

VIEWPOINT

How Should Health Professionals and Policy Makers Respond to Substandard Care of Detained Immigrants?

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Abstract

More people, including children and pregnant women, are being detained for longer periods in a patchwork of over 200 detention centers around the country, most of which are private facilities or county jails. Human Rights Watch has documented systemic medical care failures at these facilities, including incompetent treatment, which is linked to patient deaths. Clinicians working in these facilities face formidable obstacles to providing adequate care, two of which are the Department of Homeland Security's lack of reasonable alternatives to detention and insufficient staffing. Harm caused by these conditions and detention itself should be enough to prompt clinicians to insist that the government enable provision of care consistent with generally accepted standards, including through reducing the detained population.

Deaths in Immigrant Detention

For a 2018 report, Human Rights Watch worked with independent medical experts to review government records pertaining to deaths in immigration detention from late 2015 to mid-2017.¹ The report, entitled "Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention," found that in 8 of the 15 cases experts reviewed, poor medical care contributed or led to deaths. Of the 52 deaths since March 2010 in immigration detention that have been evaluated by government or outside experts, 23 were linked to substandard care.¹ We examine here the reasons for substandard health care in detention centers and propose actions and policies necessary to address these sometimes-deadly failures.

Neglect, Scope of Practice Violations, and Barriers to Care

In one case detailed in the documents, a 54-year-old male patient began to have symptoms of a heart attack in the Adelanto Detention Facility in California. At about 9 am on December 19, 2015, another detained person told a correctional officer that he was sick and needed medical care. An officer heard him vomiting but did not check on him. At 9:30 am, a licensed vocational nurse entered the patient's unit and the officer told her that the patient was sick and vomiting. The nurse did not check on the patient, however, because purportedly "she did not want to get sick."¹ This was the beginning of a 2-hour

delay in the patient's transfer to a hospital. By then, it was too late—his heart was damaged, and he died 4 days later.

The extreme indifference exhibited in this patient's case is the outlier in these deaths. What is more common is systemic problems with the quality of care, including frequent use of licensed vocational nurses to assess and diagnose symptoms that require the attention of more highly trained practitioners. In one case we reviewed, a nurse resigned in protest over the facility's medical practices, which included having licensed vocational nurses regularly conduct clinic visits and clinically assess patients for danger that might follow placing them in isolation—which was far outside the nurses' scope of practice.² In another case, a 65-year-old male patient

suffered from the symptoms of congestive heart failure for most of the 15 months he was detained at the LaSalle Detention Facility in Louisiana, including fainting, swelling, anemia, coughing, and shortness of breath. Instead of properly diagnosing and treating these classic symptoms [or referring him to a clinician who could], a nurse recommended he increase his fluid intake, which likely increased his risk of heart failure.¹

Barriers to accessing care and detention center staffing models also cause concern. We reviewed court filings in a wrongful death suit brought by the family of Gerardo Cruz-Sanchez, who died in the Otay Mesa Detention Center in San Diego, California, in 2016. Cruz-Sanchez was a migrant who had recently crossed the border and was being held in the US Immigration and Customs Enforcement (ICE) detention facility as a material witness for the US Marshal Service. According to a wrongful death suit filed by Cruz-Sanchez's family, his cellmate said Cruz-Sanchez reported shortness of breath, respiratory distress, and wheezing a few days after being detained and complained to correctional officers.³ Another detainee reported that the officers did nothing, "saying that they only take detainees to the hospital when they are dying."¹ The family's complaint said that "an officer screamed at Cruz-Sanchez, angry that he stained a table when he spat up blood in the cafeteria. It was not until later, when an officer happened upon him after he had coughed up so much blood that his bedsheets were soaked, that he was taken to a hospital."¹ In a deposition for the case, the former training manager for the company that runs the Otay Mesa facility said that "understaffing issues" meant that correctional officers often did not have sufficient backup to go to the bathroom much less escort someone to the medical unit.³ In a detention facility in Eloy, Arizona, run by the same company, a nurse who resigned in 2007 released her resignation letter, which described severe nursing shortages on nights and weekends, an unstaffed and understocked pharmacy, and directives from medical directors instructing staff to stop the medications of stable psychiatric patients to save money, which had resulted in suicide attempts.⁴

The 2018 Human Rights Watch report also documents the continued misuse of isolation, detailing 3 cases of people with psychosocial disabilities who committed suicide after being held alone and denied adequate mental health treatment.¹ In all 3 cases the

detention staff knew of the detainees' mental health problems, as all of them had been on various forms of treatment, but the staff nonetheless isolated them as punishment for prior self-harm or for psychiatric observation.¹

Increased Detention and Detention of Families

The problem of poor medical care in immigration detention is growing in scale and potential severity. As of September 2018, the US immigration detention system held an average of 40 770 people on any given day, but the current administration has requested funding to increase that number to 47 000.^{5,6} These developments place more people at risk in a poorly run and dangerous system. Detention facilities hold recent migrants and asylum seekers, some separated from their children and others detained together, as well as long-term US residents, including people with lawful permanent resident status.

The vulnerabilities of the detained population are also increasing. An ICE directive made public in late March eliminates the presumption that ICE should not detain **pregnant women** except in extraordinary circumstances, allowing ICE to detain many more pregnant women.⁷ ICE officials have told the media that detention centers are equipped to care for pregnant detainees,⁸ but in 2017 advocacy organizations filed a formal complaint to the Department of Homeland Security on behalf of 10 pregnant women who had been detained.⁹ Some said they received poor prenatal care. Others miscarried and blamed their miscarriage on the stress of being detained.

More **children** also risk being detained. After sustained and vociferous public outcry about the mass separation of families at the border in the summer of 2018, an executive order was signed that halted family separation by ordering federal agencies to work together to detain tens of thousands of families with children together.¹⁰ Proposed federal regulations would remove court-mandated limitations on the length of time children may be detained in ICE facilities, exposing more children to potentially substandard care for prolonged periods.¹¹ The mother of a toddler who died this year after being detained in one of these family detention centers filed a wrongful suit in August, claiming her daughter received substandard care while detained.¹²

Policy Recommendations

The report concludes that ICE has proven unable or unwilling to provide adequately for the health and safety of those it detains. Oversight and accountability mechanisms have too often failed, and the current administration's proposal to expand detention and weaken existing standards will further endanger lives. In light of these findings, action is needed on many fronts.

As an immediate priority, Human Rights Watch has called on Congress to decrease rather than expand detention; demand robust health, safety, and human rights standards for all types of immigration detention facilities; and monitor and engage in

strong oversight of detention facilities through frequent information requests, hearings, and investigations.¹

In the medium-to-long term, the United States government should use proven alternatives to detention to restructure this system and dramatically reduce unnecessary detention. One alternative ICE piloted was the Family Case Management Program, which had 630 asylum-seeker enrollees as of April 2017. As the second author has noted elsewhere,

In the program, social workers helped participants in five US cities navigate the immigration court system, get housing and health care, and enroll their kids in school. Of those participating, 99 percent attended their immigration hearing and check in requirements and it cost only \$36 dollars a day per family. That's in contrast to an average cost of \$319 a day per person in family immigration detention and \$124 a day in adult facilities.¹³

Unfortunately, ICE canceled this program last year despite its promising outlook as a viable national model.¹³

We should not overlook the important role that medical institutions and practitioners can play in addressing substandard care in detention. State licensing boards can be an effective avenue for ensuring quality of care, particularly with respect to disciplinary proceedings against clinicians who practice outside the scope of their license. Clinicians can also seek to join [medical-legal partnerships](#) to find opportunities to help individual detained people. One such program is being developed by New York Lawyers for the Public Interest (NYLPI).^{14,15} As part of this program, NYLPI is recruiting qualified doctors nationally "to perform outside evaluations of detainees health conditions and current treatment regimens" in support of efforts to get individuals treated and released appropriately.¹⁴ Clinicians contributing to such efforts could well be ensuring that their patients do not join the list of people whose deaths are linked to substandard care in detention.

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