding standards.**
- **Require and ensure that local facilities that detain people in ICE custody expeditiously release and provide records** relevant to deaths in detention for release under FOIA.
- **Pass legislation prohibiting 287(g) agreements** and collaboration with ICE in civil immigration enforcement.

Introduction

Medical and Mental Health Care in ICE Detention

Immigration detention in the United States is a relatively recent phenomenon: in the 1980s, fewer than 2,000 people were held in immigration detention nationwide.⁶ During the 1990s, however, immigration detention expanded dramatically following the passage of a range of criminal justice and immigration laws,⁷ which are now widely recognized as having fueled the mass incarceration and detention of communities of color.

As of May 2024, ICE, under the direction of the Department of Homeland Security (DHS), detains over 36,000 people each day in approximately 135 detention facilities nationwide.⁸ As the federal law enforcement agency responsible for enforcing laws

91% of people detained by ICE are held in detention facilities owned or operated by private prison corporations.

ACLU analysis of ICE data

governing border control and immigration, ICE frequently employs detention as a means of holding people who may not have up-to-date immigration paperwork to reside legally, asylum-seekers, or those who are awaiting deportation.

Despite the legal distinction between civil detention and criminal incarceration, ICE detention facilities are carceral in nature. ICE frequently contracts with prisons and jails to hold detained immigrants on its behalf, with significant reliance on facilities owned or operated by private prison corporations. In 2020, under the Trump administration, 81 percent of people detained by ICE were held in facilities owned or operated by private prison corporations.⁹ Since then, private prison control of the ICE detention system has only grown. As of July 2023, 90.8 percent of people detained by ICE are held in detention facilities owned or operated by private prison corporations.¹⁰ Contracts with ICE continue to generate a significant amount of revenue for private prison corporations like the GEO Group, CoreCivic, LaSalle Corrections, and the Management and Training Corporation (MTC). In 2022, GEO made \$1.05 billion in revenue from ICE contracts; CoreCivic similarly made \$552.2 million from ICE detention contracts in 2022.¹¹

Medical and public health experts have widely documented the significant harm to physical and mental health suffered by people in detention. Increased exposure to infectious disease, inadequate nutrition, substandard health care, punitive practices such as sleep deprivation, solitary confinement, physical and psychological abuse have a cumulative and measurable negative effect on detained people's health.¹² Clinicians have noted the severe impact that delayed access to care, medication interruptions, and barriers to mental health care have had on detained immigrants, even after release. A survey of 85 clinicians across the United States in 2022 found that, of the approximately 1,300 patients they had

seen, all of them had experienced adverse health conditions related to their time in detention.¹³

This report – a collaboration between the American Civil Liberties Union, American Oversight, and Physicians for Human Rights, focuses on systemic failures in detainee death analyses and accountability mechanisms employed by DHS, and deficient medical and mental health care received by detainees in ICE detention.

This report builds on previous reports published by advocacy organizations including the ACLU, Detention Watch Network, Freedom for Immigrants (formerly known as Community Initiatives for Visiting Immigrants in Confinement), Human Rights Watch, and National Immigrant Justice Center regarding deaths in ICE detention between 2010 to 2017,¹⁴ investigatory reports by journalists,¹⁵ as well as research studies by medical and public health researchers.¹⁶ Like these prior reports, *Deadly Failures* examines publicly released records by ICE about deaths in custody, including those obtained as a result of FOIA litigation. In addition, this study relies on a wider variety of DHS and ICE investigatory reports developed during investigations into detainee deaths, including Detainee Death Reviews, Health Security Compliance Analyses, Mortality Reviews, and independent autopsies. Where available, the report analyzes internal agency email communications and medical records obtained under FOIA and state public records requests, publicly-available documents obtained in litigation via discovery, such as emails, deposition transcripts, and detention contracts, and interviews with surviving family.

Background

Oversight of Medical and Mental Health Care in ICE Detention

The ICE Health Service Corps (IHSC) is responsible for oversight of medical and mental health care for people in ICE detention. IHSC provides direct medical and mental health care at 19 detention facilities nationwide.¹⁷ Private prison companies

and local jails, however, are responsible for directly providing or contracting medical and mental health care at over 120 other ICE detention facilities—the vast majority of facilities. Seventy-three percent, or 3 out of 4 detained people, are held at facilities where on-site care is provided by non-IHSC staff, including employees of private prison corporations, their private medical contractors, or local government staff.¹⁸

Although IHSC has promulgated directives regarding the provision of medical and mental health care at the 19 facilities in which it directly provides care, these directives are not binding on the vast majority of the ICE detention system. Instead, medical care at facilities that are not staffed by IHSC personnel are required to comply only with very general requirements regarding the provision of medical and mental health care included in one of five sets of ICE detention standards.¹⁹ No single set of detention standards is applicable to all ICE detention facilities; each facility is subject to a different set of detention standards by contract. Although ICE has pledged its intention to update all facility contracts to adhere to the most recent, and most stringent version of the Performance Based National Detention Standards, updated in 2016, 92 of 135 current detention facilities are not subject to these standards.²⁰

Instead, ICE has permitted scores of detention facilities to abide by only lax standards for the provision of medical and mental health care. For example, the 2000 National Detention Standards, which are still in effect in at least 19 facilities nationwide,²¹ do not require a minimal time by which the facility must conduct initial medical screening; include no provisions for mental health care; do not specify the minimal staffing levels or require that medical staff are available at all times; do not include minimal requirements for the provision or prescribing of prescription medication; do not specify requirements for accommodations in the delivery of medical or mental health care to detained people with disabilities; and have no gender-specific medical care standards.²²

The ICE Office of Detention Oversight (ODO) conducts compliance inspections to assess

compliance with detention standards. However, as the DHS Office of Inspector General has noted, these inspections are “too infrequent to ensure the facilities implement all deficiency corrections,” and ICE “does not adequately follow up on identified deficiencies or consistently hold facilities accountable for correcting them.”²³ Moreover, ICE ODO inspections are not comprehensive and focus only on a limited number of standards.²⁴ Because binding detention standards often lack specificity to benchmarks for the delivery of medical care, such compliance inspections mean little in ensuring even a minimal standard of care at facilities.

IHSC also states that it monitors the quality of medical care provided at detention facilities where on-site care is provided by private prison corporations or local government staff with field medical coordinator site visits. During these site visits, IHSC staff are tasked with assessing facility compliance with detention standards, and conducts a “Quality of Medical Care” review against 20 medical care practices.²⁵ These site visits, however, are infrequent: IHSC reportedly does “its best to go at least once per year to each facility,” and such site visits may be conducted virtually, not in-person.²⁶ Moreover, as an internal IHSC whistleblower complaint published by BuzzFeed News in December 2019 noted, IHSC has “systematically provided inadequate medical and mental health care and oversight to immigration detainees across the U.S.”²⁷ Along with a series of allegations of life-threatening lapses in medical care affecting a child and adults in ICE custody, the complaint includes claims that four deaths between 2017 and 2019 were linked to dangerous, neglectful care that IHSC leadership knew or should have known about but failed to address.²⁸

Reported Deaths in ICE Detention by the Numbers, 2017-2024

This report primarily analyzes deaths that took place between January 1, 2017 to December 31, 2021, instead of all deaths to the present, because of ICE’s failure to promptly release full records about deaths in detention. However, between January 1, 2017 and June 20, 2024, ICE reported that at least 70 detained

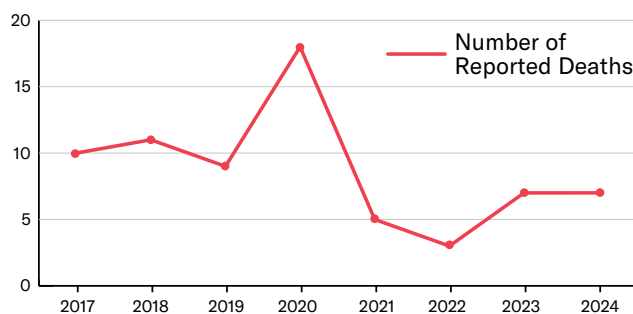
immigrants died while detained in its custody (see Table 1 and Figure 1). Of these, at least 14 people died by suicide, while at least 9 people died as a result of COVID-19.²⁹ At least 15 died as a result of cardiovascular disease. ICE has not publicly provided a cause of death for 13 of the 68 deceased individuals.

These numbers, however, do not include people that ICE detained, but formally released from its custody while they were hospitalized, upon imminent death. Between 2019-2021, ICE released at least three detained people during hospitalizations prior to their deaths, allowing the agency to avoid public reporting and accountability requirements. These cases were reported by the media only after family members or advocates alerted the public.³⁰ This suggests that the death toll of people detained by ICE is likely higher than officially reported, particularly in light of the high incidence of COVID-19 in ICE detention and fatality rates during the pandemic.³¹

TABLE 1.
Reported Deaths in ICE Detention, 2017–2024*

Year	Number of Reported Deaths
2017	10
2018	11
2019	9
2020	18
2021	5
2022	3
2023	7
2024	7
Total	70

FIGURE 1.
Reported Deaths in ICE Detention, 2017–2024*



* (as of June 20, 2024); Source: Immigration and Customs Enforcement



Memorial for those who have died at Stewart Detention Center, 2024. Photo: Eunice Cho

Between 2017 and 2024, at least ten people died after being detained at the Stewart Detention Center in Georgia, while at least six people died after being detained at the Krome North Service Processing Center in Florida. (See Table 2). Although healthcare failures are systemic across ICE’s detention network, repeated deaths raise grave concern that

ICE has failed to impose meaningful consequences on facilities after a death has occurred, including contract termination, and that oversight and accountability measures have failed to address deadly conditions.

Public Reporting of Deaths in ICE Custody

Since its inception, ICE has only reluctantly provided information about deaths in detention to the public. Over the last two decades, advocates and media representatives have had to resort to FOIA litigation to obtain basic information regarding the deaths of detained immigrants. In 2005, a National Public Radio investigation into the deaths of detained immigrants³² prompted a Congressional investigation of the issue.³³ ICE reportedly issued standard procedures for deaths to be reported in detail to headquarters, but actively fought to control public disclosure of any information regarding these cases.³⁴

TABLE 2.
Highest Number of Deaths by Detention Facility, 2017–2024*

Name	Operator	Number of Reported Deaths (2017–2024)
Stewart Detention Center, GA	CoreCivic, Inc.	10
Krome North Service Processing Center, FL**	Akima Global Services	5
Otay Mesa Detention Center, CA	CoreCivic, Inc.	4
Port Isabel Detention Center, TX	Ahtna Corp	4
Adelanto Detention Facility, CA	GEO Group, Inc.	3
Adams County Detention Center, MS	CoreCivic, Inc.	2
Denver Contract Detention Facility (Aurora), CO**	GEO Group, Inc.	2
Baker County Detention Center, FL	Baker County Sheriff	2
Calhoun County Jail, MI	Calhoun County Sheriff	2
Central Louisiana ICE Processing Center, Jena, LA**	GEO Group, Inc.	2
Karnes County ICE Processing Center, TX**	GEO Group, Inc.	2
Northwest ICE Processing Center, WA**	GEO Group, Inc.	2
PrairieLand Detention Center, TX	LaSalle Corrections	2
Torrance County Detention Facility, NM	CoreCivic, Inc.	2
Winn Correctional Facility, LA	LaSalle Corrections	2

*(June 19, 2024)

**ICE has renamed these facilities between 2017-2024, current name is listed.

Source: Immigration and Customs Enforcement

In 2009, the ACLU filed a FOIA lawsuit for records related to the approximately 107 deaths counted in ICE custody since the creation of the agency in 2003.³⁵ As the New York Times reported based on files recovered from the lawsuit, the **Obama administration also disclosed that one in 10 immigration detention deaths had been omitted from a list submitted to Congress, and that the agency had also discharged detainees shortly before they died, leading to a reduction in the number of reported deaths.**³⁶

In October 2009, ICE promulgated its first official policy regarding detainee deaths, including investigation, notification, and reporting requirements. The directive outlined agency requirements for notification of in-custody deaths to next-of-kin, consular officials, members of Congress, the media, and non-governmental organizations. The directive also required the ICE Office of Professional Responsibility (OPR) to initiate investigations into the circumstances of death, the Office of Detention and Removal Operations (DRO) Assistant Director for Management to conduct an internal review of all facility inspection reports and review of contracts of the detention facility, and provide autopsy and other forensic information for a mortality review by the DHS Office of Health Affairs. ICE reapproved this directive in 2012.³⁷

As a result of ICE's 2009 directive, the ICE OPR's Office of Detention Oversight (ODO) began to issue detainee death review documents that summarized investigations of detention center deaths. The death reviews were carried out by a centralized team of ICE personnel and subject-matter experts who interviewed local personnel and reviewed medical and custody records to evaluate medical care related to the death.³⁸ These detainee death reviews typically included an accounting of relevant facts leading up to the death, analysis and assessment of the care provided, and a comparison of the care provided to the relevant standards in place at the facility.³⁹ Over the last decade, advocacy organizations and the media have had to resort to FOIA litigation to obtain copies of these detainee death reviews. Analyses of these reviews in prior reports published by ACLU and its partners,⁴⁰ as well as by medical and public

health scholars,⁴¹ have revealed a consistent pattern of deficient investigations, inadequate care, and deep systemic issues with the standard of medical care that directly led to the deaths of detained immigrants.

In 2018, recognizing the importance of these detainee death records, Congress required that ICE "complete and make public an initial report regarding any in-custody death within 30 days of such death," and to complete and release subsequent reporting about the death within 60 days of the initial report.⁴² In practice, ICE frequently ignores these requirements and has failed to post reports regarding deaths within the required time. In some instances, ICE instructed advocates and the media to file FOIA requests for information or claimed that its press release constituted an initial report.⁴³ When news agencies filed suit under FOIA for records related to detainee deaths, however, ICE's response has often been to simply point to this brief initial report on its website.⁴⁴ In addition, ICE's media advisories include little information regarding deaths in custody, providing only cursory details about the circumstances of a detained person's death. Currently, ICE publishes a truncated report, titled "Detainee Death Report," which provides a brief, bulleted summary of a selection of events prior to each death, on its website.⁴⁵

ICE is also obligated to report detainee deaths to the Department of Justice under the Death in Custody Reporting Act of 2013 (DCRA). DCRA requires federal law enforcement agencies to report to the Attorney General "the death of any person" who is "en route to be incarcerated or detained, or is incarcerated or detained at . . . any facility (including any immigration or juvenile facility) pursuant to a contract with such Federal law enforcement agency."⁴⁶ Unfortunately, the Department of Justice has failed to collect reliable data nationwide, or to publish studies that use this data to identify ways to reduce deaths in custody as required under the DCRA.⁴⁷

ICE's Current Approach to Investigating and Reporting Deaths in Custody

In October 2021, ICE issued a revised directive that currently governs the agency's investigation of

deaths of detained people. ICE Directive 11003.5, “Notification, Review, and Reporting Requirements for Detainee Deaths” outlines its “multilayered, interagency approach” to investigate deaths of noncitizens in ICE custody.⁴⁸ According to ICE, the agency “conducts medical reviews as well as oversight and compliance investigations, timely prepares reports based on the finding of reviews and shares reports with appropriate parties and stakeholders.”⁴⁹

Within 12 hours after a death occurs in ICE custody, the Field Office Director with oversight of the relevant facility must report the death to ICE’s Assistant Director for Field Operations, ICE’s Custody Management Division, ICE’s Joint Intake Center (JIC),⁵⁰ and ICE’s Office of the Principal Legal Advisor (OPLA). Within two business days, ICE must

post a news release with “relevant details” of the death on the agency’s public website.⁵¹

The ICE Office of Professional Responsibility (OPR) then “examines the circumstances surrounding the individual’s death and drafts a report to determine whether the agency adhered to all policies and protocols.”⁵² Once ICE completes its review, “the results are provided to ICE senior management and the DHS Office of Civil Rights and Civil Liberties.”⁵³

The Paper Trail: Relevant Documents Regarding ICE Detainee Deaths

ICE Directive 11003.5 identifies several documents that the agency produces when reviewing a detainee death. Including those listed in Table 3.

TABLE 3.
Documents Released Upon Death in ICE

Document Name	Description
Interim Notice of a Detainee Death	An “objective statement announcing the death of a death in ICE custody, as well as additional facts, circumstances, and information relevant to a particular death at issue, that is timely posted to ICE’s public facing website.” ⁵⁴
Detainee Death Report	A “publicly available document, detailing relevant information and circumstances regarding any detainee death, in accordance with congressional reporting mandates.” ⁵⁵ These reports should not be confused with “Detainee Death Reviews,” which typically include a more complete accounting of relevant facts leading up to the death, analysis and assessment of the care provided, and a comparison of the care provided to the governing standards in place at the relevant facility.
Detainee Death Review (also titled the “Detainee Death Review Findings Memo”)	ICE describes this document as “an objective examination of the facts and circumstances surrounding the detention and death of an individual in ICE custody or post release (when a death occurs within a reasonable time, not to exceed 30 days of release from ICE custody and review is requested by the ICE director), to determine whether or not the deceased detainee received treatment in accordance with applicable detention standards on health, safety, and security.” ⁵⁶ Prepared by the ICE Office of Professional Responsibility’s (OPR) ICE Inspections and Oversight Division, this memorandum is prepared for ICE Office of Enforcement and Removal Operations (ERO) and summarizes ICE OPR’s review of the death. The memo often includes a summary of the chronology of the individual’s death and identified deficiencies against ICE detention standards. To the authors’ knowledge, ICE has never ordered any discretionary review of the death of an immigrant who died after release.
Healthcare and Security Compliance Analysis (also referred to as a Medical and Security Compliance Analysis)	Private government contractors such as Creative Corrections or the Nakamoto Group often prepare a Healthcare and Security Compliance Analysis (also referred to as a Medical and Security Compliance Analysis) upon request by the ICE OPR’s External Reviews and Analysis Unit (ERAU). This report includes a synopsis of the death, description of the relevant detention facility and its medical services, a narrative summary of events, and conclusions regarding compliance with detention standards governing medical care and security operations. These government contractors may conduct site visits and telephone interviews with witnesses. ⁵⁷ Notably, Creative Corrections is also currently tasked to conduct annual ICE detention inspections for the ICE Office of Detention Oversight, which may determine eligibility for a facility’s contract renewal. ⁵⁸
IHSC Mortality Review	Prepared by the ICE Health Service Corps (IHSC), this document is “conducted to determine the appropriateness of the clinical care provided and the effectiveness of the facility’s policies and procedures relevant to the circumstances surrounding the death.” ⁵⁹ The Mortality Review includes an “administrative review, a clinical review, and in the event of a suicide, a psychological autopsy.” ⁶⁰

Custody

Additional documents created by ICE or other sources can provide further information regarding deaths in detention, including those in Table 4.

In addition to documents generated by ICE, state agencies may also conduct investigations into deaths that occur in ICE detention facilities.

International Legal Standards for Immigration Detention

In addition to domestic regulations and standards, international human rights treaties that the United States has ratified also provide necessary protections against cruel treatment and arbitrarily prolonged detention. These treaties provide a framework by which the actions of the United States regarding immigration detention may be assessed in the context of global standards for practice in these settings.

In most cases, international treaties include provisions to enact domestic legislation to enforce accountability mechanisms. Relevant treaties

that the United States has ratified include the International Covenant on Civil and Political Rights (1992), which establishes rights to life, liberty, dignity, and security of persons, as well as protections against arbitrary detention. The Covenant explicitly states that “all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.”⁶¹

The United States has also ratified the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment and Punishment, and is therefore subject to the absolute prohibition of torture under international law.⁶² The Committee Against Torture—the monitoring body of the Convention—has found that failure to provide adequate medical care can violate the Convention’s prohibition of cruel, inhuman or degrading treatment.⁶³ Solitary confinement that lasts more than 15 consecutive days is recognized by the United Nations⁶⁴ and multiple human rights organizations⁶⁵ as torture.

TABLE 4.
Additional Relevant Documents Regarding ICE Detention Deaths

Document Name	Description
Root Cause Analysis (RCA)	In the past, IHSC has conducted a “root cause analysis” to determine the “root cause” of an event, and to identify opportunities for risk reduction. The “root cause” is “typically a finding related to a process or system that has a potential for redesign to reduce risk.” ⁶⁶ This standardized IHSC form summarizes the sequence of key events and responsible providers, and provides prompts to identify vulnerabilities in the detention process or system, with space for an action plan with specific risk reduction strategies. The requirement that IHSC conduct a root cause analysis is no longer included in ICE Directive 11003.5, the current operative version of ICE’s detainee death protocol.
Independent Autopsy	An autopsy conducted by a medical examiner lays out the cause and manner of death for a person who has died. The examiner conducts an external and internal examination of the body of the deceased as well as a toxicology report.
Office of the Inspector General (OIG) Report of Investigation	If the Department of Homeland Security (DHS) Office of Inspector General (OIG) chooses to investigate a death in custody, it publishes a report of its investigation.
Medical records and communications regarding detainee death	Medical records and other records of communication regarding a detained person, obtained under FOIA or other litigation, provide the most fulsome view of incidents that took place in the treatment of a detained person in custody.

In addition to these binding international treaties, the United Nations Standard Minimum Rules for the Treatment of Prisoners, 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 collectively establish a consensus regarding the entitlement of detained individuals to a level of medical care equivalent to that accessible to the general community, irrespective of their legal immigration status.⁶⁷ These standards underscore the importance of non-discriminatory access to healthcare for detainees. The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment mandates the prompt provision of a proper medical examination upon admission to a detention facility, followed by necessary medical care and treatment.

Finally, the U.N. High Commissioner for Refugees (UNHCR), in its Guidelines pertaining to the detention of asylum-seekers and alternatives to detention, underscores the obligation to provide appropriate medical treatment, including psychological counseling, to detained people requiring such care. It highlights the importance of transferring detained people in need of medical attention to suitable facilities or providing on-site treatment when available.

This report is based on a review of records for the 53 people whom ICE reported to have died in its custody between January 1, 2017 and December 31, 2021.⁶⁸ Between January 1, 2022 and the completion of this report in May 2024, ICE reported that 17 additional people died in its custody. These deaths are not included in the report's analysis, as ICE has not yet released a comprehensive set of records to the authors for these deaths.

Documents Obtained Under the Freedom of Information Act (FOIA)

This report is based on a review of over 14,000 pages of documents. These documents include records that DHS components regularly prepare or incorporate when an individual dies in its custody, including Detainee Death Reviews, Healthcare and Security Compliance Analyses, Root Cause Analyses, Mortality Reviews, autopsy reports, as well as medical records and emails obtained from the United States government under the Freedom of Information Act (FOIA). Where available, the report also reviewed public agency statements, media coverage, and Congressional reports regarding deaths of detained immigrants.

Methodology

The report reviewed records regarding the deaths of 53 people in ICE detention, including over 10,000 pages of records for 41 people obtained by American Oversight as the result of FOIA litigation.⁶⁹ The report also reviewed over 4,622 pages of records regarding 19 deaths (including 12 not covered under the American Oversight disclosures) obtained under FOIA or state public records laws, and made publicly available by BuzzFeed News⁷⁰, the Project on Government Oversight (POGO),⁷¹ Andrew Free,⁷² Transgender Law Center,⁷³ and the Young Turks.⁷⁴ In addition to these records, the report also analyzed records posted publicly on ICE's FOIA website.⁷⁵ In addition, the report analyzed additional documents obtained under FOIA or state public records requests shared with the authors by Jose Olivares (formerly of the Intercept and NY Public Radio) and Tammy Jane Owen, as well as documents made available to the public in Congressional reports.

In 2019, American Oversight began investigating the deaths of individuals held in the custody of the Department of Homeland Security (DHS) components, filing dozens of FOIA requests with DHS, Immigration and Customs Enforcement (ICE), and Customs and Border Protection (CBP). ICE and CBP, however, regularly failed to provide substantive responses or produce records within the time period required by law. To enforce its rights under FOIA, American Oversight filed four lawsuits against DHS components for documents related to deaths in custody.⁷⁶ These lawsuits have since resulted in the release of nearly 10,000 pages of records. Many of the records produced to American Oversight were partially or fully redacted under various FOIA exemptions. After extensive negotiation and briefing,

ICE lifted certain of these redactions voluntarily and was ordered by the court to lift the remainder.

ICE's failure to appropriately address American Oversight's FOIA requests meant that documents were often delayed or incomplete. Indeed, the failure to appropriately respond to FOIA requests led American Oversight to litigate to obtain the records that form much of the basis of this report. In the course of the litigation process, the court concluded that ICE had not sufficiently justified its withholding of certain records and redactions or the adequacy of its search for records. As a result, the court ordered ICE to produce all redacted records at issue and to redo its search for records. ICE and CBP failed to search appropriate locations, use effective search terms, or use efficient and up-to-date methods to process electronic records. Indeed, ICE often redacted information disclosed to American Oversight that it had previously disclosed in response to other FOIA requests, including key inculpatory information.⁷⁷ By slowing the FOIA process and consuming resources through litigation, in conjunction with the assertion of unjustified withholdings, ICE obstructed access to information that the public has the legal right to view.

Documents Obtained in Civil Litigation

This report is also based on documents and testimony obtained in discovery in civil litigation related to deaths of detained immigrants.⁷⁸ These documents include transcripts of deposition testimony of ICE employees, internal agency emails, medical records, and documents related to contracts and contract performance between ICE and detention facility

operators. None of these records are subject to protective orders.

Reviews of ICE Oversight and Investigations

The report compares ICE’s official reports related to the deaths of detained people with other sources of information. Specifically, we reviewed final ICE investigatory reports, including Detainee Death Reviews, Mortality Reviews, Root Cause Analysis reports, Healthcare and Security Compliance Analysis reports, and reports issued by the DHS Office of Inspector General (OIG). We examined these documents to analyze areas where oversight investigation reports indicated incomplete investigations, omission of key facts or factors that contributed to deaths in detention, and recommendations and consequences for facilities upon a detained person’s death. We compared these with internal emails regarding those investigations and in one case, testimony from agency personnel regarding the death of a detained immigrant. Where available, we also examined reports of independent autopsies conducted on behalf of survivors or estates, and compared their findings to the autopsy reports conducted on behalf of ICE. Finally, we examined detention contracts and documents regarding contractor performance made available in Congressional reports or in civil litigation.

Reviews of Medical Care Received in ICE Detention and Other Documentation

This report uses a retrospective document review methodology, which is a widely used research method in various health and biomedical disciplines. The methodology is intended to assess events and actions that had already happened and are recorded in official documents such as hospital or institutional records for the purpose of identifying errors, trends, practice patterns, or other recurring themes, among others.

A team of medical doctors reviewed the documents available for each death and, following the review, were asked to assess each case and note whether the death may have been preventable, in their clinical opinion and based on the information they had reviewed. Even though the documentation available

for each case was not identical, all but one case had sufficient information to permit comprehensive review of what was documented in the reviews as the medical care received. In total, medical doctors reviewed 52 cases of reported deaths that occurred between 2017 and 2021, and were unable to review one case that took place in 2018 due to incomplete documentation made available by ICE. The reviewers, Drs. Radha Sadacharan, Katherine McKenzie, Elena Jiménez-Gutiérrez, Chanelle Diaz, Michele Heisler, and Ranit Mishori, are all experts with deep knowledge of, and experience in, assessing clinical care as well as in health conditions in places of detention.⁷⁹

Dr. Sadacharan, a correctional health expert, was retained by the ACLU to conduct an independent review of all 52 cases. Drs. McKenzie, Jimenez-Gutierrez, and Diaz are part of PHR’s Asylum Network, and Dr. Heisler is Medical Director for PHR. Dr. McKenzie conducted an independent review of 15 cases; Dr. Jimenez-Gutierrez conducted an independent review of 19 cases; Dr. Diaz conducted an independent review of 16 cases; and Dr. Heisler conducted an independent review of two cases. Dr. Mishori, PHR senior medical advisor, served as an additional reviewer for six cases in which the original reviewers’ classifications were considered “materially different.” The reviewers did not discuss the specifics of any case with each other or share reviews until all were complete.

The reviews were completed using a standardized form which asked the physicians to assess whether, in their independent medical judgment, the death was “preventable,” “possibly preventable,” “not preventable,” or “indeterminate.” These determinations reflect the professional and expert opinion of the physicians. If the medical reviewers identified errors in the provision of care, they were further asked to elaborate on the errors in clinical care or other non-clinical areas that led them to make this assessment. Based on the documents that were available to them, the medical reviewers also noted whether ICE had identified any failings or deficiencies within their own documentation.

The definitions listed in Table 5 below were agreed upon by all physicians involved in the review process

and are based on studies discussing consensus mechanisms for categories of preventable deaths.⁸⁰

Combined determinations of “preventable” or “possibly preventable” (n=28) were not considered to be materially different, given the substantial likelihood that, in either instance, the outcome would have been different if there was a more appropriate standard of medical care or better management of the detainees’ health condition. If, however, one reviewer determined a death was either preventable or possibly preventable, and the other determined that the death was not preventable, the reviewers’ classifications were considered to differ materially (n=6). This methodology was decided upon after considering the available medical literature, which indicates that while having reviewers meet to discuss determinations can increase consensus in record review determinations, they do not necessarily increase reliability of determinations.⁸¹ In the six cases where Dr. Mishori served as an additional reviewer, the final determination for each of these cases was the classification reached by the majority of the three reviewing physicians.

TABLE 5.
Medical Review of Deaths in Detention:
Definitions

Classification	Definition
Preventable	The person’s life could have been saved or the outcome could have been different with appropriate medical care, intervention, or management of the health condition.
Possibly Preventable	There is a reasonable possibility that, based on the documents reviewed, the person’s life could have been saved or the outcome could have been different if the person had received appropriate medical care, intervention, or management of the health condition. ⁸²
Not Preventable	It is clear that the person’s life could not have been saved or the outcome could not have been different, regardless of the medical care, intervention, or management of the health condition.
Indeterminate	It is not possible to determine whether the outcome could have been different, regardless of the medical care, intervention, or management of the health condition

Interviews

In addition to the medical case reviews, PHR and the ACLU also conducted two interviews with relatives or friends of individuals who died in ICE custody to better understand who they were, their life, and the context of their detention and death. These family members or friends were identified through contact with attorneys or community-based organizations who have worked with them.

The methodology for these interviews was reviewed and approved by PHR’s Ethics Review Board (ERB) and the ACLU’s Human Subject Research Protections Protocol to ensure compliance with U.S. requirements for human subject research. Interviews were conducted in English, and took approximately an hour each. Researchers obtained informed consent orally with the interview participants before moving forward, ensuring that the participants understood the purpose of the research, and potential risks and benefits of their participation. Interviews followed a semi-structured format, and were conducted via videoconference. Recruitment for interviews was conducted through attorneys working with or in contact with the ACLU, and researchers obtained the consent of interview subjects and their counsel to participate. Participants were given the option to have legal counsel present in the interviews, though neither subject elected to do so. Both subjects have filed – or seek to file – FOIA requests or wrongful death suits against ICE and/or detention facilities.

Limitations

The report findings and conclusions are limited due to a few factors.

Oversight and Accountability. The cases examined in our discussion of ICE’s oversight and accountability mechanisms were limited to those where additional internal agency communications regarding detainee death investigations and contract performance assessment information were available through FOIA or civil wrongful death litigation or investigation. ICE often redacted or withheld large swaths of information disclosed under FOIA. As such, there may be information or considerations

not able to be included in this study, and it is possible that there are considerations that the authors were unaware of that, if known, may have impacted their analysis.

Medical Review. Expert physicians who assessed medical care provided in death cases based their assessments on the information available to them at the time of the review process. They were not involved in providing healthcare to the deceased patients, did not have access to the original, official medical records, and their evaluations were based on a combination of secondary assessment of official government documentation or, occasionally, other independent primary documentation. Additionally, portions of these documents were redacted, or some were redacted in their entirety.

Interviews. The two interviews conducted of family members may not be representative of the 53 deaths in the sample set, nor of all family members' perspectives. Specifically, because the two subjects interviewed were identified by attorneys, they may differ from those not involved in litigation.

Disclosure

Some of the deaths analyzed in this report have been the subject of past litigation, are the subject of ongoing litigation, and may be subject to future litigation regarding wrongful deaths. The principal authors of this report are not involved in any of this litigation; the determinations made herein are independent of these efforts. While some ACLU affiliates may be involved in litigation, the ACLU's National Prison Project, which co-authored the report, is a separate legal entity. Contributing author Andrew Free, who provided analysis for the accountability and oversight portion of the report, provided representation in cases related to Jean Jimenez, Efrain de la Rosa, Ronal Francisco Romero, Ben Owen, Gourgen Mirimanian, Roylan Hernandez Diaz, Yulian Castro Garrido, and Onoval Perez Montufa.

Evidence from the review of documents and interviews were considered together to make overall assessments about individual deaths in detention and related ICE and DHS protocols and practices. Specific data sources for claims are included in the cited endnotes.

Findings and Analysis

Our investigation examined the deaths of 52 detained immigrants, comprising all but one death reported by ICE to have taken place in its custody between January 1, 2017 and December 31, 2021. This investigation revealed two findings. First, ICE's oversight and accountability mechanisms are critically flawed, and do little to prevent future deaths. Second, medical experts concluded that of these 52 deaths, **49 (95 percent) were preventable or possibly preventable if ICE had provided clinically appropriate medical care.** Systemic failures in the delivery of medical and mental health care in detention have caused or contributed to an overwhelming number of deaths that would likely otherwise have been prevented in ICE detention.

ICE's Current Oversight and Accountability Mechanisms Regarding Death in Detention Are Critically Flawed and Do Little to Prevent Future Deaths

ICE's investigations, formal and informal reports, and recommendations in response to deaths in custody are structured to avoid fault and disclaim agency accountability for the death of detained immigrants. Flaws in ICE's review and remedial processes for deaths in detention have led to continued error and system failure, leading to continued deaths of detained people. Furthermore, ICE's flawed oversight process has failed to levy meaningful consequences, including contract termination, for conditions that have led to repeated deaths in detention.

ICE's detention death investigations have allowed the destruction of evidence, have failed to interview key witnesses, and have omitted key inculpatory facts.

Public reports and final internal analyses of the deaths of detained people created by ICE often fail to provide a complete recounting of deaths and omit key information regarding the agency's failure to ensure proper care to people in detention.

A close analysis of documents regarding ICE's investigations of detained people's deaths reviewed here indicate that ICE's investigations have failed to preserve evidence, omitted key facts, and did not follow obvious leads for causes of wrongful death. Instead, ICE has omitted critical facts that are potentially inculpatory to the agency and private prison companies with which it contracts, including likely or contributory causes of death.

In several cases, ICE failed to ensure that evidence connected to deaths was preserved for investigation, allowing detention officials to destroy critical video footage without consequence. ICE also failed to ensure that all key witnesses are available for investigatory interviews. On at least two documented occasions in separate cases, ICE suddenly released crucial detained eyewitnesses from custody within hours of an investigator's arrival to the facility; investigators did not follow up with the eyewitnesses who were released from custody.

- **ICE fails to ensure preservation of evidence in detention death investigations, and contract detention facilities have destroyed evidence highly relevant to investigation**

of deaths, including video surveillance recordings. For example:

- **ICE failed to ensure the preservation of video evidence in the death of Roxsana Hernandez.** Hernandez, a transgender woman from Honduras, died in ICE custody on May 25, 2018, after her detention at the Cibola County Correctional Center in New Mexico, which is run by CoreCivic, Inc. After ICE investigators requested a copy of video of Hernandez’s medical examinations at the facility that they had previously reviewed onsite, CoreCivic reported that the video had been overwritten, and that “the requested video is no longer available.” CoreCivic claimed that the video was automatically overwritten after “up to around 90 days,” even though ICE and CoreCivic had been put on notice to preserve video evidence relevant to Hernandez’s death.⁸³
- **ICE also failed to ensure the preservation of video footage relevant to the death of Gourgen Mirimanian.** Mirimanian, a 54-year-old man, died in ICE custody on April 10, 2018, while detained at the Prairieland Detention Center in Alvarado, Texas, which is operated by the private prison corporation, LaSalle Corrections. Although the facility made available some footage “of limited value” of the dorm in which Mirimanian was located prior to his death, this footage was “compromised by distance,” while another video “was not retained.”⁸⁴

Internal emails from ERAU staffers noted their frustration with the ICE Office of Detention Oversight’s failure to secure and send video surveillance recordings from the facility, noting that “[i]t is impossible to properly prepare a witness list or accurately prepare for the review” without video recordings. The staffer further noted that, “I really feel the need to make a record of the limitations ODO is placing on us by not getting us the required materials in advance of the review.”⁸⁵

- **ICE fails to interview and releases key detained eyewitnesses from custody immediately before investigators can speak to them.** Because investigators either did not attempt to or could not contact eyewitnesses after witnesses’ release, any information available from these eyewitnesses was not factored into ICE’s investigation. For example:

- **ICE investigators failed to interview a key eyewitness to the death of Ben Owen.** Owen, a 39-year-old national of the United Kingdom, died by suicide in ICE



Photo courtesy Tammy Jane Owen

- **custody at the Baker County Detention Center in Florida on January 25, 2020.** ICE investigators identified a detained eyewitness on its list of people to interview in relation to Owen’s death. The investigators were unable to interview him, however, as the agency released him from custody *during* the investigator’s visit to the facility. As internal emails reveal, the investigator noted that “we won’t be able to interview [name redacted] today. I just pulled his record up . . . and he was released on bond at noon today.”⁸⁶
- **Less than two hours after** a Georgia Board of Investigators (GBI) agent arrived at the facility to investigate the death of Efrain de la Rosa at the Stewart Detention Center in Georgia, authorities released a detained immigrant who was a witness to the death from custody. De la Rosa, who had schizophrenia, died by suicide at the age of 40 on July 10, 2018, after spending 21 days in solitary confinement. The witness had been detained in the cell immediately next to De la Rosa’s on the night of his death. GBI investigators, however, never had the opportunity to interview the witness, because he had been released at 3:06 a.m., less than two hours after the GBI investigator

arrived at the facility. The GBI investigator arrived at the facility at 1:36 a.m., and began to take photos of the cell where de la Rosa had died at 2:20 a.m.⁸⁷

- **ICE’s detention death investigations have failed to investigate or have omitted critical facts that would suggest fault by detention facilities or ICE.** Our review shows that ICE failed to investigate important leads, or omitted critical facts that would suggest fault by the detention facility or ICE.

- **ICE investigatory reports failed to disclose that internal oversight staff had ignored reports of dangerous conditions in the death of Efrain de la Rosa.**

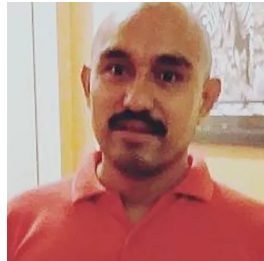


Photo courtesy of Jose Olivares.

In the month prior to his death at Stewart Detention Center, medical staff failed to ensure that de la Rosa, who had schizophrenia, receive his prescribed antipsychotic medication. Indeed, de la Rosa received no doses of the ordered psychiatric medications, even though he was under an order to receive the medication intramuscularly if he refused it.⁸⁸ Not only did medical staff fail to provide this medication—but nursing staff falsely recorded their offer and administration of psychiatric records.⁸⁹ As Dr. Sadacharan concluded, the acute destabilization caused by failure to receive his medication “most likely contributed to a preventable suicide.”⁹⁰

Notably, internal agency documents from ICE, written by a separate IHSC supervisor, stated that “[s]uicide victim, Mr. Efrain De La Rosa, could have been saved.”⁹¹ The IHSC supervisor noted that “those in IHSC listed as recipients on the [Significant Event Notification] reports do not actually review them,” and that the behavioral health unit “has long ignored SEN reports

reflecting severe mental illness.”⁹² IHSC headquarters staff had “received a total of 12 SEN reports prior to [de la Rosa’s] death, depicting suicidal ideation and psychosis.”⁹³ However, instead of intervening and ensuring that de la Rosa was treated with psychotropic medication, “he was remanded to segregation,” where he died by suicide.⁹⁴ Indeed, a CRCL whistleblower complaint later noted that IHSC leadership had instructed its Medical Quality Management Unit to cease reviewing SEN and segregation reports, “despite concerns raised to IHSC leadership that this restriction could negatively impact detainee safety.”⁹⁵ This information, however, never appeared in ICE’s investigatory reports regarding de la Rosa’s death. In addition, although the U.S. Attorney’s Office reviewed de la Rosa’s death for prosecution, the office declined to prosecute the matter.⁹⁶

- **ICE investigators failed to include critical facts regarding detention staff’s failure to provide proper Spanish interpretation and translation in the death of Maria Celeste Ochoa de Yoc,**



Photo courtesy family of Maria Ochoa de Yoc

which led to incorrect diagnoses and use of solitary confinement, in their final investigatory reports. Ochoa, a 22-year-old asylum-seeker from Guatemala, died in ICE custody on March 8, 2020, after ICE had detained her for almost six months. An autopsy documented her cause of death as liver failure due to probable acute viral hepatitis. At the time of her death, ICE had detained Ochoa for five months at the Kay County Detention Center in Newkirk, Oklahoma, and then for another month at the Prairieland Detention Center in Alvarado, Texas.⁹⁷

While detained at Kay County Detention Center, medical staff who did not speak Spanish repeatedly failed to utilize translation and interpretation services while also failing to provide proper diagnosis and treatment to Ochoa. Kay County staff incorrectly concluded that Ochoa was bulimic and suicidal, noting in clinical notes that she repeatedly vomited and expressed that she “wanted to kill herself.”⁹⁸ But Kay County’s failure to provide adequate translation led them to make this misdiagnosis, and lock Ochoa, who was on the brink of liver failure, in solitary confinement under a suicide watch protocol.⁹⁹ Kay County’s misdiagnosis was based on the staff’s failure to properly translate Ochoa’s communication. Internal notes from ICE investigators’ review of Ochoa’s written requests for medical attention concluded that “she may have been misunderstood when they claim she said she wanted to die. I believe it is likely she said she felt like she was dying.”¹⁰⁰ Although ICE’s Detainee Death Review notes that medical providers failed to use interpretation assistance while providing care to Ochoa, the review fails to report this error in detail, instead more generally concluding that “the language barrier may have interfered with delivery of care.”¹⁰¹ Inadequate treatment led Ochoa’s mental and physical condition to even further deteriorate. As medical experts noted, likely untreated hepatic encephalopathy due to liver failure may have affected her mental functioning.¹⁰²

Ochoa called someone outside the facility on February 6, 2020, the same day she submitted nine sick call requests and was placed in solitary confinement. A translation of the recorded call underscores her desperation and the facility’s failure to provide her with adequate treatment: Ochoa stated that “she felt like she was going to die, and wanted her mother and father told that she loved them very much and was sorry if she ever did anything wrong. She then said

that she loved them and could not take it any longer; also, that she felt like her heart was failing, and she no longer had any energy to move or even talk. The [person on the other line] asked her if someone could help her, and she said no one would; she said that all [Kay County Detention Center] had was incompetent nurses, and they would not help her.”¹⁰³

- **ICE does not require standardized autopsies for in-custody deaths, nor does it have consistent standards for conducting autopsies.**

Autopsies are a critical component in determining the cause of death and in the collection of medical evidence that may be useful in court proceedings. Although ICE is a federal agency and detains people in its custody nationwide, ICE lacks a standardized practice for conducting autopsies of people who have died in its custody. Instead, ICE defaults to minimum standards established by local jurisdictions, and generally relies upon each facility to develop its own procedures for ordering and scheduling an autopsy “in accordance with established guidelines and applicable laws.”¹⁰⁴ This lack of standardization means the decision to conduct an autopsy, and the quality of the autopsy, if conducted, will vary widely depending on the location of the person’s death. In addition, forensic pathologists who conduct autopsies for ICE do not consistently order full-spectrum forensic toxicology screenings upon examination, which prevents a full assessment of what substances were present in the body upon death, and the role that they may have played in the death itself. The failure to conduct autopsies by a certified forensic pathologist in accordance with national standards¹⁰⁵ may result in incomplete, unreliable, and inconsistent results that impede full accountability measures, whether civil or criminal. In contrast, the National Association of Medical Examiners, for example, recommends that “[a]n autopsy must be performed on all deaths in custody where the

death may be deemed unnatural, regardless of phase and time since injury . . . to correlate and/or confirm the reported circumstances, establish the cause of death, identify potential competing causes of death, document other significant pathologic conditions, and to assess claims of wrongful death, mistreatment, or neglect.”¹⁰⁶ In addition, detainees “with known natural disease who are expected to die and are under medical supervision should be investigated as a death in custody and receive an autopsy if appropriate.”¹⁰⁷

Properly conducted autopsies are important to assess the cause of death, and the degree to which a death may be preventable. For example:

- An autopsy of **Ronal Francisco Romero (aka Ronal Cruz)**, a 39-year-old man from Honduras, revealed that his cause of death was a sepsis infection caused by bacterial meningitis and complications of diabetes. Bacterial meningitis is a life-threatening infection of brain and spinal cord fluid, although patients provided with timely antibiotic treatment can make a full recovery.¹⁰⁸ Because the health risk posed by bacterial meningitis is so high, the Centers for Disease Control and Prevention (CDC) requires reporting of all cases, and can declare an outbreak with as few as two patients in a location; preventative antibiotic treatment must be provided to anyone who had close contact with a patient.¹⁰⁹ ICE, however, did not initially disclose that bacterial meningitis caused Romero’s death, instead reporting that he died of “diabetic ketoacidosis (a life-threatening complication of diabetes mellitus) and sepsis (infection).”¹¹⁰ Only after Romero’s family notified ICE that they planned to perform an autopsy did ICE commission one itself. Both autopsies concluded that he died as a result of bacterial meningitis.

IHSC’s mortality review committee concluded that the medical care provided at the Port Isabel Detention Center in Texas “was provided within the safe limits of

practice and did not directly or indirectly contribute to his death.”¹¹¹ But as an IHSC whistleblower stated in an internal memo first disclosed by BuzzFeed News,¹¹² the medical care provided to Romero was “grossly negligent,” and alleged that the “mortality review committee was erroneous in concluding that the care rendered to Mr. Cruz was appropriate.”¹¹³ Indeed, as medical expert reviewer Dr. Radha Sadacharan concluded, “if [Mr. Romero] had been started on broad spectrum antibiotics the morning he felt unwell, or more appropriately sent to the emergency room when he met sepsis criteria and had ketonuria and glucosuria, he likely would not have passed away.”¹¹⁴

The mortality report identified several weaknesses regarding Romero’s medical treatment in detention, including a group intake screening, where the detention facility nurse did not respond to his attempt to share any medical conditions. According to the video footage, Romero “raised his hand, pointed to his left ear,” but the nurses did not recall his response or record it.¹¹⁵ The mortality review also noted that “medications were not delivered in a timely manner after an [Advanced Practice Provider] gave a verbal order to administer a stat medication,” and that scheduled medication was not administered in a timely manner.”¹¹⁶ Upon Romero’s admission to the medical health unit, nurses did not review [Advanced Practice Provider] orders, and no orders or rechecks of his abnormal blood sugar levels were obtained.¹¹⁷ But as Dr. Sadacharan noted, ICE’s review of Romero’s death failed to find and propose sufficient remedies for the source of the error itself. “If diabetic ketoacidosis and sepsis were identified more quickly, this may have saved the patient’s life.” ICE, however only considered, but did not require, a training on diabetic ketoacidosis and meningitis for relevant staff, and no other relevant measures were suggested to prevent future error.¹¹⁸

Detention death investigations fail to include analysis of key structural factors that have led to death of detained people, and ICE fails to require systemic changes that would prevent future deaths in custody.

DHS detention death investigations are designed such that they have failed to include analysis of key structural factors that have led to the deaths of detained people. For example, DHS has limited the scope of investigation only to the subagency in which the deceased person was most recently held. For example, if someone died shortly after being transferred from Customs and Border Protection (CBP) custody to ICE custody, the death review would ignore the medical care that person received—or did not receive—in CBP custody. This precludes evaluation of systemic issues that have contributed to or caused death. DHS’s failure to ensure continued, consistent care upon a detained person’s transfer between detention facilities, including CBP and ICE facilities, can be a significant contributing factor to deaths in custody. Lapses in prescribed medication and required treatment, for example, can endanger a person’s health, or lead people with mental health disabilities to decompensate to the point of suicidality.

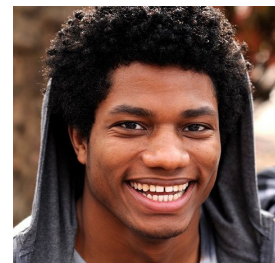
ICE investigators also typically fail to interview or evaluate Field Office or Headquarters-level decisions that have contributed to the death of detained people. Instead, detention death investigations typically focus and levy fault on the lowest-level employees involved. This focus fails to address facility-wide policies and practices that become significant contributing factors to the death, and those who have the most authority to address these factors. In addition, investigators often fail to identify systemic changes that address key factors that contributed to deaths in custody and would likely prevent future deaths.

For example:

- ICE’s root cause analysis of **Ronal Francisco Romero’s** death, described above, failed to address failures in communication and care by

Customs and Border Protection (CBP), and failed to provide any proposed solutions for delays in ambulance transport at the facility. Romero died of bacterial meningitis, a brain infection that can be effectively treated with broad-spectrum antibiotics if timely provided.¹¹⁹ ICE’s root cause analysis noted that CBP transferred Romero to ICE custody without any known medical evaluation or communication regarding his medical needs. Romero presented with symptoms of a meningitis infection almost immediately upon arrival at ICE’s Port Isabel detention facility in Texas, after his transfer from CBP custody. Lack of communication between CBP and ICE, and lack of information regarding Romero’s medical needs from CBP, likely contributed to a delay in appropriate treatment.¹²⁰ ICE, however, made no recommendations or plan to address this lack of information from CBP. ICE’s root cause analysis also noted that detention facility staff delayed the ambulance from treating Romero for at least 16 minutes, as staff failed to timely provide a facility escort vehicle in and out of the facility. ICE, however, provided no proposed solutions to decrease delays in ambulance transport in its recommendations.¹²¹

- **ICE investigators failed to interview or evaluate any officials responsible for ensuring adequate staffing of mental health personnel at the Stewart Detention Center,** operated by



Courtesy family of Jean Jimenez.

CoreCivic, in their investigation of the death of **Jean Jimenez**. Jimenez, a 27-year-old native of Panama, died by suicide by hanging on May 15, 2017, after experiencing schizophrenic hallucinations. ICE’s review of Jimenez’s death, however, failed to require any increases in psychiatric staffing or failsafe measures to ensure that individuals with decompensation were treated in a timely fashion at the facility. Instead, ICE’s remedies focused only on prescreening policies and conducting low-level

trainings. As Dr. Sadacharan concluded, “ICE did not propose to enact any solutions that would actually prevent error in the future.”¹²²

Jimenez had a well-documented case of schizophrenia, and had notified behavioral health practitioners at Stewart four times prior to his death that his medications were not effectively controlling his auditory hallucinations and impulsivity. Each time, however, mental health providers failed to timely respond, in one instance scheduling a follow-up tele-psychiatry appointment for two weeks later. As all medical reviewers concluded, lack of adequate mental health staffing at Stewart clearly contributed to Jimenez’s death:¹²³ at the time of Jimenez’s death, ICE required one full-time equivalent psychiatrist for a facility that held nearly 2,000 detainees. The ICE Health Services Administrator at Stewart later testified that this required level of staffing was not adequate for a facility of Stewart’s size, and that he had raised concerns to ICE leadership about the need for additional mental health staff at Stewart.¹²⁴ CoreCivic and ICE, however, failed to meet even this minimal level of staffing: at the time of Jimenez’s death, Stewart provided tele-psychiatry to detained people for six hours a week—a level of less than 20 percent of required staffing, with backlogs of 10-12 weeks for services.¹²⁵ ICE’s investigatory reports, however, include no recommendations for increasing staffing at the facility, or decreasing the population at the facility.

- **ICE’s investigation of the death of Jose Leonardo Lemus-Rajo failed to result in any policy changes that could prevent similar deaths in the future.** Lemus-Rajo, a 23-year-old man from El Salvador, died of complications of alcohol withdrawal during his detention at the Krome Detention Center in Florida on April 28, 2016. Alcohol withdrawal syndrome occurs when an individual discontinues alcohol intake after a period of prolonged consumption. Withdrawal can result in a broad range of symptoms from mild tremors, to severe seizures that can progress to death if not promptly treated. As medical

expert Dr. Chanelle Diaz noted, “death from acute alcohol withdrawal is always preventable with adequate identification of withdrawal and treatment,” which did not occur here.¹²⁶

The basic established clinical practice is to conduct a Clinical Institute for Withdrawal Assessment (CIWA) to monitor symptoms and determine the need for medical treatment, including provision of medications such as benzodiazepines to prevent escalating symptoms and death. ICE investigators noted that medical staff at Krome did not administer the CIWA during intake, even after Lemus-Rajo reported heavy alcohol use and symptomatic tremors. As medical expert Dr. Radha Sadacharan noted, “CIWA scoring should be initiated for every single individual who passes through booking and reports alcohol use, given the high prevalence of substance use disorders and the significant morbidity and mortality associated with acute alcohol withdrawal.”¹²⁷ ICE, however, made no policy changes as a result of its investigations, and IHSC officials noted only that “medical professionals rely on their training, education, and experience to make medical decisions and it would not be appropriate to make policies which interfere with those decisions.”¹²⁸

ICE’s oversight process has failed to result in meaningful consequences for detention facilities.

ICE’s oversight process has failed to result in meaningful consequences for detention facilities. Since 2009, congressional appropriations have included a provision that ICE cannot expend funds to detention facilities that fail two consecutive ERO inspections.¹²⁹ The applicable inspections, conducted by ICE’s Office of Detention Oversight (ODO), however, do not consider the detainee death reviews that identify any violations of contract obligations or detention standards. Inspection reports have, from time to time, merely mentioned that a death occurred at the facility or that the facility is facing “significant litigation.” Similarly, ERAU and IHSC Detainee Death Reviews do not consider prior findings of

standards violations by facilities and contractors when assessing the events leading up to a detainee’s death. No facility, however, has lost a detention contract, much less failed an ICE inspection, after a detainee death in the period of this report’s study, even where ICE’s death reviews have found multiple violations of detention standards.

Several DHS oversight bodies investigate conditions that may contribute to deaths in ICE detention facilities, including DHS’s Office of Civil Rights and Civil Liberties (CRCL) and DHS Office of Inspector General (OIG). However, ICE’s investigatory process for deaths in custody fails to consider findings regarding health and safety risks by these oversight bodies. Instead, ICE IHSC and ERAU detainee death investigations proceed in silos that do not consider or account for any conclusions made by CRCL or OIG. Similarly, ERAU and IHSC Detainee Death Reviews do not consider prior findings of standards violations by facilities and contractors when assessing the events leading up to a detainee’s death. To the authors’ knowledge, ICE has issued financial penalties against contractors on only three occasions, of the 63 deaths that have taken place between 2017 and 2023. However, these financial penalties had little impact on contractors’ bottom line, and in these instances, ICE even expanded the scope of its detention contracts at the facilities in question. Because ICE does not make information available regarding financial penalties related to detainee deaths against contractors, this information is based on information made available in Congressional reports and in civil litigation. These cases include:

- In April 2018, ICE issued a contract discrepancy penalty against the GEO Group, Inc., which operates the Aurora Detention Center, after reviewing the death of Kamyar Samimi. The penalty, which ICE levied after finding that GEO was “deficient” in meeting medical care standards, consisted of “a one-time deduction of 20% based on the December 2017 invoices amount,” or approximately \$750,000.¹³⁰ However, less than a year later, ICE expanded its detention space at Aurora by 432 beds, increasing detention capacity by 20 percent.¹³¹

CONTRACT DISCREPANCY REPORT		1. CONTRACT NUMBER IHSCDM-11-D-00003	
Report Number: 2018-0001		Date: 04-12-2018	
2. TO: (Contractor and Manager Name) The GEO Group Aurora Contract Detention Facility 3130 N. Oakland Street Aurora, CO 80010		3. FROM: (Contractor and Manager Name) MIPA - COR United States Department of Homeland Security Immigration and Customs Enforcement Enforcement and Removal Operations Denver Field Office	
DATES			
CONTRACTOR NOTIFICATION	CONTRACTOR RESPONSE DUE BY	RETURNED BY CONTRACTOR	ACTION COMPLETE
04/12/2018	05/04/2018		
4. DISCREPANCY OR PROBLEM (Please write in detail. Include reference to PHS literature. Attach communication sheets if necessary.)			
A site visit was conducted January 9 through 11, 2018, by [REDACTED], ERAU Unit Chief, [REDACTED], ERAU Inspection and Compliance Specialist and team leader; and Creative Corrections contract personnel [REDACTED], Program Manager, [REDACTED], Security Subject Matter Expert; and [REDACTED], Registered Nurse, Medical Subject Matter Expert.			
Contractor participation was requested to determine compliance with the ICE 2011 Performance Based National Detention Standards (PNDS), 2016 revision, governing medical care and security operations. The purpose of the visit was to review the death of detainee Kamyar SAMIMI which occurred on December 2, 2017, while detainee was in custody at the Denver Contract Detention Facility, Aurora, Colorado.			
Per the Immigration and Customs Enforcement (ICE) Performance-Based National Detention Standards 2011 (PNDS 2011), the Denver CDF, Aurora, CO, is found to be deficient in meeting standard 4.3 Medical Care.			
Medical Compliance Findings			
Medical Care, Section (V)(B), which states, "All facilities shall provide medical staff and sufficient support personnel to meet these standards."			
<ul style="list-style-type: none"> • Positions for key personnel, including the sole midlevel provider and Director of Nursing, were vacant for longer than six months. According to Dr. [REDACTED] and HSA [REDACTED], the midlevel provider was responsible for conducting initial health appraisals for detainees with chronic conditions. Since the position became vacant, RNs have routinely conducted these initial health appraisals. SAMIMI did not receive a health appraisal by either the physician, or an RN. In addition, absent a Director of Nursing or other nurse supervisor between nursing staff and Dr. [REDACTED], clinical supervision was inadequate to assure adherence to provider orders and necessary and appropriate care. 			
Medical Care, Section (V)(G)(12), which states, "Each detention facility shall have and comply with written policy and procedures for the management of pharmaceuticals, to include: (12) documentation of accountability for administering or distributing medication in a timely manner, and according to licenses provider orders."			
<ul style="list-style-type: none"> • Prescription orders for treatment of withdrawal were written for up to three times daily, as needed, for anxiety, restlessness, sleeplessness, nausea, and pain. In spite of frequent and progressive complaints of these symptoms, the Medication Administration Record and nursing notes show SAMIMI was given fewer than half of the allowed doses. • Neither nursing notes nor the MAR consistently document times medications were administered, making it difficult, if not impossible, for nurses on subsequent shifts to know when SAMIMI was due for his next dose. 			
Medical Care, Section (V)(J), which states, "Where there is a clinically significant finding as a result of the initial screening, an immediate referral shall be initiated and the detainee shall receive a health assessment no later than two working days from the initial screening."			
<ul style="list-style-type: none"> • The identification of early opioid withdrawal symptoms did not result in referral for initial provider assessment within two working days following intake screening. 			
Page 1 of 5			

Contract Discrepancy Report for Stewart Detention Center, Department of Homeland Security.

- In February 2018, ICE issued a contract discrepancy penalty against CoreCivic after finding that it had failed to comply with suicide prevention guidelines following the death of Jean Jimenez.¹³²
- In October 2018, ICE issued a penalty against CoreCivic for the deaths of Efrain de la Rosa and Jean Jimenez, both of whom died at the Stewart Detention Center in 2017 and 2018 respectively.¹³³ These financial penalties totaled 40% of CoreCivic’s monthly “Bed day detention” invoice for May 2017, or an estimated total of approximately \$1.4 million, and a 20% deduction of the same for July 2017, or approximately \$700,000.¹³⁴ In comparison, ICE paid CoreCivic \$441 million for detention contracts in 2017.¹³⁵ One month after issuing this penalty, ICE awarded CoreCivic a new contract to provide

medical care to detainees at Stewart.¹³⁶ Between 2017 and May 2024, ten people detained at Stewart died in ICE custody, the highest number of detention deaths in the entire nation. Despite that record, Stewart remains fully operational as an ICE detention facility.

Systemic Failures in Medical and Mental Health Care Have Caused Preventable Deaths in ICE Detention

This report examines the deaths of 52 detained people who died in ICE custody between January 1, 2017 and December 31, 2021. As detailed above, ICE's investigatory reports often fall short in the scope of investigation, and do little to identify solutions that will prevent future deaths. Even so, ICE's investigatory reports contain important, and often, the only publicly available information regarding medical and mental health care provided to people detained by ICE prior to their death.

Our team of medical experts closely reviewed these official investigatory reports, and examined whether the death was preventable based on the information released by ICE to the public. These expert reviews identified consistent failures that contributed to preventable deaths of people in ICE detention, as detailed below. Many examples described not only illustrate a specific systemic failure but also reveal how these instances often intersect with other systemic issues, highlighting the interconnectivity and prevalence of ICE's failures. These issues include:

- Incorrect, incomplete diagnoses of medical conditions by detention medical staff;
- Incomplete, inappropriate, or delayed treatment or medication, with a particularly high occurrence in cases involving manageable hypertension or cardiovascular issues;
- Flawed or delayed emergency responses, including failure to immediately intervene, provide care, or call emergency medical services,

on-site delays of ambulances that delayed emergency care during medical crises, and insufficient or malfunctioning medical equipment necessary to prevent death;

- Suicides caused by failure to provide mental health care and proper medication management, lack of mental health staff, and use of solitary treatment;
- Failure to provide necessary and required interpretation and translation services;
- Failure to follow COVID-19 protocols, including failure to release medically vulnerable people who had pending orders for release from custody;
- Chronic understaffing, inadequate and improper staff training, and inappropriate provision of care outside the scope of practice; and
- Insufficient and falsified documentation.

The overwhelming majority of deaths of detained immigrants could likely have been prevented if ICE had provided clinically appropriate medical care.

Medical experts examined documents available for each death to assess whether, in their clinical opinion, the death would have been prevented, or if there was a reasonable possibility that the death could have been prevented, if ICE had provided clinically appropriate medical care, intervention, or management of the health condition.

Medical experts concluded that of the 52 deaths reported by ICE between January 1, 2017 and December 31, 2021, that 49 deaths (95 percent) were preventable or possibly preventable if appropriate medical care had been provided. Only three deaths were deemed not preventable.

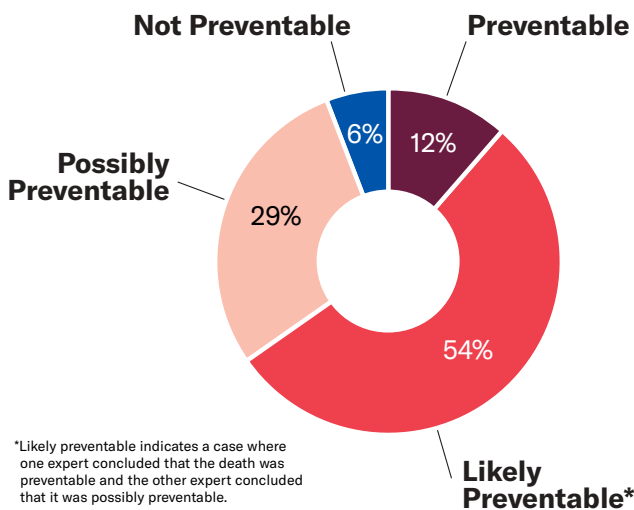
Medical experts considered a death to be preventable where the person's life could have been saved or the outcome could have been different with appropriate medical care; a death was considered to be possibly preventable where there was a reasonable possibility that the person's life could have been saved or the

outcome could have been different with appropriate medical care.

TABLE 6.
Preventable Deaths In Ice Detention
(of 52 deaths 2017-2021)

Determination ¹³⁷	Total	Percentage
Preventable. Both expert reviewers concluded that death was preventable if appropriate care had been provided.	6	12%
Likely Preventable. One expert concluded that the death was preventable with appropriate care; one expert concluded that the death was possibly preventable, where there was a reasonable possibility that death could have been prevented if appropriate care had been provided.	28	54%
Possibly Preventable. Both experts concluded that there was a reasonable possibility that death was preventable, if appropriate care had been provided.	15	29%
Not Preventable. Both experts concluded that the death was not preventable.	3	6%
Indeterminate. Both experts concluded that there was insufficient information to draw a conclusion.	0	0%

FIGURE 2.
Preventable Deaths In Ice Detention
(of 52 deaths 2017-2021)



Medical staff made incorrect or incomplete diagnoses in the overwhelming majority of deaths.

A correct diagnosis by a qualified medical provider is a basic precondition for appropriate medical care. Without a well-informed understanding of underlying causes of a patient’s symptoms and signs, a medical professional might not prescribe an accurate and adequate treatment, or they might treat symptoms without treating the root cause.

ICE detention center medical staff made incorrect, inappropriate, or incomplete diagnoses in 88 percent of deaths reviewed (n=42 of 52). In these cases, medical staff did not triage patients to the appropriate level of care, ignored key symptoms, failed to provide patients with the opportunity to be seen by a physician, did not order appropriate diagnostic tests, failed to collect or interpret information that could have led them to an appropriate response, and even threatened disciplinary action for filing repeated medical requests. For example:

- **Jesse Jerome Dean, Jr.,** died in ICE detention at the Calhoun County Jail in Battle Creek, Michigan, on February 5, 2021. Dean, a 58-year-old man from the Bahamas, **died from an undiagnosed**



Photo courtesy family of Jesse Dean.

gastrointestinal hemorrhage caused by a bleeding ulcer in the digestive tract. All medical experts who reviewed Dean’s case agreed that his death would have been prevented had he received proper medical care. As medical expert Dr. Chanelle Diaz observed, “there is evidence of gross medical negligence in this case.”¹³⁸

In the five weeks prior to his death, Dean submitted at least 27 requests because of his inability to eat, dramatic weight loss of almost 20 pounds in three weeks, and severe nausea, pain, and weakness, all of which should have led to referral to a specialist, or at least, an appointment with a physician. On multiple

occasions, Dean's symptoms were so severe that he requested medical evaluation at a hospital—and even offered to pay the cost. During this time, however, Dean did not receive care from a doctor, but rather, was seen only by nurses practicing outside the scope of their training and authority, who ordered incorrect diagnostic tests, and provided him only with laxatives, stool softeners, Tums, Pepto Bismol, and painkillers.¹³⁹ Detention facility medical staff failed to conduct a full review of symptoms (e.g., whether he had blood in stool that might suggest GI bleeding), did not conduct abdominal exams, assess his vital signs, conduct appropriate triage for his symptoms, or order diagnostic tests appropriate for these severe symptoms, including an endoscopy or CT scan.¹⁴⁰ Instead, facility staff threatened him with a citation for submitting excessive requests for medical care and labeled him a “malingerer.”¹⁴¹

Two days before Dean's death, the Bahamian embassy contacted ICE, inquiring about his medical condition and stating that it had sent travel documents to allow his release to the Bahamas. In response, detention facility medical staff wrote that “Mr. Dean is doing well,” stated that he was “hoarding food,” and that “he does have an appointment scheduled for next Monday to see his psychiatrist.”¹⁴²

On the night before his death, Dean collapsed twice, hit his face on a door, and fell to the floor. Even after medical staff decided to move him to the medical observation unit, he was never referred for evaluation by an advanced practice provider or doctor. ICE's own investigation found that no medical staff checked on Dean that night. Although one nurse stated that she checked on him after an initial assessment, ICE's review of surveillance footage showed that she did not, and indeed, “for at least 2 hours and 45 minutes throughout her shift, [the nurse] was reclining in the nursing station chair with her feet propped up, texting on her cell phone.”¹⁴³ The next morning, Dean was so weak that he could barely get up. Three hours later, medical staff called

an ambulance, where he died on the way to the hospital.¹⁴⁴

IHSC's mortality review committee determined that Dean's medical care “was not provided within safe limits of practice,” and could “pose a future risk for adverse outcomes.”¹⁴⁵ ICE, however, continues to detain 127 people at Calhoun each day.¹⁴⁶

- **Emigdio Abel Reyes Clemente died on April 3, 2019 in a solitary confinement medical isolation cell in ICE's Florence Service Processing Center in Arizona. Reyes Clemente, a 54-year-old man from Mexico, died after experiencing significant upper respiratory symptoms caused by undiagnosed and untreated bacterial pneumonia.**¹⁴⁷ On April 1, 2019, he requested a visit with detention facility medical staff because he had fever, chills, sore throat, and a cough. Contrary to the standard of care, the physician's assistant assumed, without any testing, that he had influenza, and prescribed Tamiflu, an antiviral drug that is ineffective against bacterial pneumonia.¹⁴⁸

Reyes Clemente's condition rapidly deteriorated in the next two days, with progressively critical vital signs and signs of physical decompensation, such as dangerously low oxygen levels, weakness, and inability to sit or walk without assistance. Despite these abnormal vital signs, which should have raised concern, facility staff did not call a provider. On April 2, 2019, the day before his death, Reyes Clemente's oxygen levels plummeted to 83 and 79 percent, which constitutes a medical emergency requiring immediate attention. Nursing staff, however, did not provide him with necessary oxygen therapy, nor did they send him to the emergency room for evaluation or x-rays, which would have been the appropriate immediate medical response to such a critically abnormal oxygen value. Instead, medical staff placed him in a medical isolation (solitary confinement) unit and offered him no additional treatment.¹⁴⁹

The next morning, at 6:09 a.m. on April 3, 2019, an officer entered his medical isolation cell, and found that Reyes Clemente’s “eyes were wide open and his chest did not rise and fall.” The officer called for assistance but did not start CPR because he believed that Reyes Clemente “was already dead.” A few minutes later, medical staff arrived with a mobile oxygen tank.¹⁵⁰ Within two hours, the county coroner arrived, and exited the solitary confinement unit with Reyes Clemente’s body.¹⁵¹

Reyes Clemente’s autopsy report confirmed that he had bacterial pneumonia at the time of his death, and that his corpse tested negative for influenza. The autopsy report, however, listed his cause of death as “complications of liver cirrhosis, diabetes, and hypertensive cardiovascular disease.”¹⁵² But expert medical reviewers found that this conclusion was erroneous: the progression of Reyes Clemente’s treatment and illness do not indicate that these underlying conditions were the primary causes of his death. Instead, both medical reviewers concluded that Reyes Clemente died a preventable death due to misdiagnosis of bacterial pneumonia and lack of appropriate medical care.¹⁵³ Reyes Clemente was likely even more vulnerable to infection due to his uncontrolled diabetes, as the facility stopped providing blood glucose checks the week before his death.¹⁵⁴

Incomplete, inappropriate, or delayed treatment or medication

Our medical experts concluded that medical staff provided incomplete, inappropriate, or delayed treatment or medication that caused or contributed to death in 79 percent of cases reviewed (n=38). ICE detention medical staff administered treatment that was inconsistent with evidence-based medical standards or was inadequate to resolve the medical issue, or delayed care beyond a reasonable timeframe. These cases also include instances where medical staff failed to appropriately manage necessary medication, and prescribed medications that were

contraindicated or had harmful interactions with already prescribed drugs. Medical staff also failed to appropriately administer oxygen support, pain relief, or other support when needed.

In 14 deaths, ICE detention medical staff also failed to provide appropriate care related to cardiovascular disease, failing to take EKG readings when presented with heart attack symptoms, or delaying the provision of emergency CPR. As our medical experts concluded, this failure directly caused or contributed to preventable deaths. For example:

- **Carlos Mejia-Bonilla**¹⁵⁵, a 46-year-old man from El Salvador, died of gastrointestinal bleeding in ICE custody on June 10, 2017, after being detained at the Hudson County Department of Corrections and

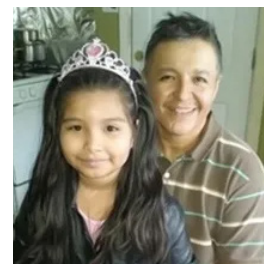


Photo courtesy family of Carlos Mejia Bonilla

Rehabilitation in New Jersey. During the 10 weeks that ICE detained him, Mejia-Bonilla struggled to receive the medication that he had been prescribed for anemia and cirrhosis. Ultimately, the facility’s careless approach to medication management may have proved fatal. Unlike ICE’s medical review, our medical expert reviews noted that **the detention facility’s primary care provider—without seeing Mejia-Bonilla in person—prescribed him naproxen, which poses a significant risk of gastrointestinal bleeding and renal failure in patients with cirrhosis of the liver** and was thus contraindicated. **Four days later, Mejia died of gastrointestinal bleeding.** As Dr. Radha Sadacharan concluded, “this medical decision, combined with the poor attention to detail the medical staff had in assessing Mr. Mejia at intake, and the lack of appropriate and timely follow-up care for any of his medical needs are evidence of substandard medical care at Hudson County Jail that will continue to lead to unnecessary morbidity and mortality if it is not improved.”¹⁵⁶

Mejia-Bonilla had lived in Long Island for 25 years with his wife and children, where he had established a successful construction business. He was detained in a case of mistaken identity by ICE, whose officers arrested him after searching for a different person.¹⁵⁷ When Mejia-Bonilla first entered ICE custody, he informed the medical staff that he had diabetes, anemia, and cirrhosis of the liver, and that he was on prescription medication to treat these conditions. Although the facility nurse entered these preexisting medical conditions into his chart, she provided him only with diabetes medication, but never started medication for anemia or cirrhosis, even after his local pharmacy verified his current medication. The facility made no attempts to identify and seek medical records from his medical providers who had ordered his medications. The nurse also failed to order required laboratory diagnostic testing to determine iron and liver function blood levels. In a later investigatory interview, the staff physician confirmed that laboratory work should have been ordered, stating that “I don’t know what she was thinking.”¹⁵⁸ Mejia repeatedly requested that the facility provide him with his prescribed medication, which went unanswered.¹⁵⁹

As Dr. Elena Jimenez Gutierrez noted about Mejia-Bonilla’s care, “there were various missed opportunities for intervention and gaps in clinical care, including no documented use of interpretation assistance, insufficient monitoring of blood pressure and blood glucose, absence of medication reconciliation, lack of review of initial health appraisal by clinical medical authority, break in continuity of chronic disease treatment/ inadequate clinical management of chronic conditions, prescriptions of inappropriate medications, lack of communication about abnormal findings amongst clinical staff, inappropriate nursing call protocol, lack of notification regarding laboratory studies’ cancellation, lack of referrals for mental health professional, dentist, and medical providers, care delivery outside the safe limits of practice,

and lack of timely access to necessary and appropriate higher level of care.”¹⁶⁰

- **Wilfredo Padron** died in ICE custody on November 1, 2018, at the Monroe County Detention Center in Key West, Florida. Padron, a 58-year-old man from Cuba, died of coronary artery disease due to atherosclerotic cardiovascular disease – blocked heart arteries which resulted in a heart attack. Medical expert reviewers concluded that detention facility medical staff repeatedly failed to provide critical interventions where Padron reported symptoms of chest pain, which would have likely prevented his death.

Mr. Padron’s health began to deteriorate on October 19, 2018, when he submitted a request for medical attention regarding elevated blood pressure in Spanish, but detention facility medical staff mistakenly read it as a request to be seen for depression and placed him on a list for mental health support, thereby delaying his medical request by a week. In the week before his death, facility medical staff failed to intervene appropriately when Padron complained of chest pain and elevated blood pressure. On October 26, Mr. Padron again complained of chest pain that radiated to his left arm and back, which are symptoms of a heart attack. Medical staff conducted an EKG, and he was transported to the emergency room. However, the emergency room was informed that Mr. Padron was suffering from abdominal pain instead of chest pain, and the emergency room concluded that he had constipation. He was returned to the facility three hours later, with his chest pain and elevated blood pressure untreated.¹⁶¹ The facility staff did not follow up on the cardiac symptoms, nor did they send Padron back for reevaluation, which, as Dr. Sadacharan noted, would have likely changed the outcome of his case.¹⁶² Two days later, on October 28, Padron again requested medical attention due to a pain in his chest that radiated down his left arm. The detention facility nurse did not conduct an EKG, or follow treatment procedures for hypertensive patients, and instead provided

him Motrin for pain.¹⁶³ The next day, on October 29, Padron again complained about chest pain. Despite his ongoing and severe chest pain, detention medical staff did not order an EKG test.¹⁶⁴

On October 31, 2018, the day before his death, Padron once again complained of chest pain and

was seen in the medical unit. Detention medical staff, however, did not obtain an EKG test or refer him to a higher level of care. At 11:00 p.m. that night, he showed a guard his ID card through his cell window during count. That was the last time anyone saw him alive.¹⁶⁵ The next morning, on November 1, around 6:41 a.m., another detainee went to Padron's cell, and could not wake him

PROFILES

Kamyar Samimi

Neda Samimi-Gomez keeps a memory box of the things she remembers about her father, Kamyar Samimi. “My biggest fear is forgetting about things with him,” she said. She remembers her father as the one who always took her to doctor’s appointments, girl scout meetings, and the movies, an incredible cook who loved sweets, and as the family prankster with a dramatic sense of humor. “He was very much a part of the small moments that make relationships so special. He loved his family and wanted to make sure we were happy and safe,” she recalls.

Neda’s father came to the United States from Iran in the 1970s to study computer science and was a legal permanent resident. He lived with his family in Colorado for over 40 years, until November 2017, when ICE officers detained him at the Aurora ICE Detention Center. Neda found out that ICE had detained him when she couldn’t reach him to invite him for Thanksgiving dinner. The family assumed that he would be released from custody on

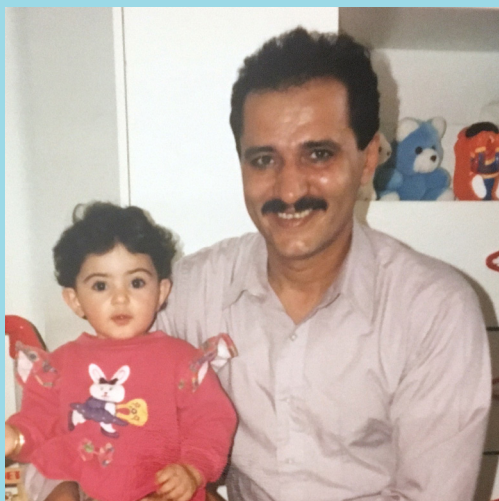


Photo courtesy Neda Samimi-Gomez

the day of his first immigration court hearing, December 4, 2017. But Kamyar never made it to that hearing. Instead, Neda received a call that day from an ICE officer, who told her that her father had died in detention of cardiac arrest two days before.

After Neda contacted the ACLU of Colorado, she and her family filed suit against the government and the GEO Group, Inc., the private prison corporation that operates the Aurora detention facility. As a result, they learned more details about his treatment — and lack thereof — in ICE detention. “He was failed by ICE and GEO, and the medical staff,” Neda concluded, noting the multiple

times that his requests for medical attention went ignored. “He was unjustly detained. Two weeks later, after none of his medical concerns were heard, he died. There is nothing in the world that can bring back my father. What I want is for no one else to ever experience this.”

up. Officers tried to rouse Padron but found his body “cold and blue.” Medical staff arrived soon after, and unsuccessfully administered CPR.¹⁶⁶ An autopsy concluded that he had died of a heart attack caused by thrombosis of the right coronary artery due to atherosclerotic cardiovascular disease.¹⁶⁷

- **Kamyar Samimi**, a 64-year-old man from Iran, died on December 2, 2017, at the Aurora Detention Center in Colorado. Samimi came to the United States in the 1970s to study computer science, married, and had three children. He had been prescribed and had successfully taken methadone for over two decades to manage opioid use disorder, which had started as a child in Iran when he was given opium for tooth pain.¹⁶⁸ Detention medical staff, however, discontinued medication assisted treatment for opioid use disorder upon his arrival at Aurora on November 17, 2017, putting him into withdrawal from methadone. Over the next sixteen days, Samimi’s condition deteriorated rapidly. Samimi experienced tremors, pain and weakness, nausea, vomiting, an inability to sit up in bed or a wheelchair, incontinence, and signs of dehydration. He also attempted suicide, telling staff that he wanted to die due to his symptoms of methadone withdrawal. Facility medical staff, however, did not transfer him into acute care in a timely manner, did not monitor his vital signs as ordered, and never completed monitoring of his withdrawal symptoms using the Clinical Opiate Withdrawal Scale (COWS) assessment, as ordered. During this time, the facility’s physician never physically examined Samimi. The nurses who treated him viewed him as “malingering or seeking drugs,” and “did not see an urgent need to notify the physician of his worsening condition.”¹⁶⁹

On December 1, 2017, the night before his death, Samimi began to spit up blood, vomited frequently, and began to have seizure symptoms, leading facility staff to call an ambulance. Samimi stopped breathing shortly after their arrival, and paramedics were unable to resuscitate him.¹⁷⁰

As expert medical reviewer Dr. Chanelle Diaz noted, Samimi’s autopsy “demonstrated evidence of aspiration pneumonia and a gastrointestinal bleed, both of which could have resulted from repeated vomiting due to opioid withdrawal, which could have been treated with medication and prevented.”¹⁷¹ Dr. Diaz concluded that detention facility staff inappropriately discontinued Samimi’s medication assisted treatment for opioid use disorder putting him into acute withdrawal. As she noted, **Samimi’s “withdrawal symptoms were then inadequately monitored and under-treated, resulting in his death.** He was treated with callous disregard by nursing staff who thought he was ‘drug-seeking. He did not receive treatment aligned with existing evidence-based guidelines for the management of opioid withdrawal. There were multiple missed opportunities to escalate his care that could have prevented his death.”¹⁷²

- **Kuan Hui Lee**, a 51-year-old man from Taiwan, died on August 5, 2020 as a result of hypertensive left thalamic hemorrhage, a type of stroke caused by bleeding in the brain due to longstanding uncontrolled high blood pressure. He died in ICE custody after being detained at the Krome North Service Processing Center and the Broward Transitional Center, both in Florida. Lee had a significant history of severely elevated blood pressure, requiring tight control given his cardiovascular risk. However, detention facility medical staff failed to provide Lee with blood pressure medications during the 48 hours prior to his medical emergency, which occurred early on July 31, 2020.¹⁷³ As Dr. Sadacharan concluded, the detention facility’s failure to provide Lee with his blood pressure medication in the 48 hours prior to his medical emergency, combined with staff’s failure to alert doctors to severely elevated blood pressure, directly contributed to Lee’s death.¹⁷⁴

Medical experts who reviewed Lee’s case noted multiple occasions where **facility medical staff failed to appropriately respond to Lee’s symptoms and the facility’s significant delay**

in providing emergency care. Reviewers noted repeated failures, including insufficient blood pressure monitoring, failure of nurses to notify providers regarding abnormal vital signs, including high blood pressures, and the administration of clonidine and ibuprofen by nurses without provider orders, practicing outside the scope of their license.

Medical expert reviewers also raised concerns with the detention facility's failed emergency response. On July 31, 2020, detention center staff failed to immediately initiate medical emergency and 911 notifications.¹⁷⁵ Medical staff did not conduct any vital sign checks or assessments for 12 minutes after Lee was found in his cell, and instead, tried to wake Lee and adjust his position.¹⁷⁶ It took 10 minutes for a vital sign machine to be brought into the room and a further eight minutes to check Mr. Lee's oxygen level. Medical staff only provided him with oxygen 27 minutes after he was found unconscious. Although medical staff reported hearing heavy breathing with phlegm, which required suction, nurses did not immediately suction Lee because they did not know how to use the machine and could not find an electrical outlet for the machine. After clearing Lee's airway, medical staff placed him on his back for 28 minutes, which is contrary to basic life support guidance. When emergency medical staff arrived, they found Mr. Lee still unconscious and without supplemental oxygen.¹⁷⁷ Emergency medical staff took Lee to a local hospital, where he remained unresponsive and was pronounced dead five days later.¹⁷⁸

- **Samuelino Pitchout Mavinga**, a 40-year-old man from Angola, died in ICE custody after being detained at the Otero County Processing Center in New Mexico on December 29, 2019.¹⁷⁹ During Mavinga's detention, medical staff at Otero missed multiple opportunities for clinical intervention, failed to work up abnormal imaging and clinical findings, failed to assess his mental capacity to refuse treatment, failed to manage severe malnutrition over the course of his

detention, and did not consult with neurology or psychiatric experts upon symptoms of psychosis.

Upon his arrival at Otero, Mavinga began to demonstrate symptoms of mental illness.¹⁸⁰ On November 17, 2019, several other individuals detained with Mavinga complained to staff about his behavior and poor hygiene, such as urinating in his bed and refusing meals and medication.¹⁸¹ However, nursing staff did not follow mental health protocol, and Mavinga did not receive a timely and appropriate consultation with a mental health provider.¹⁸² Staff also did not evaluate Mavinga's neurological state, mental capacity, or legal competency to refuse assessment or treatment despite his evident agitation and rapid weight loss; indeed, he lost 30 pounds in about 30 days. Between November 18, 2019, to December 11, 2019, Mavinga ate only two full meals, 18 apples, and one slice of pizza. Although medical staff documented this rapid, significant weight loss, they did not actively manage this medical problem. Although Mavinga agreed to take liquid nutritional supplements such as Ensure, facility staff never provided any because the ICE Health Service Administrator "was trying to find it at a 'reasonable or discounted price.'"¹⁸³ The ICE detention medical team was responsible for following up on concerning symptoms and providing appropriate treatment. Instead, medical staff allowed him to deteriorate for over a month, until ICE sent him to the hospital on December 12, where he died 17 days later.¹⁸⁴ Mavinga's death was determined to be caused by coccidioidomycosis, a fungal infection of the lungs, as well as complications from refractory shock caused by sepsis.¹⁸⁵

Flawed or delayed emergency response

Appropriate and timely medical response in an emergency is critical to saving lives.¹⁸⁶ Detention facilities are required to ensure the delivery of 24-hour emergency health care, and that medical and safety equipment be made available and maintained for staff use. Our review, however, found that in 40 percent (n=21) of the reviewed cases of death,

ICE detention facilities failed to provide timely and appropriate emergency care. In 13 percent of cases (n=7), the equipment used during the medical response either failed or was insufficient to effectively respond to the medical emergency. ICE detention facilities also delayed emergency medical personnel from accessing patients by failing to call 911 in a timely manner or blocking ambulances from entering the facility. For example:

- **Henry Missick** (a/k/a Anthony Jones), a 51-year-old man from the Bahamas, died of a heart attack in the waiting room of an ICE detention facility medical unit after staff repeatedly failed to provide timely emergency care necessary to save his life. Missick died on December 17, 2020 at the Adams County Detention Center in Mississippi.¹⁸⁷

On the morning of December 17, 2020 at 7:24 a.m., Missick reported to a guard that he was experiencing burning chest pain that also radiated down his arms, classic symptoms of a heart attack that require an immediate emergency response. Detention facility officials, however, did not allow Missick to go to the medical unit until guards finished their morning count of detainees. Missick was forced to wait 12 minutes to go to the medical unit, and then waited an additional 18 minutes to be assessed with an electrocardiogram or EKG. At 7:54 a.m., the EKG test resulted in findings that indicated a heart attack or reduced blood flow to the heart, which should have led medical staff to immediately call emergency medical services or request a transfer to the emergency department for further evaluation and management. Medical staff, however, did neither. Instead, at 8:01 a.m., detention medical staff instructed Missick to remain in the clinical waiting room for an hour before he could be released back to his housing unit.¹⁸⁸

According to video surveillance footage, Missick began to move his arms and slumped over in his chair while sitting in the waiting room at 8:30 a.m. Seconds later, he began to convulse, and then laid motionless in his chair. It was not until

almost 45 minutes later, at approximately 9:14 a.m., when a facility officer entered the waiting room and found Missick slumped over. It then took medical staff nine more minutes to initiate CPR.¹⁸⁹ During this time, none of the staff who first responded, including the facility officer, registered nurse (RN), or licensed practical nurse (LPN), initiated CPR, nor did they retrieve any emergency equipment, a gurney, or an automated external defibrillator, which is used to revive someone from sudden cardiac arrest. At 9:22 a.m., other medical staff initiated CPR and attempted to defibrillate Missick without success. Paramedics arrived on the scene at 9:56 a.m., 40 minutes after first being called. Soon after, paramedics declared Missick deceased.¹⁹⁰

Dr. Elena Jimenez Gutierrez, a medical expert who reviewed ICE's reports, concluded that Mr. Missick's abnormal clinical and EKG findings "were not managed appropriately," nor was CPR initiated in a timely manner. Dr. Jimenez Guterrez further noted that ICE's review "failed to note lack of appropriate emergency triage and escalation to higher level of care for probable acute coronary syndrome in an adult patient with active chest pain and risk factors for cardiovascular disease. ICE failed to address systemic problems, including communication channels and protocols for triage and escalation of care to improve quality of care and accountability."¹⁹¹

- When **Nebane Abienwi**, a 37-year-old asylum-seeker from Cameroon, entered ICE detention on September 19, 2019, he told medical staff at the Otay Mesa Detention Center that he had recently been hospitalized for hypertension (high blood pressure). Detention medical staff, however, did not monitor him for high blood pressure despite this known medical history. One week later, on October 1, 2019, he had a stroke in detention and died soon after of a hypertensive basal ganglia hemorrhage, a brain hemorrhage that results from poorly controlled high blood pressure.¹⁹²

At 3:26 a.m. on September 26, 2019, one week after ICE detained him, a detention officer

reported to the medical unit that Abienwi had fallen from the top bunk of his bed to the floor. Medical staff arrived within two minutes at 3:28 a.m. and found that Abienwi was unable to answer questions and had slurred speech and jerky movements. It took 50 more minutes before emergency medical services arrived to treat Abienwi, because the on-call medical provider did not respond to the nurse's request for authorization to call for emergency medical services. At 3:45 a.m., the nurse decided to call for an ambulance. The facility, however, delayed paramedics' ability to provide immediate treatment, as the facility hampered their ability to move through the facility upon arrival because it was "count time."¹⁹³ As Dr. Sadacharan noted, "this delay in EMS services and a higher level of care may have changed the outcome for Mr. Abienwi."¹⁹⁴

- **Huy Chi Tran**, a 47-year-old man from Vietnam, was found unresponsive in his cell due to cardiac arrest on June 5, 2018 while detained at the Eloy Detention Center. He died a few days later after being taken off life support on June 12, 2018.¹⁹⁵

While detained at Eloy, medical providers focused primarily on Tran's mental health symptoms, prescribing him with antipsychotic medications for schizophrenia. On June 5, 2018, facility medical staff observed Tran with altered consciousness, as well as sweating, shaking, and hand tremors during an appointment.¹⁹⁶ As medical expert reviewer Dr. Sadacharan noted, the nurse should have at this time referred Tran to be seen in person by a doctor, as he had symptoms for undiagnosed neuroleptic malignant syndrome, a life-threatening reaction to neuroleptic medication that can lead to seizures or heart attacks.¹⁹⁷ Instead of referring Tran to a doctor, however, medical staff placed him in a mental health segregation unit at 2:54 p.m., without completing the authorization process required to place someone in solitary confinement.¹⁹⁸

Although officers were supposed to check on Tran every 15 minutes in the solitary confinement

cell, video evidence shows that this did not take place. Over the next 51 minutes, an officer walked by his cell five times, never looking in to confirm Tran's welfare. At 4:06 p.m., the officer placed a meal through a flap in the cell door, which remained untouched. Six minutes later, the officer looked inside Tran's cell, removed the meal from the door, and opened the cell door. The officer reported that when he entered the cell, he shook Tran's back, which "was warm." The officer then exited the cell and reported a medical emergency. Additional staff arrived at Tran's cell at 4:15 p.m. and began to start CPR. Three minutes later, medical staff arrived. Medical staff detected a faint, irregular pulse, and attempted defibrillation. However, medical staff did not place the automated external defibrillator (AED) pads in the correct position on Tran's chest, nor did the pads adhere to his chest, which are necessary to provide accurate analysis and effective shock during a sudden cardiac arrest. The nurse practitioner later surmised that the AED pads were expired, which may have caused the pads to be dry and non-adhering; the emergency bag inventory, however, had no extra pads available.¹⁹⁹ Emergency medical services arrived at 4:30 p.m. and transported Tran to a local hospital, where he was placed on a respirator and admitted to intensive care.

One week later, on June 12, 2018, Tran was declared brain dead and removed from life support.²⁰⁰ Tran's death underscores the danger of overlooking serious medical symptoms in patients with mental health issues. His death also highlights staff's failure to adequately monitor people in medical isolation, and malfunctioning emergency equipment.

Elba Maria Centeno Briones, a 37-year-old woman from Nicaragua, died on August 3, 2021 of COVID-19 after her detention at El Valle Detention Facility in Texas.²⁰¹ Confusion amongst staff over who was responsible for calling an ambulance led to a half-hour delay in calling 911.

On July 27, 2021, between 4:00 and 5:00 p.m., a nurse took Centeno Briones’s vital signs and found her oxygen saturation levels at 70 percent, with blue fingernails, shortness of breath, and wheezing in her right lung. Centeno soon after tested positive for COVID-19 on a rapid test, and medical staff determined that she needed emergency transport via ambulance to the hospital. At 5:26 p.m., medical staff notified a facility lieutenant that Centeno Briones needed an ambulance. The facility, however, did not call 911 for an ambulance until 6:18 p.m., 52 minutes after medical staff had requested one, because of “confusion as to responsibility to call 911.”²⁰² As ICE’s investigatory report showed medical staff understood that security personnel should call 911 when an ambulance was needed, but security staff thought that medical staff or central control officers were responsible for calling emergency services. The detention facility nurse did not know that no one had called 911 until 30 minutes after the medical staff requested an ambulance, when a sergeant asked her if she was calling 911. The nurse then left the medical unit to find an outside phone line and called 911 herself, because there were no outside phone lines in the medical unit. Paramedics did not reach Centeno Briones until 6:30 p.m., over an hour after the medical unit had determined the need for an ambulance.²⁰³

Suicides caused by failure to provide mental health care, properly manage medication, and adequate mental health staff

Our analysis shows that ICE detention facilities have failed to provide mental health care necessary to address suicidal ideation and prevent deaths by suicide. This failure has led to a precipitous rise in the rate of deaths by suicide in ICE detention. Since 2017, at least 15 people in immigration detention have died by suicide, and ICE has not disclosed the cause of death for several additional cases that may be by suicide.²⁰⁴ In 2020 alone, the rate of deaths by suicide while in ICE custody rose 11 times higher than the

prior 10-year average, when adjusted for admissions per year.²⁰⁵

Of the cases examined by our experts, 21 percent of cases (n=12) were deaths by suicide. All 12 cases were listed in autopsies or other documents as the result of hanging by the neck, in some cases deemed “asphyxia by hanging” or “anoxic encephalopathy.”

These cases were marked by an alarming lack of mental health care support provided in ICE detention facilities, including absence or near absence of mental health care providers in detention facilities and consistent failure to appropriately manage or provide psychiatric medication. Detainees who died by suicide had frequently expressed despair about systemic barriers to justice in the days before their deaths, noting barriers such as prolonged detention, delayed adjudication, lack of access to legal resources, failed case outcomes, and miserable conditions. Detention facilities failed to promptly identify or prevent suicidal behavior due to a significant lack of staffing and staff failure to conduct welfare checks and security rounds. In some cases, other detainees alerted security staff that there was an urgent situation regarding a fellow detainee before action was initiated. ICE’s reliance on solitary confinement of people in psychological distress, instead of appropriate treatment and support in non-carceral settings, further heighten the likelihood of suicide.

This report has discussed above the deaths of **Jean Jimenez** and **Efrain de la Rosa** by suicide at Stewart Detention Center in Georgia. In both cases, medical and mental health staff failed to ensure that Jimenez and de la Rosa received prescribed medications for schizophrenia, which directly contributed to decompensation, and ultimately, death by suicide. The following examples also underscore ICE’s failure to protect detained immigrants from suicide:

- 43-year-old Cuban asylum-seeker, **Roylan Hernandez Diaz**, died by suicide on October 15, 2019 after participating in a hunger strike to protest conditions he endured while in ICE custody. Hernandez Diaz, was being held at the Richwood Correctional Center in Louisiana.

Although Hernandez Diaz had passed a credible fear screening, making him eligible for release from detention on parole, ICE’s New Orleans Field Office denied his release, as it had done with 99 percent of all parole applications.²⁰⁶ Although Hernandez Diaz had submitted requests for mental health support and had participated in a hunger strike, the detention facility never provided him any mental health interventions. Notably, Richwood failed to hire an on-site mental health specialist at the time of Hernandez Diaz’s death.²⁰⁷

On October 9, an immigration judge told Hernandez Diaz that he needed to provide more evidence of persecution to establish his asylum claim—evidence overwhelmingly difficult to obtain while in detention. Thereafter, Hernandez Diaz began his second and final hunger strike.²⁰⁸ The next day, on October 10, the detention facility placed him in administrative segregation (solitary confinement) for threatening a hunger strike. Although a health care provider should have reviewed whether to keep Hernandez Diaz in segregation within 72 hours no evidence exists that this review occurred.²⁰⁹

Detention facilities are required to monitor anyone in a segregation cell at least every 30 minutes. However, video surveillance of the hallway outside his cell showed that in the hour before Hernandez Diaz was found hanging in his cell, officers walked by his cell and logged an entry into the binder by the door, without ever looking in the window. At 2:04 p.m., a jail captain noticed a “strong odor” coming from the cell, and then unlocked the cell. He opened the door, and discovered that Hernandez Diaz hanging from the post of his bunk bed, with a sheet tied around his neck.²¹⁰

Officers prohibited facility medical staff from entering the cell to cut Hernandez Diaz down or to resuscitate him. More than an hour passed between the time that officers found Hernandez Diaz hanging in his cell and the time that the county coroner’s office arrived and cut him down.²¹¹

- **Mergansana Dabaevich Amar**, a 39-year-old man from Russia, died by suicide on November 18, 2018 after his detention at ICE’s Northwest Detention Center in Washington.²¹² Amar’s case underscores how failure to provide mental health support, and systemic barriers to justice, can lead to preventable death.

Amar came to the United States seeking asylum after reportedly being beaten and imprisoned for demonstrating for the independence of Buryatia, a province in Russia.²¹³ Amar was detained immediately upon arrival while his asylum application was pending. On August 7, 2018, after nine months of detention, Amar lost his case before an immigration judge and was given a September 6, 2018 deadline to appeal to the Board of Immigration Appeals.²¹⁴ Ten days later, Amar complained to the staff that he was suffering depression and isolation, because he had lost his immigration case and because there was no one he could speak to in Russian. Although he requested a change to another housing unit where other Russian-speaking detainees were held, GEO Group, Inc., the private prison corporation that owns the facility, denied his request.

On August 22, 2018, Amar announced that he was starting a hunger strike. In response, ICE placed him in solitary confinement, and on September 7, 2018, won a federal court order that would allow the government to administer intravenous fluids and forcibly restrain Amar if he refused. As a result, Amar agreed to begin taking liquid nutritional supplements.²¹⁵ He also submitted a belated appeal in his case on October 1, 2018, explaining that he had missed the deadline because he had been in medical isolation and lacked access to the law library.²¹⁶

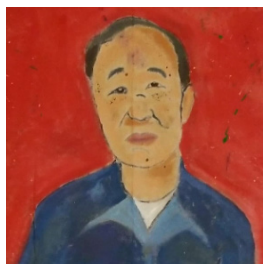
Amar began to gain weight again, but over the next few weeks, exhibited warning signs of suicide. On October 26, 2018, medical staff placed him on suicide watch after finding a six-foot rope under his mattress. The next day, however, the facility discontinued suicide watch and ordered mental health observation. On November 4,

2018, an officer found a sheet torn in thirds in his cell, but failed to notify medical staff or report this fact, despite this clear indication of his deteriorating mental condition. The next day, the facility discontinued mental health observation, but Amar remained in solitary confinement. Amar requested that he be moved to general population, and on November 15, 2018, the facility approved his release from solitary confinement.²¹⁷

At 1:40 p.m. that day, officers placed Amar in handcuffs, and escorted him to an administrative office, where an ICE official informed Amar that the Board of Immigration Appeals had dismissed his appeal, and that he was scheduled to be deported to Russia. Amar had not known of this information, even though his appeal had been dismissed two weeks earlier. Despite knowing of Amar's fragile mental state, ICE failed to provide mental health support upon notifying Amar of his impending deportation.²¹⁸ In addition, had Amar been adequately treated and provided access to legal resources to fully inform him of his rights, he might have known that he could have appealed his case to the Ninth Circuit Court of Appeals and requested a stay of removal to prevent deportation during his appeal.²¹⁹

Less than two hours later, at 3:06 p.m., an officer found Amar hanging in his cell with a sheet wrapped around his neck. Paramedics arrived and transported Amar to a local hospital, where he was placed in intensive care. A doctor concluded that day that Amar was brain dead, but kept him on a ventilator. On November 24, 2018, after discussions with his family in Russia, Amar was removed from life support.²²⁰

- **Choung Woong Ahn** died by suicide on May 17, 2020 at the Mesa Verde ICE Processing Center in California. Ahn, a 74-year-old man from South Korea who had lung disease, diabetes, hypertension, and had



Drawing of Choung Woong Ahn by Tania Bernal

previously had heart attacks, was particularly vulnerable to COVID-19, **especially as** vaccines or antiviral treatments were not yet available at that time. Ahn had petitioned for release from the Mesa Verde ICE Processing Center in California on at least three different occasions at the height of the COVID-19 pandemic. Each time, however, Ahn's petitions were denied.

After returning from an offsite medical visit on May 14, 2020, detention facility officers placed Ahn in a solitary confinement cell.²²¹ The next day, Ahn learned that a judge had denied his request for release from custody. Ahn began to refuse meals and medication, stating that he was depressed at the prospect of being deported. A facility provider diagnosed Ahn with unspecified depressive disorder, noting that he appeared to be "a high suicide risk if deported."²²² Facility officials were well aware that Ahn had a history of mental health issues, including severe depression that had led to three prior suicide attempts. The most recent attempt occurred in 2019, one year before he was placed in ICE detention.²²³

On May 17, 2020, the day of his death, Ahn spoke to his brother and sister, telling them that "the attorney was going to have news" the following day. At 8:53 p.m., Ahn hung himself with a bedsheet around his neck.

Expert reviewer Dr. Elena Jimenez Gutierrez noted that detention and isolation in ICE custody appears to have significantly deteriorated Ahn's mental health, and that release from detention would likely have prevented his death. Dr. Jimenez Gutierrez also faulted the facility's low frequency of mental health assessments relative to a standard of care for a patient with depressive symptoms, passive suicidal ideation, a history of depression, and prior suicide attempts.²²⁴

- **Osmar Epifanio Gonzalez Gabda**, a 32-year-old man from Nicaragua, died by suicide on March 22, 2017, while detained at Adelanto Detention Facility in California.²²⁵ Two weeks before his death, Gonzalez was transferred from Adelanto and admitted to a local psychiatric

hospital after refusing meals for several days and reporting that he had been sexually assaulted while detained.²²⁶ Gonzalez was diagnosed with paranoid schizophrenia, psychosis, and suicidal thoughts. After a week of treatment, Gonzalez was discharged back to Adelanto. Upon his return to Adelanto on March 15, detention medical staff placed Gonzalez in medical segregation (solitary confinement), even though, as Dr. Chanelle Diaz noted, “isolation is a known risk factor for self-harm and suicide.”²²⁷

At approximately 7:50 p.m. on March 22, a nurse and officer making rounds found him hanging in his cell with a sheet tied around his neck.²²⁸ Medical staff activated emergency medical services at 7:56 p.m. after laying him on the floor and administering CPR.²²⁹ EMS arrived at 8:16 p.m. and transferred Gonzalez to Victor Valley Global Medical Center at 9:00 p.m. after his pulse was restored.²³⁰ He went into cardiac arrest later that night and died.²³¹

In the week prior to his death, Gonzalez had been prescribed a high dose of haloperidol, an antipsychotic drug. Records show that he failed to take psychiatric medication in the two days before his death. Medical expert reviewer Dr. Sadacharan concluded that “it is not surprising that Mr. Gonzalez suffered an acute destabilization that led to suicide.”²³²

It is unclear from the records released by the government what medical intervention, if any, the facility took to address this refusal of medicine.²³³

Failure to provide necessary and required interpretation and translation by medical and mental health providers

ICE detention standards consistently require that detention facilities provide professional interpretation and translation, particularly in health encounters.²³⁴ This is especially important in a medical setting, as consent for medical assessment and treatment must be conducted in a language the

detainee understands in order to qualify as informed consent. Medical staff must also understand the person detained to assess and manage medical complaints. However, records indicated that some cases (n=12) involved inappropriate interpretation or failures to translate between staff and detainees, often leading to disastrous consequences.²³⁵

This report has discussed the Kay County Detention Center’s failure to provide Spanish language interpretation when treating **Maria Celeste Ochoa de Yoc**. As a result of the facility’s lack of proper translation, medical staff incorrectly concluded that Ochoa was bulimic and suicidal and placed her in solitary confinement under a suicide watch protocol, instead of properly treating her for liver failure.

- **Simratpal Singh** died by suicide on May 3, 2019 in ICE custody at the age of 20, after his detention at the La Paz County Adult Detention Facility in Arizona. Singh, a native of India, spoke Punjabi, not English. Over the course of his 3-day detention at La Paz, facility medical staff did not use interpreters to communicate with Singh.²³⁶ The nurse on duty during his medical intake recalled that the only words that Singh knew in English were “court” and “lawyer,” but marked in his medical record that he was not allergic to any medications. The nurse further decided that Singh did not exhibit any suicidal ideations based on her observation of his appearance alone.²³⁷ The intake nurse did not screen Singh for mental health issues or assess his suicide risk, although hospital records later made clear that he had previously attempted suicide. The intake nurse also failed to follow up on troubling vital signs, including elevated pulse and blood pressure, as well as difficulty breathing and poor appetite.²³⁸

Security and nursing staff at the facility did not receive periodic training on suicide prevention and intervention.²³⁹ No security rounds were recorded on May 2, 2019.²⁴⁰ At 5:13 p.m. that day, a detention staff member gave Singh a pair of socks, per his request. Singh was last seen moving in his cell on video surveillance at approximately 5:43 p.m. When another detainee informed an officer at 5:50 p.m. that Singh was

hanging in his cell, the officer on duty wrongly believed that Singh was already deceased. The officer did not immediately call the medical emergency over the radio or lift Singh upward to protect his airway before additional staff arrived.²⁴¹ Singh was transferred by EMS to La Paz Regional Hospital and subsequently to the Abrazo West Campus hospital, where he died the following day.

Medical expert Dr. Sadacharan concluded that there was a reasonable possibility that Singh's death could have been prevented with appropriate treatment, in light of the medical staff's apparent lack of training and their decision not to use interpretation services.²⁴² She also noted that a "likely diagnosis of anxiety/panic attack may have been missed" and that "there could have been time to save Mr. Singh's life" if the emergency response had not been delayed.²⁴³ Dr. Katherine McKenzie, a medical expert reviewer, similarly identified a lack of adequate mental health assessment, "inadequate language interpretation," and "a delay in giving... emergency care."²⁴⁴ She cited several systemic failures in Mr. Singh's case, including an overall lack of training across facility staff in interpretation services, emergency response (including CPR certification), and suicide prevention.²⁴⁵

Failure to follow COVID-19 protocols

As early as February 2020, DHS medical experts began to warn of the threat posed by COVID-19 to people held in ICE detention. At a time when no vaccine or known treatment for COVID-19 was available, experts warned of a tinderbox scenario, where the virus would spread rapidly in congregate settings and lead to devastating consequences. These experts recommended that ICE immediately implement preventative measures to allow for social distancing by releasing medically vulnerable people from detention. Experts also recommended that ICE enact rigorous mitigation processes of screening, testing, and quarantine.²⁴⁶

ICE, however, failed to take basic precautions to protect detained people in its care from COVID-19. Detained immigrants staged hunger strikes and begged for basic protections from the virus, including soap, masks, and cleaning supplies.²⁴⁷ ICE failed to test detained people for COVID-19 at facilities nationwide, leading to a dramatic undercount of cases. ICE also transferred detained people from facilities with COVID-19 outbreaks across the country, further spreading the virus.²⁴⁸

ICE reported that nine detained immigrants died of COVID-19 during the pandemic. These cases reflect ICE's failure to protect detained immigrants from the virus, made especially clear in cases where ICE insisted on detaining people who had been granted compassionate release from criminal custody, and where ICE failed to timely release people from its custody, even when a legal basis existed to do so. In addition, these reported deaths do not include individuals who were released from ICE's legal custody immediately prior to death.²⁴⁹

- **James Thomas Hill**, a 72-year-old citizen of Canada, died on August 5, 2020 of COVID-19, after his detention at the Immigration Centers of America Farmville in Virginia. Hill should have been released from detention and returned to Canada months before he contacted COVID-19 in detention. An immigration judge had ordered Hill removed on May 12, 2020, but ICE did not set his deportation flight back to Canada to take place until July 9, nearly two months later.²⁵⁰ This delay would prove fatal.

On June 2, 2020, ICE flew 74 people from detention facilities in Florida and Arizona that had active outbreaks of COVID-19 to Farmville Detention Center in Virginia.²⁵¹ This transfer ultimately sparked a COVID-19 outbreak at Farmville, where over 300 people, including Hill, eventually contracted the virus.²⁵² On July 1, 2020, detention facility officers pepper-sprayed more than 40 detainees, including Hill, after detainees voiced frustration over their lack of access to ICE staff. Detainees also voiced their desire to be released or deported in order to protect them from COVID-19. Two days later, Hill

reported body aches, weakness, and an elevated temperature, and was taken to the hospital with a diagnosis of suspected COVID-19. By July 10, 2020, Hill's oxygen levels dropped, and he was taken again to the hospital, where he tested positive for COVID-19 and was moved to the intensive care unit. His condition deteriorated until his death on August 5, 2020.

- **Cipriano Chavez-Alvarez**, a 61-year-old man from Mexico and father of six children,²⁵³ died on September 21, 2020, after contracting COVID-19 at the Stewart Detention Center in Georgia. Chavez-Alvarez had already been granted compassionate release from the Edgefield Federal Correctional Institution by a federal judge in light of his medical vulnerabilities to COVID-19, which included gout, lymphoma, and hypertension. Chavez-Alvarez looked forward to his rapid deportation to Mexico, but ICE officials kept him in detention instead.²⁵⁴ Eleven days after Chavez-Alvarez was detained at Stewart, he began to feel ill. His oxygen saturation rate had fallen to 76 percent, and medical staff ordered to transfer him by ambulance to a local hospital. Chavez-Alvarez never left the hospital and died in the intensive care unit six weeks later.

ICE Health Service Corps's mortality review determined that Mr. Chavez-Alvarez's medical care was "not provided within safe limits of practice," and that medical care at Stewart "or lack thereof, could pose a future risk of adverse outcomes." Specifically, the mortality review concluded that the facility failed to receive Chavez-Alvarez's COVID-19 test results in a timely manner. The facility also failed to provide timely follow-up care when needed.²⁵⁵

Chronic understaffing, inadequate and improper staff training, and care outside the scope of practice

Prison and detention systems are constitutionally required to provide sufficient medical staff who are competent to diagnose illnesses, treat medical problems or refer patients to qualified providers.

They are also required to either ensure that there are adequate numbers of medical providers to meet the needs of the detained population or decrease the population to a level where adequate medical care can be provided.

ICE detention facilities lack adequate staffing and frequently fail to hire staff for unfilled positions. When there are not enough staff at a location, time pressure can drive patient visits to be shorter and less comprehensive. High rates of staff turnover can also intensify issues of inadequate and improper training, which can have deadly consequences. Staff who are unaware of emergency procedures, interpretation resources, or the limits to their scope of practice can make mistakes that delay or prevent appropriate patient care. Ensuring safe ratios of medical and mental health staff to detainees is essential to ensure that medical and mental health services are actually met. Patients may not receive basic care, such as receiving medication, monitoring of symptoms and vital signs, or timely attention or treatment. A shortage of mental health staff may mean that people with emergent mental health care issues are never treated, leading to escalation of symptoms or decompensation that can lead to suicide.

ICE detention facilities also rely heavily on care provided by low-level providers and often prevent detained patients from accessing care from more highly-trained professionals. ICE's own investigatory reports found frequent examples of care provided outside the scope of licensed practice, leading to deadly consequences. For example, registered nurses frequently provided medication without prescriptions. Licensed Vocational Nurses ("LVN" or "LPN"), who have only one year of post-high school training, also provided unauthorized care to detained patients. Lower-level staff were often unable to locate higher-level providers, such as doctors, nurse practitioners, or physicians' assistants, who are licensed to assess patients, provide treatment, and prescribe medication.

Agency reports frequently noted medical and mental health positions that had not been filled for months, and ICE investigation reports are replete with statements from medical staff reporting overwork.

In 40 percent (n=21) of all cases, records indicated a staffing issue, including shortages, improper training, or care outside the scope of practice.

For example:

- The Aurora Detention Center in Colorado, operated by the GEO Group, a private prison corporation, had multiple critical medical staff vacancies that contributed to the death of **Kamyar Samimi**. Samimi died because medical staff had discontinued medication assisted treatment for opioid disorder. **At the time of his death, GEO Group had only one practicing physician responsible for the entire facility. It also left vacant multiple required positions – including a mid-level provider, such as a nurse practitioner or physician’s assistant, or a nursing director position – for longer than six months.** The midlevel provider was responsible for conducting initial health appraisals for detainees with chronic conditions, and **Samimi never received a health appraisal by a physician or a registered nurse (RN).** ICE’s own investigators concluded that “absent a Director of Nursing or other nurse supervisor . . . clinical supervision was inadequate to assure adherence to provider orders and necessary and appropriate care.”²⁵⁶
- **Roberto Rodriguez Espinoza**, a 37-year-old man from Mexico, died on September 10, 2019, after ICE detained him at the McHenry County Correctional Facility in Illinois. One week after he was detained, Rodriguez died from a subdural hematoma and complications of chronic alcoholism. Facility officers – not medical staff – conducted Rodriguez Espinoza’s medical intake when he entered the facility. Although Rodriguez Espinoza informed officers upon intake that he regularly consumed a six-pack of beer a day, which would be enough to trigger withdrawal symptoms in a detention setting, the facility’s medical staff did not follow up. Five days later, after Rodriguez Espinoza began exhibiting acute mental status changes, a licensed practical nurse – who is not licensed to provide medication without a prescription – completed

a Clinical Institute for Withdrawal Assessment without supervision by a RN, and administered chlordiazepoxide, without a prescription or a provider order.²⁵⁷

- As noted earlier in the report, **Jean Jimenez** died by suicide on May 15, 2017 at the Stewart Detention Center in Georgia. The lack of adequate mental health staffing clearly contributed to Jimenez’s death. ICE required only one full-time equivalent psychiatrist for a facility that held nearly 2,000 people. The ICE Health Services Administrator at Stewart testified that this level of staffing was inadequate, and that he had raised concerns to ICE about the need for additional staff, to no avail.²⁵⁸ Even so, at the time of Jimenez’s death, Stewart provided tele-psychiatry to detained people for six hours a week – **a level of less than 20 percent of required staffing, with backlogs of 10-12 weeks for services.**²⁵⁹



Photo courtesy family of Jean Jimenez.

Insufficient and falsified documentation of patient checks and provision of medical care

Accurate and truthful record keeping is vital to ensure continuity of medical care. For example, officers must document each time they have conducted a required check on a detained person’s welfare, particularly those who are in solitary confinement or on suicide watch. However, in 46 percent (n=24) of cases, there was at least one occasion where a wellbeing check was either not conducted or made without visualization of the detained person. Many of these instances also involved falsification of records. In some cases, documentation of medical care and wellbeing were absent from records at the facilities in which they were housed. In other cases, the incorrect form was filled out or the correct form only partially completed. In some cases, documentation was falsified,

Ben Owen

Ben Owen, from the United Kingdom, was 39 years old when he died at the Baker County Detention Center in Florida on January 25, 2020. Ben was newly married to his U.S. citizen wife, Tammy Owen, and father to their baby girl. The young family lived in Daytona Beach, Florida.

Tammy describes Ben as being an amazing soul and a loving, doting husband, a good father to his daughter, and a good son to his mother. He worked hard as a successful sound engineer for bands including Metallica and Five Finger Death Punch. Ben tended to and cooked for Tammy. She says he loved life and being a father to his newborn daughter. “He was amazing, or I wouldn’t have married him.”

Their lives changed abruptly on January 12, 2020, when Ben was arrested. While he was not detained in criminal custody, his encounter with the police led him to be “picked up” by ICE on January 15. He was held in ICE custody at Baker Country Detention Center, despite the fact that he was married to a U.S. citizen and was not in the U.S. illegally, according to Tammy.

Tammy spoke with Ben numerous times while he was detained by ICE, conversations during which he told her he was “very, very scared.” While Tammy felt that Ben had protected her from the reality of how bad conditions in Baker County really were, he did tell her

about being “freezing.” He also mentioned difficulty breathing due to extensive mold, and that he had not seen daylight. He was becoming increasingly isolated, as he was the only person detained in his unit who spoke English as a first language.

Tammy has spent the last four years trying to piece things together as best she can. She believes that ICE “pushed him to [a] breaking [point]” and that he was “treated worse than an animal on the street.” She also stated that “he was told he was going to be sent back [to the UK] and taken away from his family. No human being should have to go through that.”

Tammy could tell Ben’s mental health may have been deteriorating from what he said on phone calls, but she believes he kept her in the dark about how bad he was feeling. He died less than two weeks after first being detained.

Tammy has since found

out that Ben was never seen or assessed by a psychiatrist at Baker. Worse, Tammy believes ICE has covered up facility staff’s failings. By the time she found out about how poor the conditions were in the detention facility, it was too late — Ben had died.

Tammy wants to help other families so they don’t have to suffer like her and her daughter. Tammy wants to know the truth about what happened to Ben and says she will not stop fighting. “He was my best friend and I miss him every day. Our daughter knows he’s in heaven. She knows about her Daddy.”



Tammy and Ben Owen, Photo © Savannah Payne

sometimes after the person had already died. Overall, issues with documentation occurred in 61 percent (n=32) of cases.

For example:

- **Ben Owen**, a 39-year-old British man, died by suicide on January 25, 2020, only 10 days after being detained at the Baker County Detention Center in Florida.²⁶⁰ At the time of his detention, Owen, who had moved from London only seven months before, had a pending green card petition sponsored by his U.S. citizen wife.²⁶¹

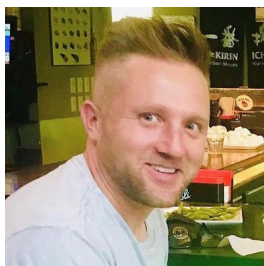


Photo courtesy Tammy Jane Owen.

Although Owen had no demonstrated history of mental health conditions at the time of intake, his behavior while in detention pointed to increasing levels of psychological distress. Over the 10-day period, for example, he made 129 phone calls to his wife and expressed feeling that he was losing his mind.²⁶² On the day of his death, which was also the same day of his wedding anniversary, Owen shut himself in his cell with the privacy screen lifted.²⁶³ Detention center officers logged two wellbeing checks at his cell.²⁶⁴ **But the detention center had falsified these records. The officers had not completed the checks — they had never entered the cell or seen Owen.**²⁶⁵ The officers, moreover, reported that this method of logging security rounds was consistent with their training and an accepted practice at the facility.²⁶⁶ Two hours after he had shut himself in, another detained person notified staff that Owen was hanging from a sheet in his shared cell.²⁶⁷

Baker County Detention Center lacks any accreditation to provide healthcare services as a correctional facility.²⁶⁸ ICE, however, continues to detain over 200 people at the facility each day.²⁶⁹

- **Anthony Oluseye Akinyemi**, a 56-year-old man from Nigeria, died by suicide on December

21, 2019, less than 24 hours after being detained by ICE at Worcester County Jail in Maryland. At intake, Akinyemi demonstrated significant mental distress and visible agitation, showing restlessness while sitting, jumping during telephone conversations, pacing, and rubbing his head. Akinyemi also verbalized his inability to cope emotionally, and verbalized concerns of losing his family. Facility staff, however, failed to provide him with timely mental health support. Although the intake licensed practical nurse informed the supervising registered nurse of the statement, nothing was reported to the on-call provider, as required.²⁷⁰

On the night before his death, facility staff placed Akinyemi in a solitary confinement unit. Medical expert reviewer Dr. Katherine McKenzie concluded that confinement in a segregation unit likely exacerbated Akinyemi's mental distress.²⁷¹ At 5:03 a.m. on December 21, an officer discovered that Akinyemi had hung himself from a ventilation grate. Although medical staff started CPR and attempted defibrillation, Akinyemi was pronounced dead at 5:23 a.m. Although the officer claimed to have completed six security checks over the course of approximately five hours, the facility could not produce a time-stamped report. The officer claimed his reader device, used to track and verify that officers completed his rounds on time and in the appropriate location, had malfunctioned.²⁷² On review, the warden of the facility verified the functionality of the reader, implying that the officer conducting rounds either failed to document at the beginning of his shift that his reader was not working and went to complete his duties regardless, or he falsified his use of the reader, failing to document that he did not use the reader appropriately over the course of his shift.²⁷³

ICE's mortality review committee "unanimously determined that Mr. Akinyemi's medical care . . . was not provided within the safe limits of practice."²⁷⁴

- **Guerman Volkov**, a 56-year-old man from Russia, died of a bowel obstruction with gastrointestinal hemorrhage. Before he was hospitalized, Mr. Volkov was detained in ICE custody at Baker County Detention Center in Florida prior to his death on November 30, 2018.²⁷⁵

Mr. Volkov entered Baker on June 26, 2017.²⁷⁶ He consented to initial medical exams after entering the facility, at which time medical staff discovered that Mr. Volkov had a history of hypertension and seizure disorder.²⁷⁷ However, soon after his intake exams, Mr. Volkov began repeatedly refusing medical assessments and treatment.²⁷⁸ Among other medical exams, Mr. Volkov refused a physical assessment from medical staff on July 7, 2017;²⁷⁹ a medical appointment on July 23, 2017;²⁸⁰ chronic care appointments on Dec 7, 2017, March 8, 2018, June 5, 2018, and September 6, 2018;²⁸¹ and his annual medical evaluation on August 9, 2018.²⁸² He also repeatedly refused medications.²⁸³

When Mr. Volkov did consent to assessments, it was clear that he was suffering from serious mental illness. Mental health professionals noted that his behavior was characterized by anxiety and delusional thinking,²⁸⁴ and his mental health continued to deteriorate throughout his time at Baker.²⁸⁵

Medical staff made serious errors when attempting to manage Mr. Volkov's medical conditions. They routinely failed to properly document Mr. Volkov's medical care; refusal forms often were not filled out when he refused medical assessment, and when they were, they were often late or incomplete.²⁸⁶ Medical staff also failed to document the medical and mental health conditions that Mr. Volkov developed while in custody and failed to provide appropriate treatment that had been ordered.²⁸⁷ For example, on September 12, 2017, a medical provider ordered that Mr. Volkov receive a hernia belt; however, staff never provided him with one.²⁸⁸ Similarly, medical staff renewed Mr. Volkov's prescriptions on multiple occasions without re-evaluating him to determine the proper

medication dosage.²⁸⁹ Additionally, medical staff administered psychotropic medication to Mr. Volkov without first obtaining his informed consent, as is required before administering such medication.²⁹⁰

On November 26, 2018, Mr. Volkov was transferred to Memorial Hospital of Jacksonville after being found unresponsive at Baker.²⁹¹ Two days later, Mr. Volkov was returned to Baker against medical advice.²⁹² Medical staff at Baker were ordered to check on Mr. Volkov every 15 minutes; however, this did not happen.²⁹³ Staff failed to log at least 42 wellbeing rounds accurately and within the time restriction over the next three days, according to video surveillance footage and timestamps.

On November 30, 2018, medical staff failed to check on Mr. Volkov for at least two hours. After that, correctional staff noticed that Mr. Volkov was experiencing trouble breathing, a distended abdomen, and severe abdominal pain.²⁹⁴ He was then transported to a local hospital and died that same day.²⁹⁵

Conclusion and Full Recommendations

The stories of the people who died while locked in ICE detention facilities shock the conscience. Investigatory reports and documents, however, are incomplete reflections of the entire story. Missing from this report are the voices of detained people who died alone, without proper medical and mental health attention, and without loved ones near during their final moments. The ultimate tragedy, of course, is that none of these people needed to be detained, and the provision of proper medical care could have prevented these deaths. Although this report focuses on death — the most extreme consequence of ICE detention — tens of thousands of people continue to face lasting medical and psychological consequences as a result of immigration detention each day.

This report also laid out the many ways in which ICE's investigations allow the agency to avoid fault and disclaim accountability for the death of detained immigrants. ICE's review and remedial process has allowed the continued deaths of detained people, and failed to levy meaningful consequences — including contract termination — for conditions that have led to repeated deaths in detention. In the interest of preventing additional deaths in ICE detention, the report offers the following recommendations below.

To the Department of Homeland Security:

Our organizations believe that ICE's reliance on immigration detention is unnecessary, expensive, and deeply harmful. We strongly urge that ICE dismantle the mass immigration detention machine that has resulted in far too many deaths. ICE should phase out the immigration detention system, invest in community-based social

services instead of placing people in detention, and avoid surveillance of immigrants as an alternative to detention. As ICE shifts from a detention-based system, ICE should adopt the following recommendations to reduce the number of people held in detention and prevent deaths of people in ICE detention:

- **Issue a directive ensuring the prompt release of people with medical and mental health vulnerabilities from ICE detention.** It should include a presumption of release for people with medical and mental health vulnerabilities, ensure prompt medical screening of detained immigrants to identify those who face increased medical and/or mental health risk in detention, and set forth procedures to ensure the prompt release of these individuals from custody.
- **Immediately release people who have prevailed in their immigration cases before an immigration judge, instead of continuing detention upon ICE's administrative appeal.**
- **Require the release of people from and prohibition of the use of ICE detention facilities upon a finding by DHS's Office of Civil Rights and Civil Liberties that health and safety standards are not being met, or cannot be met.** Reasons may include lack of medical and mental health staff, unlicensed medical and mental health staff or provision of medical services outside the scope of licensed care, and prolonged or delayed emergency medical care services.

- **Prohibit solitary confinement.** Until it is fully prohibited, issue and implement a directive barring solitary confinement for anyone who has a disability, has a diagnosed mental health condition, is pregnant, postpartum, or caring for a child, or has identified or is known or perceived to be LGBTQ+ or gender non-conforming.
- **Ensure meaningful consequences for detention facilities that have caused deaths of detained people.**
 - Promptly terminate ICE detention contracts for facilities with any death resulting from substandard medical and mental health care, including deaths that occur within 30 days of release from custody.
 - Require that Enforcement and Removal Operations (ERO) and Office of Detention Oversight (ODO) inspectors review and include agency death review documents for all deaths that have occurred at a given facility in their inspection reports, and evaluate and report on corrective actions taken, including imposition of contract penalties, as a result of the death review.
- **Undertake full, comprehensive, and unbiased investigation of deaths in detention.**
 - Ensure preservation of all relevant evidence, including video surveillance, emails, medical records, and the content of the individual’s detention file. Ensure that all final investigatory reports include a comprehensive list of evidence requested, any records that were not produced by the facility, and the reason why such records were not available.
 - Ensure that interviews of detainee witnesses are conducted and included in death investigations and ensure protection from retaliation and deportation of detainee witnesses. If a facility or ICE elects to release an eyewitness from custody prior to the investigation, ensure that the investigators interview the eyewitness, and note the circumstances of the witness’s release from custody in the investigatory report.
 - Require that all detention facilities provide investigators unimpeded access to staff and contractors, without interference or retaliation, for participation in investigations regarding detainee deaths.
 - Require tracking, reporting, and investigation of deaths that occur in medical facilities within 30 days of release from detention.
 - Require full physical autopsies and full-spectrum forensic toxicology screen for all people who die in custody, and psychological autopsies for any apparent suicides. Ensure that family members and estates of all people who have died in custody can conduct independent autopsies, and that all autopsies performed by ICE comply with the National Association of Medical Examiners (NAME) Forensic Autopsy Performance standards.²⁹⁶ Autopsies should also be performed by a pathologist who is board certified in Anatomic and Forensic Pathology by the American Board of Pathology, with a valid license to practice medicine.
 - Ensure that investigations of deaths in detention follow best practices for morbidity and mortality reviews, including multidisciplinary, comprehensive discussions that document and disseminate recommendations to ensure action.²⁹⁷
- **Provide timely, quality medical and mental care to all in ICE detention,** with the caveat that increased funding for detention has not resulted in improvement of health conditions for those in detention. Detention is fundamentally harmful to health and wellbeing of all who are detained.
 - Ensure that all detention facilities, whether care is provided by ICE Health Service Corps (IHSC) or another entity, are bound

by IHSC directives and standards for the provision of medical and mental health care through contract modifications or uniform updates to all detention standards. Violations of these directives and standards shall be immediately remedied.

- Ensure that all detention facilities are bound by, and in compliance with, the 2016 Performance Based National Detention Standards.
 - Ensure routine collection and reporting on the number of individuals in detention with medical vulnerabilities, including chronic conditions, communicable and non-communicable diseases, and severe mental illness.
 - Ensure that all detention facilities provide sufficient and adequate levels of health care staffing, by tracking and publishing vacancy rates for medical and mental health staff at each facility.
 - Require that detention population levels do not exceed medical and mental health staffing levels for the facility at any time.
 - Ensure that all ICE detention facilities strictly prohibit medical and mental health professionals from practicing outside the scope of licensed practice, and improve access of those in detention to physicians, nurse practitioners, and physicians' assistants.
 - Ensure that all healthcare and detention staff are trained in and routinely participate in emergency (code) drills.
 - Ensure that all facilities are required to provide medical interpretation at all encounters, and that metrics of rates of medical interpretation use are publicly reported.
 - Create and enforce protocols for strict documentation and reporting of acute medical situations.
 - Create and enforce protocols for immediate consultations 24/7 with physicians on call.
 - Ensure that all ICE detention facilities provide translation and interpretation for all medical encounters, including the ability to request medical care, in accordance with Performance Based National Detention Standards (PBNDS).
 - Ensure that all ICE detention facility medical staff are trained in and utilize screening tools for the Clinical Institute of Withdrawal Assessment (CIWA) and Clinical Opiate Withdrawal Symptoms (COWS).
 - Create, enforce, and audit protocols and implementation of regular wellness checks, every 15 minutes, to engage with the person in custody, evaluate and treat any urgent health needs, and attempt de-escalation if needed.
 - Create and enforce protocols for routine and frequent inspection of medical equipment.
 - Perform regular quality audits of medical documentation and create mechanisms to identify gaps in management, errors, and other practice failures.
- **Comply with Requests for Public Records Under the Freedom of Information Act.**
 - ICE should comply with FOIA requests more expeditiously, including by better organizing files related to deaths of detained people to enable more rapid productions.
 - ICE frequently withholds significant portions of productions, later lifting redactions when challenged either informally or in litigation. As instructed in Attorney General Garland's March 15, 2022 Memorandum regarding Freedom of Information Act Guidelines, ICE should apply a "presumption of openness"

at the outset when evaluating records rather than trickling out previously redacted material as a case continues.²⁹⁸ (“In case of doubt, openness should prevail.”)

- In all stages of the agency’s response to a FOIA request – during the initial response, administrative appeal, or in litigation – ICE should share with the requester information about the scope of the agency’s search. Search transparency will encourage discussion regarding the parameters used, increasing the opportunity for consensus and possibly avoiding litigation and/or briefing on the adequacy of ICE’s search.
- In practice, ICE’s initial productions of records are physical copies of records sent by postal mail. ICE should instead produce records electronically, which will increase efficiency and align ICE with the FOIA practices of the majority of other federal agencies.
- When producing documents electronically, the PDF files of records should not be password protected. FOIA is a statute granting the public access to public records: the records produced are not confidential, and thus there is no justification for maintaining password protection over the files at the time of production.

To the Department of Justice:

- Ensure full implementation of the Death in Custody Reporting Act (DCRA). Ensure that DHS fully complies with its reporting obligations under the DCRA, and release annual reports on key data trends of deaths in DHS custody.

To Congress:

- Substantially reduce funding for immigration detention. Increase funding for community-based social support and legal representation programs

as alternatives to detention that are far more effective and humane.

- Conduct rigorous oversight of detention conditions, including through hearings with senior government officials. Request a GAO investigation into ICE’s failure to prevent the deaths of detained people, including those who have died in custody and those who have died, while hospitalized, within 30 days of release from ICE custody.
- Require that ICE track, publicly report, and investigate the death of any detained person who died while hospitalized or within 30 days of release from ICE custody.
- Require that ICE make publicly available on its website, as a matter of course, detainee death reviews, healthcare and security compliance analyses, mortality reviews, root cause analyses, autopsy reports, and psychological autopsy reports regarding all individuals who have died in ICE custody or those who have died while hospitalized or within 30 days of release from ICE custody. Require that ICE disclose the cause of death, and make only those redactions necessary to comply with federal privacy laws.
- Require monthly publication of all medical and mental health vacancies by facility, as well as average length of time for detained patients to be seen by a physician, physician’s assistant, or nurse practitioner.
- Require that ICE make publicly available within 30 days any corrective actions taken to enforce contract terms for the provision of medical or mental health care in ICE detention facilities or any other contract violations that may have contributed to a death in custody, as well as Office of Detention Oversight (ODO) inspection reports, OPR detainee death reviews, and IHSC mortality reviews.
- Hold ICE accountable for meeting specific standards with regard to provision of care and data reporting. At a minimum, all facilities that detain individuals who are in ICE custody must

be held to the Performance Based National Detention Standards (rev. 2016), though more stringent standards are required to ensure delivery of quality health care. ICE facilities should be subject to regular independent inspections with enforceable penalties and ongoing monitoring and defunding when standards are not met.

- Pass the Dignity for Detained Immigrants Act (H.R. 2760/S. 1208), which would significantly reduce the number of people held in immigration detention and set enforceable standards to ensure those who remain in custody are in a system that is safe, transparent, subject to robust independent oversight, and accountable to the public.
- Pass the End Solitary Confinement Act (H.R. 4972/S. 3409), which would ban solitary confinement in federal facilities with limited exceptions.
- Pass legislation prohibiting 287(g) agreements and collaboration with ICE in civil immigration enforcement.

To State and Local Governments:

- Pass legislation to prohibit intergovernmental services agreements between state or local agencies and the federal government for civil immigration detention, and to prevent contract modifications to expand detention.
- Pass local ordinances or legislation to prohibit the physical expansion of detention facilities that would allow increased capacity for detention.
- Pass legislation that provides causes of action against for-profit detention facilities that deviate from contractually binding standards. *See, e.g.* California's AB 3228.
- Enact measures that promote local oversight and accountability of state and local facilities.
- Require and ensure that local facilities that detain people in ICE custody expeditiously release and provide records relevant to deaths in detention for release under FOIA.

Appendix 1: Medical Experts

Dr. Chanelle Diaz

Dr. Diaz is a board-certified General Internist practicing primary care in New York City. She is the Internal Medicine Medical Director at the Charles Rangel Community Health Center and an Assistant Professor of Medicine at Columbia University Medical Center. She attended Williams College, received her MD/MPH from the University of Miami Miller School of Medicine, and completed her residency training in Primary Care and Social Internal Medicine at Montefiore Medical Center/Albert Einstein College of Medicine. Dr. Diaz's work focuses on community-engaged approaches to address immigrant health inequities. Dr. Diaz volunteers with the PHR Asylum Network where she provides forensic medical examinations for survivors of torture and/or trauma. She is a volunteer and steering committee member of the New York Lawyers for the Public Interest Medical Providers Network, a community-medical-legal partnership linking volunteer clinicians to individuals with serious medical conditions in immigration prisons to assess and document unmet medical needs. Dr. Diaz has published peer reviewed studies and opinion pieces in the media on the health harms of immigration detention. She has collaborated with other medical and legal experts to develop best practices in the medical evaluation of individuals in immigration detention and has trained dozens of residents and medical students.

Dr. Elena Jiménez Gutiérrez

Elena Jiménez Gutiérrez is an Associate Professor in the Division of Hospital Medicine, Co-Director of the Health Equity track for Internal Medicine residents, Medical Director of San Antonio Refugee Health Clinic, and Director of the Human Rights

and Asylum Medicine elective for medical students at the University of Texas Health Science Center at San Antonio. Over the years, she has attended to medically underserved communities in Chinle, Arizona, Pittsburgh, Pennsylvania, San Antonio, Texas, Chiapas, Mexico, La Romana, Dominican Republic, and Beira, Mozambique. As a member of the Physicians for Human Rights (PHR) Asylum Network, she has expertise in reviewing medical records of individuals held in U.S. Immigration and Customs Enforcement detention centers and in conducting forensic physical and psychological evaluations of asylum-seekers. She served on the Asylum Medicine Training Initiative (AMTI), a national working group that developed a peer-reviewed, virtual asylum medicine curriculum to standardize best practices in the field and improve access to high quality educational content. With the support of peers and trainees, she created and presented an AMTI module. Her passions include health equity, care of underserved populations, asylum medicine, medical education and evidence-based clinical practice in low-resource settings, and chronic kidney disease of unknown etiology.

Dr. Katherine McKenzie

Katherine C. McKenzie, MD, FACP is a faculty member at Yale School of Medicine and the director of the Yale Center for Asylum Medicine (YCAM). She teaches undergraduates, students, and residents, and is a member of Yale Refugee Health Program. She is a physician advocate for social justice and human rights.

Dr. McKenzie founded and directs YCAM. In this capacity, she performs forensic evaluations of asylum-seekers at Yale and in detention facilities, and testifies as an expert witness in immigration court

for individuals referred by law schools, human rights organizations, and immigration attorneys. She leads the asylum medicine teaching program for trainees and faculty at Yale, mentors clinicians across North America, and lectures extensively on topics of asylum, detention, and physician advocacy. She is an expert advisor for Physicians for Human Rights and serves on the boards of the Society for Refugee Healthcare Providers, Project Access New Haven, and Integrated Refugee and Immigrants Services. She is involved in medical legal partnerships and collaborates with attorneys on civil litigation that supports human rights. She is a founder and director of the Society of Asylum Medicine.

She has written reviews, clinical case reports, and opinion essays in publications including the *New England Journal of Medicine*, the *Journal of the American Medical Association*, the *Journal of General Internal Medicine*, the *British Medical Journal*, *Time* magazine and *CNN*, among many others.

At Yale, she received the Leonard B. Tow Award for Humanism in Medicine and the Faculty Award for Achievement in Clinical Care. She has been named a “Top Doctor” for many years by *Connecticut Magazine*. She is a Fellow of the American College of Physicians and has been certified by the American Board of Internal Medicine since 1995.

Dr. Ranit Mishori

Ranit Mishori is a former professor of family medicine at the Georgetown University School of Medicine, and served as Georgetown University’s Chief Public Health Officer, helping lead their COVID-19 response. A former journalist, she has built a multi-dimensional career that includes academia, scholarship, clinical care, mentorship, and leadership roles in public health, global health, medical education, the care of underserved populations, and human rights.

Dr. Mishori has been a champion of migrant health for the past two decades, through intensive engagement in various activities, including clinical care of immigrants, refugees and asylum-seekers in the primary care setting, documentation of human rights violations affecting forced migrants domestically and abroad, education, and scholarship on these issues.

Dr. Mishori has been a member of PHR’s Asylum Network since 2006, has served as an expert consultant to PHR’s Program on Sexual Violence in Conflict Zones since 2011, and has served as the faculty advisor to Georgetown University’s Asylum Program since its inception in 2014.

At PHR, she provided technical and medical expertise to multiple programs, in particular the Asylum Program, the Program on Sexual Violence in Conflict Zones, and the MediCapt project.

Her training includes an MSc in International Human Rights Law from Oxford University; an MD from Georgetown University School of Medicine, and a residency in family medicine, also at Georgetown; and an MHS in International Health from Johns Hopkins Bloomberg School of Public Health.

Dr. Michele Heisler

Michele Heisler, MD, MPA is the medical director at Physicians for Human Rights, a board-certified internist, a practicing clinician at the VA Ann Arbor Healthcare System, and a professor of internal medicine and of public health at the University of Michigan. Before assuming the role of medical director, she served on PHR’s board of directors from 2010 to 2019. She has participated in multiple PHR field investigations and co-authored PHR reports since she was a medical student in the mid-1990s. Before medical training, Dr. Heisler was in charge of human rights and poverty programs in Latin America and the Caribbean as a program officer at the Ford Foundation.

Dr. Heisler received her MD degree from Harvard University and MPA degree from Princeton University’s School of Public and International Affairs. She completed residency training in internal medicine and health services research training as a Robert Wood Johnson Clinical Scholar at the University of Michigan.

Dr. Radha Sadacharan

Dr. Radha Sadacharan is a correctional health physician who has worked in multiple jail and prison settings.

Appendix 2: Deaths in ICE Custody

Jan. 1, 2017 to May 31, 2024

Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Reported Cause of Death
Roger Rayson	M	47	Jamacia	3/13/2017	LaSalle Detention Facility, LA	Remote subdural hemorrhage
Osmar Epifanio Gonzalez Gabda	M	32	Nicaragua	3/22/2017	Adelanto Detention Facility, CA	Suicide - Asphyxia by hanging
Sergio Alonso Lopez	M	55	Mexico	4/13/2017	Adelanto Detention Facility, CA	Gastrointestinal bleed from esophageal varices secondary to liver cirrhosis secondary to alcohol abuse
Jean Jimenez	M	27	Panama	5/15/2017	Stewart Detention Center, GA	Suicide by hanging
Atulkymar Babubhai Patel	M	58	India	5/16/2017	Atlanta City Detention Center, GA	Congestive heart failure with complications from diabetes
Vincente Caceres	M	46	Honduras	5/31/2017	Adelanto Detention Facility, CA	Cardiomegaly and hepatomegaly
Carlos Mejia-Bonilla (aka Rolando Arnulfo Meza Espinoza)	M	44	El Salvador	6/10/2017	Hudson County Department of Correctional and Rehabilitation, NJ	Gastrointestinal bleed
Osvadis Montesino-Cabrera	M	37	Cuba	9/1/2017	Krome Services Processing Center, FL	Suicide by hanging
Felipe Dionisio Almazan-Ruiz	M	51	Mexico	9/17/2017	IAH/Polk County Detention Center, TX	Necrotizing cholecystitis with rupture and hemoperitoneum associated with cirrhosis and thrombocytopenia
Kamyar Samimi	M	64	Iran	12/2/2017	Denver Contract Detention Facility, CO	Undetermined, contributing factors COPD and GI bleeding
Yulio Castro-Garrido	M	33	Cuba	1/30/2018	Stewart Detention Center, GA	Bronchopneumonia with pulmonary abscesses and viral influenza
Luis Ramirez-Marcano	M	59	Cuba	2/19/2018	Krome Detention Center, FL	None provided
Gourgen Mirimanian	M	54	Armenia	4/10/2018	PrairieLand Detention Center, TX	Hypertensive and atherosclerotic cardiovascular disease
Ronal Francisco Romero (aka Ronald Cruz)	M	39	Honduras	5/16/2018	Port Isabel Detention Center, TX	Sepsis infection caused by bacterial meningitis and complications of diabetes
Roxsana Hernandez	F (Transgender)	33	Honduras	5/25/2018	Cibola County Correctional Center, NM	Multicentric Castleman disease Due to Acquired immunodeficiency syndrome

Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Reported Cause of Death
Huy Chin Tran	M	47	Vietnam	6/12/2018	Eloy Detention Center, AZ	Coronary artery disease
Efrain Romero de la Rosa	M	40	Mexico	7/10/2018	Stewart Detention Center, GA	Suicide
Augustina Ramirez-Arreola	F	62	Mexico	7/25/2018	Otay Mesa Detention Center, CA	Complications of aortic valve replacement (AVR), due to rheumatic heart disease, with coronary artery disease, pneumonia, and tuberculosis (TB) as contributing factors
Wilfredo Padron	M	58	Cuba	11/1/2018	Monroe County Detention Center, FL	Coronary artery disease due to atherosclerotic cardiovascular disease
Mergensana Dabaevich Amar	M	40	Russia	11/24/2018	Northwest Detention Center, WA	Suicide - Anoxic encephalopathy due to hanging
Guerman Volkov	M	56	Russia	11/30/2018	Baker County Detention Center, FL	Small bowel obstruction, with gastrointestinal hemorrhage
Emigdio Abel Reyes-Clemente	M	54	Mexico	4/3/2019	Florence Service Processing Center, AZ	Complications of liver cirrhosis, diabetes, and hypertensive cardiovascular disease (Bacterial pneumonia)**
Simratpal Singh	M	20	India	5/3/2019	La Paz County Adult Detention Facility, AZ	Suicide
Yimi Alexis Balderramos-Torres	M	30	Honduras	6/30/2019	Houston Contract Detention Facility, TX	Cardiac death associated with bi-ventricular cardiac dilation
Pedro Arriago Santoya	M	43	Mexico	7/24/2019	Stewart Detention Center, GA	Valvular Heart Disease with Cardiomegaly.
Roberto Rodriguez Espinoza	M	37	Mexico	9/10/2019	McHenry County Correctional Facility, IL	Subdural hematoma and complications of chronic alcoholism
Nebane Abienwi	M	37	Cameroon	10/1/2019	Otay Mesa Detention Center, CA	Hypertensive basal ganglia hemorrhage
Roylan Hernandez-Diaz	M	43	Cuba	10/15/2019	Richwood Correctional Center, LA	Suicide
Anthony Olyseye Akinyemi	M	56	Nigeria	12/21/2019	Worcester County Jail, MD	Suicide - Asphyxia by hanging
Samuelino Pitchout Mavinga	M	40	Angola	12/29/2019	Torrance County Detention Facility, NM	Coccidioidomycosis
Ben James Owen	M	39	England	1/25/2020	Baker County Detention Center, FL	Suicide
Alberto Hernandez-Fundora	M	63	Cuba	1/27/2020	Krome North Service Processing Center, FL	Congestive Heart Failure
David Hernandez-Colula	M	34	Mexico	2/20/2020	Northeast Ohio Correctional Center, OH	Suicide - Asphyxia by hanging
María Celeste Ochoa-Yoc de Ramírez	F	22	Guatemala	3/8/2020	PrairieLand Detention Center, TX	Liver failure due to complications of probable acute viral hepatitis

Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Reported Cause of Death
Orlan Ariel Carcamo-Navarro	M	27	Honduras	3/18/2020	Karnes County Family Residential Center, TX	Suicide – Asphyxia by hanging
Ramiro Hernandez-Ibarra	M	42	Mexico	3/21/2020	Port Isabel Detention Center, TX	Multiorgan failure and metformin overdose
Carlos Ernesto Escobar-Mejia	M	58	El Salvador	5/6/2020	Otay Mesa Detention Center, CA	Acute respiratory failure, pneumonia secondary to
Choung Woung Ahn	M	74	South Korea	5/17/2020	Mesa Verde ICE Processing Facility, CA	Suicide - Asphyxia by hanging
Santiago Baten-Oxlaj	M	34	Guatemala	5/24/2020	Stewart Detention Center, GA	Acute respiratory distress syndrome (ARDS) to COVID-19
Onoval Perez-Montufa	M	51	Mexico	7/7/2020	Glades County Detention Center, FL	COVID-19 pneumonia
Luis Sanchez-Perez	M	46	Guatemala	7/15/2020	Catahoula Correctional Center, LA	Complications of diabetes mellitus with hypertensive arteriosclerotic cardiovascular disease
James Thomas Hill	M	72	Canada	8/5/2020	Immigration Centers of America, VA	COVID-19
Kuan Hui Lee	M	51	Taiwan	8/5/2020	Krome North Service Processing Center, FL	Hypertensive left thalamic hemorrhage
Jose Freddy Guillen-Vega	M	70	Costa Rica	8/10/2020	Stewart Detention Center, GA	COVID-19
Fernando Sabonger-Garcia	M	50	Honduras	8/28/2020	Joe Corley Processing Center, TX	Acute myocardial infarction
Cipriano Chavez-Alvarez	M	61	Mexico	9/21/2020	Stewart Detention Center, GA	COVID-19
Romien Jally	M	56	Marshall Islands	9/26/2020	Winn Correctional Center, LA	COVID-19
Henry Missick (aka Anthony Jones)	M	51	Bahamas	12/17/2020	Adams County Detention Center, MS	Atherosclerotic cardiovascular disease
Felipe Montes	M	57	Mexico	1/30/2021	Stewart Detention Center, GA	Cardiopulmonary arrest, secondary to complications of COVID-19
Jesse Dean	M	58	Bahamas	2/5/2021	Calhoun County Correctional Center, MI	Gastrointestinal hemorrhage
Diego Fernando Gallego-Agudelo	M	45	Colombia	3/15/2021	Port Isabel Detention Center, TX	Acute myocardial infarction
Elba Maria Centeno-Briones	F	37	Nicaragua	8/3/2021	El Valle Detention Facility, TX	COVID-19
Pablo Sanchez-Gotopo	M	40	Venezuela	10/1/2021	Adams County Detention Center, MS	Pneumonia with HIV and COVID-19
Benjamin Gonzalez-Soto	M	36	Mexico	7/8/2022	Florence Service Processing Center, AZ	Spontaneous bacterial peritonitis
Kesley Vial	M	23	Brazil	8/24/2022	Torrance County Detention Facility, NM	Suicide
Melvin Calero	M	39	Nicaragua	10/13/2022	Aurora ICE Processing Center, CO	Pulmonary embolism tied to untreated injury
Cristian Dumitriscu	M	50	Romania	3/5/2023	Otay Mesa Detention Center, CA	None provided

Name	Gender	Age at Death	Country of Birth	Date of Death	Detention Center	Reported Cause of Death
Salvador Rosales-Vargas	M	61	Mexico	4/4/2023	Stewart Detention Center, GA	None provided (stroke in custody)*
Ernesto Rocha-Cuadra	M	42	Nicaragua	6/23/2023	LaSalle Detention Center, LA	Cardiac Arrest
Julio Cesar Chirino Peralta	M	32	Nicaragua	10/8/2023	Port Isabel Detention Center, TX	None provided (stroke in custody)*
Subash Shrestha	M	34	Nepal	11/13/2023	Karnes City ICE Processing Center, TX	None provided (likely suicide)*
Carlos Juan Francisco	M	42	Guatemala	12/4/2023	Krome Service Processing Center, FL	None provided
Frankline Okpu	M	39	Cameroon	12/6/2023	Moshannon Valley ICE Processing Center, PA	MDMA (ecstasy) toxicity
Ousmane Ba	M	33	Senegal	2/24/2024	Winn Correctional Center, LA	None provided (likely cardiac arrest)*
Charles Leo Daniel	M	61	Trinidad and Tobago	3/7/2024	Northwest Detention Center, WA	None provided (reported suicide)*
Jaspal Signh	M	57	India	4/15/2024	Folkston ICE Processing Center, GA	None provided
Edixon Del Jesus Farias-Farias	M	26	Venezuela	4/18/2024	Joe Corley ICE Processing Center, TX	None provided
Cambric Dennis	M	44	Liberia	5/21/2024	Stewart Detention Center, GA	None provided
Hugo Boror Urla	M	39	Guatemala	5/22/24	Calhoun County Jail, MI	Suicide
Jhon Jaier Benavides-Quintana	M	32	Ecuador	6/15/24	Otero County Processing Center NM	None provided

*ICE has not reported a cause of death, but initial reporting or public sources have provided relevant detail regarding suggested cause of death

**ICE has provided a cause of death, but medical experts concuded an alternative cause of death

Endnotes

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