

CHANGES IN THE WIND:
HOW INCREASED DETENTION RATES, NEW
MEDICAL CARE STANDARDS, AND ICE POLICY
SHIFTS ALTER THE DEBATE ON IMMIGRANT
DETAINEE HEALTHCARE

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I. Introduction

Immigration detention is the “fastest-growing, least-examined type of incarceration in America.”¹ In the past fifteen years, the number of immigrants detained pending removal from the United States has risen from an annual rate of several thousand to nearly half a million.² Three policy changes account for the dramatic increase in removal rates. First, Congress has greatly expanded the ways in which an immigrant can become eligible for removal. Second, the government body responsible for overseeing removal – the United States Immigration and Customs Enforcement agency (ICE) – has recently begun placing a heightened focus on removals. Finally,

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¹ Nina Bernstein, *City of Immigrants Fills Jail Cells With Its Own*, N.Y. Times, Dec. 27, 2008, at A1, available at <http://www.nytimes.com/2008/12/27/us/27detain.html> [hereinafter *City of Immigrants*].

² *Id.* For instance, in fiscal year 2007, ICE attorneys participated in 365,861 cases before immigration courts, which included 323,845 removal cases. U.S. Immigration and Customs Enforcement, FY07 Accomplishments (2008), <http://www.ice.gov/pi/news/factsheets/index.htm> (follow Accomplishments FY07 hyperlink) (last visited Apr. 8, 2009) [hereinafter FY07 Accomplishments]. Please note that the author will be using the terms “immigrant” and “alien” interchangeably throughout this paper.

state and local police enforcement agencies have begun seeing removal as an effective crime-management technique. The combination of increased removal rates and the detention period that typically precedes removal has caused a proportionate increase in detention rates.³

ICE does not own or maintain enough facilities to hold the amount of immigrants now being detained. Instead, it sends the overflow of detainees to facilities owned by private corporations and state and local governments.⁴ To ensure that all contracted facilities meet minimum safety, health, and procedural requirements, ICE and its predecessor, the Immigration and Naturalization Service (INS), created standards for all facilities holding immigration detainees. ICE maintains responsibility for monitoring these contracted facilities;⁵ in addition, it has retained two private companies to provide similar services.⁶ Thus, ICE has enacted policies to ensure that all the facilities – even those it does not own – comply with the medical standards it deems appropriate for detainees.

Significant controversy surrounds the medical standards created by ICE. As the number of detainees continues to rise, the concern about the medical care provided has become even more acute. Two main issues emerge from the debate – whether the standards are effective and whether the facilities adhere to those standards. ICE addressed the first issue by converting facilities from reliance on its prior medical standards, known as the 2000 National Detention Standards (2000 Standards),⁷ to a revised version known

³ New York Times Death in Detention Article, U.S. Immigration and Customs Enforcement (May 6, 2008), http://www.ice.gov/pi/nytimes_myth_fact.htm (last visited Feb. 24, 2009) [hereinafter ICE and New York Times].

⁴ Detention Management Program, U.S. Immigration and Customs Enforcement, <http://www.ice.gov/partners/dro/dmp.htm> (last visited Feb. 13, 2009) [hereinafter Detention Management].

⁵ Washington Post Detainee Health Care Series – Day 1, U.S. Immigration and Customs Enforcement, http://www.ice.gov/pi/wash_post_myth_fact1.htm (last visited Feb. 24, 2009) [hereinafter ICE and Washington Post Day 1].

⁶ *Id.*; The Op-ed the New York Times Editorial Page Refused to Run (May 14, 2008), http://www.ice.gov/pi/ny_times_op_ed.htm (last visited Feb. 24, 2009) [hereinafter ICE Op-ed].

⁷ Detention Operations Manual: Medical Care, U.S. Department of Homeland Security (2000), <http://www.ice.gov/pi/dro/opsmanual/index.htm> (follow “Medical

as the 2008 Performance Based National Detention Standards (2008 Standards).⁸ Because the 2008 Standards are superior in several critical respects, it is likely that their widespread adoption will quell many of the concerns over whether the standards themselves are acceptable.

The issue of adherence, however, remains far more difficult to analyze. Some case studies present clear violations that ICE has acknowledged and attempted to remedy by demanding stricter compliance or even canceling its contract with the offending facility. Other instances yield an extreme disconnect between ICE and those who have allegedly suffered and died from poor healthcare, or a complete lack thereof, while in detention. The continuing discrepancy among the parties and the difficulty in determining the truth behind the alleged violations is itself a cause for valid concern. Furthermore, several objective reports from other government agencies have highlighted consistent flaws in the adherence to and the monitoring of the prior 2000 Standards.⁹ News reports and academic literature have consistently cited to these reports in their arguments that adherence and monitoring are critical flaws in the ICE detention

Care” hyperlink] [hereinafter 2000 Standards].

⁸ Operations Manual ICE Performance Based National Detention Standards: Medical Care, U.S. Department of Homeland Security (2008), <http://www.ice.gov/partners/dro/PBND/index.htm> (follow “Medical Care” hyperlink) [hereinafter 2008 Standards].

⁹ See Office of Inspector General, Department of Homeland Security, Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities (Dec. 2006), http://www.dhs.gov/xoig/rpts/gc_1193965173651.shtm (follow OIG-07-01 hyperlink) (last visited Mar. 25, 2009) [hereinafter OIG Treatment]; Office of Inspector General, Department of Homeland Security, ICE Policies Related to Detainee Deaths and the Oversight of Immigration Detention Facilities (June 2008), http://www.dhs.gov/xoig/rpts/mgmt/OIG_mgmtrpts_FY08.shtm (follow OIG-08-52 hyperlink) (last visited Mar. 24, 2009) [hereinafter OIG Policies]; Richard M. Stana, Director, Homeland Security and Justice Issues, U.S. General Accountability Office, Testimony before the Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law of the H. Comm. on the Judiciary, 110th Cong *on Alien Detention Standards: Observations on the Adherence to ICE’s Medical Standards in Detention Facilities* (June 4, 2008) *available at* <http://www.gao.gov/products/GAO-08-869T> (follow Full Report hyperlink) [hereinafter Stana]. These three reports are discussed in greater detail in Section V.F1. *infra*.

scheme.¹⁰

This paper does not dispute the accuracy of the agency reports and prior academic criticisms. Instead, it argues that those reports and the critiques relying upon them are dated. ICE has enacted multiple policy changes since the time of that research. The 2008 Standards are one of the newest and most notable modifications, but other recent facts and trends also support ICE's renewed claims of proper adherence.

Importantly, the number of deaths in all detention facilities has actually decreased despite the increased numbers of detainees and the increased use of contracted facilities.¹¹ Additionally, ICE has established a history of acknowledging when detainee deaths have resulted from failure to uphold the medical standards. The fact that ICE has accepted responsibility in some situations and has taken dramatic steps—including removing its detainees and canceling its contracts—to protect future detainees from those facilities lends credence and merit to ICE's positions on the disputed cases.

While some facts remain contested, the importance of detainee healthcare is acknowledged by all. The greatly increased rates of removal are leading to more detainees every year. Standards of medical care for these increased numbers of detainees must be closely analyzed, particularly in light of the allegations of negligence and abuse made by immigrants, their advocates, and the news media. Upon review of the available facts, and particularly in light of the new 2008 Standards, the situation today is not as dire as that painted in the news and prior academic literature. Detainee deaths have

¹⁰ See Michelle Brane & Christiana Lundholm, *Human Rights Behind Bars: Advancing the Rights of the Immigration Detainees in the United States Through Human Rights Frameworks*, 22 *GEO. IMMIGR. L.J.* 147, 161-63 (2008); Kelsey Papst, *Protecting the Voiceless: Ensuring ICE's Compliance with the Standards that Protect Immigrant Detainees*, 40 *MCGEORGE L. REV.* 261, 275-76 (2009); Steven Neeley, *Immigration Detention: The Inaction of the Bureau of Immigration and Customs Enforcement*, 60 *ADMIN. L. REV.* 729, 731-32 (2008).

¹¹ Mortality Rates at ICE Detention Facilities, U.S. Immigration and Customs Enforcement (July 17, 2008), http://www.ice.gov/pi/news/factsheets/detenti_on_facilities_mortality_rates.htm (last visited Mar. 24, 2009) [hereinafter *Mortality Rates*].

dropped despite a rapid increase in the number of detainees.¹² ICE has enacted several independent monitoring services to ensure that its medical standards are upheld in all facilities-including the contracted ones.¹³ The agency has acknowledged certain criticisms and has made important procedural changes in response. Thus, so long as ICE demands that its facilities adhere to the 2008 Standards, and effectively monitors and enforces them, the majority of immigrant healthcare concerns should be effectively addressed.

This paper provides an analysis of the recent changes in immigration detainee healthcare and argues that ICE is taking significant and proactive steps to address the systemic failures of the prior regime. Briefly discussed at the conclusion of this paper is ICE's significant August 6, 2009 announcement that it is enacting additional major reforms to the immigration detention system. This critical development lends credence to this paper's argument that ICE is developing a workable framework for providing appropriate healthcare to immigrant detainees. However, as the announcement came after this paper had been written, a detailed discussion of how those changes support the ideas espoused herein must await another day.

Section II of this paper will therefore discuss the increase in the numbers of immigrant detainees, explain the three primary reasons for this increase, and examine all three in the context of Operation Community Shield. Section III will comment upon how the increased detention rates have led to heavy reliance on state, local, and private prison facilities. In Section IV, the paper will analyze the substance of the 2000 and 2008 National Detention Standards. The discussion of adherence to the standards will be provided in Section V, which will include consideration of immigration allegations of failures, ICE's responses to those allegations, and case studies demonstrating that ICE has alternately acknowledged and disputed the allegations. Section VI will argue that both adherence and monitoring are now possible and will recommend a full embrace of both the

¹² Mortality Rates at ICE Detention Facilities, U.S. Immigration and Customs Enforcement (July 17, 2008), http://www.ice.gov/pi/news/factsheets/detention_facilities_mortality_rates.htm (last visited Mar. 24, 2009) [hereinafter Mortality Rates].

¹³ ICE and Washington Post Day 1, *supra* note 5; ICE Op-ed, *supra* note 5.

letter and the spirit of the 2008 Standards. It will also provide a short discussion of how ICE's August 9, 2009 announcement substantiates the claims made in this paper. Finally, Section VII will conclude.

II. The Number of Immigration Detainees Has Dramatically Increased

A. Background Information

The Immigration and Nationalization Act (INA)¹⁴ provides that immigrants can be removed from the United States for a variety of reasons, including criminal conviction, economic well-being, health concerns, and national security risks.¹⁵ In most circumstances, when ICE agents allege that an immigrant is eligible for removal, that immigrant receives the right to a removal proceeding before an immigration judge.¹⁶

ICE is authorized to detain immigrants during the removal proceedings.¹⁷ The decision of whether or not to detain an immigrant facing removal is made on a case-by-case basis.¹⁸ The decision considers such things as whether the individual poses a threat to national security or public safety, whether he or she is a flight risk, and whether or not mandatory detention is required.¹⁹ The Illegal Immigration Reform and Immigrant Responsibility Act of 1996²⁰ established mandatory detention for a variety of immigrants subject to removal, particularly those subject to removal based on criminal

¹⁴ Immigration and Nationality Act, 8 U.S.C. §§ 1101-1537 (2007).

¹⁵ Office of Detention and Removal, U.S. Immigration and Customs Enforcement, <http://www.ice.gov/pi/dro/index.htm> (last visited Feb. 13, 2009) [hereinafter DRO]; *See also* 8 U.S.C. §§ 1226, 1227, 1229, 1229(a), and 1357 (2007) (discussing provisions granting ICE the authority to arrest, detain, and remove immigrants from the United States).

¹⁶ DRO, *supra* note 15.

¹⁷ ICE and Washington Post Day 1, *supra* note 5. Detained immigrants have the right to receive an attorney, but not at any expense to the government. *Id.*

¹⁸ ICE and New York Times, *supra* note 3.

¹⁹ *Id.*

²⁰ Pub. L. No. 104-208, 110 Stat. 3009-546 (1996).

convictions.²¹ Immigration detention and removal are therefore inexorably linked. As the number of removal cases rise, so does the number of immigrants facing detention.

Fifteen years ago, only several thousand immigrants were detained pending removal each year.²² Today, upwards of half a million immigrants cycle through detention centers in the United States on an annual basis.²³ On any given day, approximately 32,000 detainees are incarcerated.²⁴ Reflecting this dramatic increase, Congress has doubled annual spending on immigration detention in the last four years.²⁵ In October 2008, Congress approved a \$2.4 billion immigration detention budget as part of the \$5.9 billion total allocated to immigration enforcement for the 2008-2009 fiscal year.²⁶

Increased eligibility for removal, a heightened focus from ICE on enforcing removal cases, and greater participation from state and local agencies all contribute to a larger number of immigrants facing removal than ever before. Each of these reasons for increased removal is important in understanding the bigger picture of detainee healthcare and will be discussed separately below. This section concludes with a discussion of Operation Community Shield, an ICE program that combines all three factors into one extremely active removal program.

B. Increased Eligibility for Removal

First, Congress has greatly expanded the list of reasons that one may be removed. With a greater list of behaviors that make one eligible for removal, more aliens are inherently eligible for removal

²¹ American Immigration Lawyers Association, INS Detention Facilities Home Pages Going Online (2002), <http://www.aila.org/content/default.aspx?bc=12228> (follow “INS Detention Facilities Home Pages Going Online” hyperlink) (last visited Feb. 27, 2009).

²² *City of Immigrants, supra* note 1.

²³ *Id.*

²⁴ Press Release, American Civil Liberties Union, ACLU Welcomes Immigration Detention Medical Treatment Legislation (May 5, 2008), *available at* <http://www.aclu.org/immigrants/detention/35234prs20080505.html> [hereinafter ACLU].

²⁵ *City of Immigrants, supra* note 1.

²⁶ *Id.*

than before. Of particular note in this context is the greatly increased overlap between criminal activities and removal eligibility.

In 1988, Congress added the conviction of an aggravated felony to the list of removal grounds.²⁷ At that time, only murder, weapons trafficking, and drug trafficking qualified as aggravated felonies.²⁸ Since then, a variety of amendments have greatly expanded the list of activities that qualify one for removal under this ground. For instance, the Immigration Act of 1990 added “crimes of violence”²⁹ and the Immigration and Nationality Technical Corrections Act of 1994 added theft, receipt of stolen property, burglary, trafficking in fraudulent documents, RICO, prostitution offenses, tax evasion, and people smuggling.³⁰ Later, the Antiterrorism and Effective Death Penalty Act of 1996 added commercial bribery, forgery, counterfeiting, certain gambling offenses, vehicle trafficking, obstruction of justice, perjury, and bribery of a witness.³¹ Sexual abuse of a minor and rape were also added that year.³² Because many of these new standards were applied retroactively,³³ these new additions make immigrants eligible for removal for activities committed long before Congress labeled the behavior an aggravated felony.

C. ICE’s Increased Focus on Removal

A second cause of the increased detention rate is ICE’s heightened emphasis on removal. For several years after the terrorist attacks of September 11, 2001, the vast majority of ICE resources were

²⁷ The Anti-Drug Abuse Act of 1988, Pub. L. No. 100-690, § 7347(a), 102 Stat. 4181 (1988).

²⁸ *See id.* § 7342.

²⁹ The Immigration Act of 1990, Pub. L. No. 101-649, § 501(a)(3), 104 Stat. 4978, 5048 (1990).

³⁰ Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416, § 222, 108 Stat. 4305 (1994).

³¹ Antiterrorism and Effective Death Penalty Act of 1996, Pub. L. No. 104-132, § 440(e)(8)(R), 110 Stat. 1214 (1996).

³² Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, Div. C., Title III § 321, 110 Stat. 3009, 3636-37 (1996).

³³ Immigration and Nationality Act, 8 U.S.C. § 1101(a)(43)(2006) (stating that an aggravated felony can be found regardless of whether the conviction occurred before enactment of any portion of the aggravated felony provision).

devoted to terrorism-related concerns.³⁴ However, the last few years have seen a large increase in the amount of money, time, and attention that ICE has put towards removal. While some immigrants targeted this way may also fall under the scope of terrorism concerns, most pose no such threat.³⁵ Thus, the increased ICE focus on removal cannot be wholly subsumed under the terrorism-fighting umbrella and must be considered an independent factor in the number of immigrants facing detention.

1. Office of Detention and Removal

The Office of Detention and Removal (DRO) is the primary ICE division responsible for identifying, apprehending, and removing illegal aliens from the US.³⁶ It focuses on processing illegal, fugitive, and criminal aliens³⁷ through the immigration courts and then on ensuring their removal from the United States.³⁸ By actively overseeing the removal process and ensuring that all final removal orders are carried out, the DRO attempts to prevent growth in the “illegal alien absconder population.”³⁹ To successfully ensure this mission, DRO coordinates with foreign government officials, oversees the logistical and transportation needs in removing aliens, and pro-

³⁴ Jon Feere & Jessica Vaughan, *Taking Back the Streets: ICE and Local Law Enforcement Target Immigrant Gangs*, Center for Immigration Studies (2008), <http://www.cis.org/ImmigrantGangs> (last visited Feb. 20, 2009).

³⁵ *Id.*

³⁶ DRO, *supra* note 15; Gary E. Mead, Assistant Director for Management, Office of Detention and Removal Operations at U.S. Immigration and Customs Enforcement, Statement on the Medical Care and Treatment of Immigration Detainees and Deaths in DRO Custody Regarding a Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law of the H. Comm. on the Judiciary, 110th Cong. (October 4, 2007), *available at* judiciary.house.gov/hearings/pdf/Mead071004.pdf [hereinafter Mead]. For the purpose of this paper, the term “illegal” immigrant or alien is being used to refer to individuals not currently authorized to be present in the United States, including those with expired visas, those who entered without inspection, and those who are eligible for deportation but have not yet been ordered deported.

³⁷ The DRO specifically lists its scope of responsibilities as covering these three categories of immigrants – illegal, fugitive, and criminal – but does not define how it is using those terms.

³⁸ DRO, *supra* note 15.

³⁹ *Id.*

vides escorts to the foreign country, if necessary.⁴⁰ Additionally, DRO is responsible for ensuring safe and humane conditions of confinement for detained immigrants, including the provision of health services.⁴¹

One subset of the DRO is the Intelligence Operations Unit, which “manages the collection and dissemination of law enforcement information and intelligence.”⁴² Using this information, it focuses on the “identification and removal of dangerous, often recidivist, criminals engaged in crimes such as murder, predatory sexual offenses, narcotics trafficking, alien smuggling, and a host of other crimes that have a profoundly negative impact on our society.”⁴³

To support its increased removal activities, the DRO has increased its on-board staffing levels from approximately 4,000 full time employees in 2004 to 6,300 such employees in 2008.⁴⁴ Additionally, the DRO has created new programs to focus more intensely on removing certain immigrants – notably, immigrant fugitives.

2. *National Fugitive Operations Program*

In 2003, ICE created the National Fugitive Operations Program (NFOP) to expand its ability to locate, arrest, and remove fugitives.⁴⁵ NFOP defines fugitives as aliens who have failed to leave the United States after issuance of a final order of removal, deportation, or exclusion; the definition also includes those who have failed to report to ICE after being told to do so.⁴⁶ ICE directed NFOP to

⁴⁰ DRO, *supra* note 15.

⁴¹ Detainee Health Care, U.S. Immigration and Customs Enforcement (Nov. 19, 2008), http://www.ice.gov/pi/news/factsheets/detainee_health_care.htm (last visited Mar. 24, 2009) [hereinafter Health Care].

⁴² DRO, *supra* note 15.

⁴³ *Id.*

⁴⁴ Washington Post Detainee Health Care Series – Day 3, U.S. Immigration and Customs Enforcement, http://www.ice.gov/pi/wash_post_myth_fact3.htm (last visited Feb. 24, 2009) [hereinafter ICE and Washington Post Day 3].

⁴⁵ ICE Fugitive Operations Programs, U.S. Immigration and Customs Enforcement (2008), http://www.ice.gov/pi/news/factsheets/NFOP_FS.htm (last visited Feb. 20, 2009) [hereinafter ICE Fugitive].

⁴⁶ *Id.*

prioritize those fugitives who create public safety concerns,⁴⁷ such as those with prior convictions for violent crimes, sexual abuse of minors, or membership in transnational street gangs.⁴⁸ According to ICE, the NFOP is achieving its goals – 2008 was the first year with a decline rather than an increase in the number of outstanding fugitive cases.⁴⁹ As a result of NFOP's creation, ICE's heightened focus on removal, and the DRO's employment expansions, an increased number of immigrants are now entering the removal process.

D. State and Local Law Enforcement Removal Activities

A final reason for the increased number of immigrant detainees is the growing participation of state and local police agencies in the immigration arena. As discussed below, ICE has provided a variety of possible programs that state and local enforcement authorities can utilize to fight illegal immigration and related criminal activities in their communities. As the state and local police activities increase, so do the number of immigrants being caught up in the removal process.⁵⁰

1. ICE's 287(g) Program

State and local police now have several ways in which they can participate in the removal process. For instance, the 287(g)⁵¹

⁴⁷ DRO, *supra* note 15.

⁴⁸ ICE Fugitive, *supra* note 45.

⁴⁹ *Id.* To accomplish this, ICE has consistently increased the number of Fugitive Operations Teams dedicated to identifying and arresting fugitives. In 2005, ICE had 18 teams but that number had increased to 75 teams by 2007. FY07 Accomplishments, *supra* note 2.

⁵⁰ See Kris W. Kobach, *The Quintessential Force Multiplier: The Inherent Authority of Local Police to Make Immigration Arrests*, 69 ALB. L. REV. 179, 181(2005) ("The nearly 800,000 police officers nationwide represent a massive force multiplier. This assistance need only be occasional, passive, voluntary, and pursued during the course of normal law enforcement activity").

⁵¹ The ICE 287(g) Program: A Law Enforcement Partnership, U.S. Immigration and Customs Enforcement (Nov. 19, 2008), http://www.ice.gov/pi/news/factsheets/section287_g.htm (last visited Mar. 24, 2009) [hereinafter Partnership]; see also Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub L. 104-208, 110 Stat. 3009 (1996) (referring to Section 287(g) of the Immigration and Nationality Act).

program provides police with training on immigration law, access to ICE databases, and the authority to enforce immigration law under ICE supervision.⁵²

Training for the 287(g) program is held at the Federal Law Enforcement Training Center in Charleston, South Carolina and covers “immigration law, intercultural relations, civil rights and access to federal law enforcement databases in order to identify criminals and immigration violators.”⁵³ The major benefit this program offers to police participants is the ability to launch the removal process against immigrants.⁵⁴ Although most police forces have the authority to arrest for immigration violations, only ICE and 287(g) participants can enact removal proceedings. Participation in the program has been slow, but is steadily increasing. By July 2008, fifty-five police jurisdictions across the country had completed training and eighty more were on waiting lists to do so.⁵⁵ By October 2008, over 840 local law enforcement officers had completed their training.⁵⁶

Thus, the 287(g) training provides two ways for state and local police to become more involved in the immigration context. First, the training enables officers to learn about and become comfortable with identifying and arresting immigration violators. This results in an increased number of aliens incarcerated on immigration charges. Second, the training empowers local officers with the authority to institute removal proceedings—both for criminal and administrative violations.⁵⁷

The results of this program have been strong and it has continued to receive increased federal funding. For example, local officers are credited with identifying over 70,000 possible immigration

⁵² Feere & Vaughan, *supra* note 34. For a brief summary of the 287(g) program, see Partnership, *supra* note 51.

⁵³ Press Release, U.S. Immigration and Customs Enforcement, Las Vegas Metropolitan Police Department Partners with ICE in 287(g) Program (Oct. 15, 2008), available at <http://www.ice.gov/pi/nr/0810/081015lasvegas.htm> [hereinafter Las Vegas].

⁵⁴ Feere & Vaughan, *supra* note 34.

⁵⁵ *Id.*

⁵⁶ Las Vegas, *supra* note 53.

⁵⁷ Feere & Vaughan, *supra* note 34.

violators in the last two years.⁵⁸ While the program received only \$15 million in funding in 2007, it received over \$42 million in 2008.⁵⁹ The direct result of this program's growing success is that many more criminal aliens are being put on the path to removal, rather than solely being directed to jail for their crimes.

2. ICE's Law Enforcement Support Center

Many jurisdictions have taken additional measures to ensure that state and local police officers are aware of and are enforcing immigration law. Virginia, for instance, now requires all jails and prisons to screen inmates for immigration status, notify ICE of any incarcerated criminal aliens, and track the status of all such aliens.⁶⁰ State officers accomplish this by using ICE's Law Enforcement Support Center (LESC).⁶¹ LESC is a twenty-four hour call center that verifies legal status, uncovers prior immigration law violations, and tracks criminal histories.⁶² Local agents contact LESC to check the immigration status of those arrested or under investigation.⁶³ Because 85% of requests return results in under fifteen minutes,⁶⁴ the system is efficient, easy-to-use, and becoming more popular with state and local police.⁶⁵ While this program has its supporters and its critics,⁶⁶ the end result of its use is that more criminal aliens are be-

⁵⁸ Feere & Vaughan, *supra* note 34; Partnership, *supra* note 51.

⁵⁹ Las Vegas, *supra* note 53.

⁶⁰ *Id.*

⁶¹ Law Enforcement Support Center, U.S. Immigration and Customs Enforcement (2008), <http://www.ice.gov/partners/lesc/> (last visited Apr. 8, 2009) [hereinafter LESL]; Press Release, U.S. Immigration and Customs Enforcement, Law Enforcement Support Center (Nov. 19, 2008), *available at* <http://www.ice.gov/pi/news/factsheets/lesc.htm> [hereinafter LESL Press Release]. For a brief summary of all LESL activities and recent accomplishments, *see id.*

⁶² LESL, *supra* note 61; LESL Press Release, *supra* note 61.

⁶³ LESL Press Release, *supra* note 61.

⁶⁴ Feere & Vaughan, *supra* note 34.

⁶⁵ FY07 Accomplishments, *supra* note 2. For instance, LESL responded to 728,243 requests for information from law enforcement officials in fiscal year 2007, setting a record high for the department. *Id.*

⁶⁶ One suggested benefit to coordination with LESL is that it can be used as an alternative to the "formality, negotiation, and delays" that may be involved with participation in the 287(g) program. Thus, some jurisdictions choose only to im-

ing tracked and tagged for removal.

3. Future Plans

Despite the increased emphasis by ICE and by state and local police agencies on removing aliens – particularly criminal aliens—there is no system in place that alerts federal officials when criminal aliens are released from state or local jails.⁶⁷ Once released from jail, ICE is not ensured of any opportunity to pick such aliens up on immigration charges or hold them until deportation.⁶⁸ Because approximately 450,000 US jail inmates were in the country illegally when they committed the crimes for which they were imprisoned, the lack of notice to ICE results in many of these inmates being released rather than processed for removal through ICE.⁶⁹

Recently, the U.S. Secretary of Homeland Security, Janet Napolitano, announced plans to create a database network that would ensure criminal aliens are deported after jail time.⁷⁰ By creating mandatory communication between federal immigration officials and state and local detention centers, the new program will theoretically ensure that every alien arrested on criminal charges is brought to ICE's attention shortly before release from incarceration.⁷¹ State and local jail officials will be required to notify ICE before releasing any criminal aliens.⁷² This policy enhances state and local involvement in increasing the number of removal cases.

plement LESC coordination, while others combine that with participation in the 287(g) program. Kris W. Kobach, *Reinforcing the Rule of Law: What States Can and Should Do to Reduce Illegal Immigration*, 22 GEO. IMMIGR. L.J. 459, 479 (2008). For a critique of how this non-uniform approach to local involvement in immigration law harms immigrants, see Stella Jane Elias, "Good Reason to Believe": *Widespread Constitutional Violations in the Course of Immigration Enforcement and the Case for Revisiting Lopez-Mendoza*, 2008 Wis. L. Rev. 1109, 1136-38 (2008).

⁶⁷ Stephen Dinan & Audrey Hudson, *Database Targets Jailed Immigrants*, WASH. TIMES, Jan. 30, 2009, available at <http://washingtontimes.com/news/2009/jan/30/database-targets-jailed-immigrants/>.

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² Dinan & Hudson, *supra* note 67.

E. Operation Community Shield

Operation Community Shield (OCS) provides an illustration of how the increased emphases of eligibility for removal, ICE's focus on removal, and state or local assistance can overlap. OCS is a proactive, investigative program that aims to find and remove dangerous aliens from the streets.⁷³ Instead of focusing solely on removing aliens already incarcerated, this program takes advantage of the increased cooperation between ICE and local law enforcement in order to actively remove violent predators from the streets.⁷⁴

OCS began in February 2005 in direct response to the increase in immigrant gang activity and the Department of Homeland Security's⁷⁵ (DHS) desire to expand its focus beyond terrorism-related immigration concerns.⁷⁶ Many of the most notorious immigrant gangs⁷⁷ are largely composed of illegal aliens.⁷⁸ Simply removing members already in jail did not prove effective in dealing with the problem of increasing gang violence.⁷⁹ The concept underlying OCS was to identify alleged gang members, investigate if they have committed any immigration violations, arrest and remove them—from the streets and from America – without having to wait for that person to commit a future crime. Unlike gang members who

⁷³ Press Release, U.S. Immigration and Customs Enforcement, ICE Arrests More Than 1,700 During Largest Ever Nationwide Gang Surge (Oct. 1, 2008), available at <http://www.ice.gov/pi/nr/0810/081001losangeles.htm> [hereinafter Gang Surge].

⁷⁴ *Id.*

⁷⁵ ICE is a subdivision of the Department of Homeland Security.

⁷⁶ Feere & Vaughan, *supra* note 34.; U.S. Immigration and Customs Enforcement, Operation Community Shield (Oct. 1, 2008), <http://www.ice.gov/pi/news/factsheets/opshieldsheet.htm> (last visited Apr. 8, 2009) [hereinafter OCS] (Specifically, OCS began with the stated goal of interrupting the activities of the Mara Salvatrucha organization. It was later expanded to cover all criminal immigrant gangs).

⁷⁷ Feere & Vaughan, *supra* note 34; OCS, *supra* note 76 (citing examples of such gangs as Mara Salvatrucha (more commonly known as MS-13), Sureños-13, and 18th Street).

⁷⁸ Gang Surge, *supra* note 73; see Jennifer M. Chacón, *Whose Community Shield?: Examining the Removal of the "Criminal Street Gang Member,"* 2007 U. CHI. LEGAL F. 317 (2007) (challenging the widespread social assumptions between immigrant status and gang membership).

⁷⁹ Feere & Vaughan, *supra* note 34.

have to commit a crime before they can be arrested, illegal aliens are already in violation of the law and can be arrested and removed based solely upon their immigration status.⁸⁰

1. Increased State and Local Interaction

Because OCS focuses on gangs and does not dictate other policy priorities, many state and local agencies have agreed to partner with ICE on this program.⁸¹ Local police forces that have concerns about particular gang members refer those people to ICE.⁸² From there, ICE investigates that person. Because their focus is on immigration violations, ICE has special tools available to it that enable a very different investigation than that available to the local police.⁸³

For instance, ICE can enter and search the home of a suspect without a traditional criminal warrant.⁸⁴ Unlike police, who must have a warrant to enter a home, immigrant residents will rarely deny ICE entry to their residences.⁸⁵ Because the resident typically assumes that ICE is merely looking to check immigration-related issues, that person is not alerted that he is under any type of criminal-related investigation.⁸⁶ ICE can therefore collect evidence about the alien's criminal activities or gang affiliations without tipping him off to the true nature of the investigation.⁸⁷

Whereas, police are required to have probable cause before

⁸⁰ Immigration and Nationality Act, 8 U.S.C. § 1227 (2006).

⁸¹ OCS, *supra* note 76.

⁸² *Id.* There is no established standard for state and local officers to use in identifying an immigrant as a member or associate of a gang. For a critique of how this broad discretion results in greater risks of abuse than those accompanying traditional criminal investigative techniques, see Chacón, *supra* note 78, at 329-333.

⁸³ For criticism on how these different enforcement techniques create constitutional procedural concerns, see Yafang Deng, *When Procedure Equals Justice: Facing the Pressing Constitutional Needs of a Criminalized Immigration System*, 42 COLUM. J.L. & SOC. PROBS. 261 (2008).

⁸⁴ Deng, *supra* note 83, at 263-64.

⁸⁵ Feere & Vaughan, *supra* note 34.

⁸⁶ *Id.*

⁸⁷ *Id.*

arresting alleged criminals,⁸⁸ ICE can question any person if there are “articulable facts” suggesting that person may be an alien and can then arrest that person if he is unable to provide proof of legal presence.⁸⁹ This enables ICE to remove people from the street *before* any proven criminal violation occurs, rather than having to wait until the suspected gang member has committed a crime that the police would be able to pursue.

Finally, upon arrest, most aliens have greater incentives to cooperate with ICE than with state or local police. Although police can threaten jail time or attempt persuasion with promises of leniency, ICE can threaten removal and can promise immigration benefits for cooperation. The arrested alien is therefore typically more cooperative with ICE, which in turn allows agents to collect more information and more deeply infiltrate the gang’s activities.⁹⁰

2. Increased Removal Eligibility

The increased ways that aliens can become eligible for removal have allowed ICE more flexibility in determining that a suspected immigrant gangster has violated the Immigration Code. When ICE agents arrest the immigrants, they can charge them with either criminal or administrative immigration violations. The most common criminal immigration charges include reentry after deportation, using false documents, smuggling other aliens, possessing firearms, committing immigration fraud, or having previous convictions for serious crimes of violence, theft, or drugs.⁹¹ Although the majority of aliens arrested under OCS could be charged with criminal immigration violations,⁹² ICE only charges about one third of them with such violations.⁹³ Instead, the majority of the aliens are charged with administrative immigration violations⁹⁴— notably, entering ille-

⁸⁸ U.S. CONST. amend. IV.

⁸⁹ Feere & Vaughan, *supra* note 34.

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ OCS, *supra* note 76.

⁹⁴ *Id.* From its inception through September 2008, arrested a total of 11,106 gang members and associates. This figure included 7,109 administrative arrests in

gally or violating the terms of their entry.⁹⁵ Because criminal and administrative immigration violations both result in removal and the administrative violations are easier and cheaper to prove, ICE has typically used administrative charges where applicable.⁹⁶ Thus, although 71% of those arrested were charged only with violating administrative sections of the INA, the majority of them had committed criminal violations of the INA that ICE could have pursued, if needed.⁹⁷

3. *Increased ICE Activity*

From its inception in February 2005 through October 2008, ICE arrested over 11,000 immigrant gangsters.⁹⁸ Of those arrested by that date, 7,109 have been processed for removal.⁹⁹ Current OCS arrests are up by 533% from fiscal year 2005 and 134% from fiscal year 2006.¹⁰⁰

Participating cities have indicated that the program is a success.¹⁰¹ For example, Dallas, Texas credited a 20% drop in its 2005 murder rate to OCS.¹⁰² In 2006, Fairfax County, Virginia credited a 32% drop in gang-related activity to its participation and saw those crimes continue to decrease in 2007.¹⁰³ Therefore, OCS serves as an example of how increased ICE activity, increased removal eligibility, and increased state and local involvement has led to the dramatic rise

comparison with 3,997 criminal arrests. *Id.*

⁹⁵ *Id.*

⁹⁶ OCS, *supra* note 76.

⁹⁷ *Id.*

⁹⁸ Gang Surge, *supra* note 73.

⁹⁹ *Id.*

¹⁰⁰ Operation Community Shield, U.S. Immigration and Customs Enforcement, <http://www.ice.gov/pi/investigations/comshield/index.htm> (last visited Oct. 23, 2009).

¹⁰¹ *Id.* ICE also touts the program as a success. For a brief description of its major enforcement activities from 2005 to 2007, *see id.*

¹⁰² First Assistant Chief David O'Neal Brown, Dallas Police Department, Remarks at a DHS Press Conference (Mar. 10, 2006) (transcript available at http://www.dhs.gov/xnews/releases/press_release_0879.shtm).

¹⁰³ Amy Gardner, *Gang Crimes Have Fallen in Fairfax*, WASH. POST, Sept. 22, 2007, at B01, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/09/21/AR2007092102223.html>.

in immigrant removals over the past several years.

III. Greater Detention Rates Have Led to Heavy Reliance on State, Local, and Private Prison Facilities

A. Types of Facilities

When an immigrant is charged as being removable and is placed in detention, ICE is responsible for determining where that immigrant will physically be held. There are several types of detention facilities that are available; understanding the differences between them is critical because the medical standards vary by the facility type.

ICE directly owns and operates eight detention facilities that house 13% of the detainee population.¹⁰⁴ These facilities are found primarily in states with serious immigration problems, including California, New Mexico, Texas, Florida, and New York.¹⁰⁵

ICE contracts out its remaining detainees to a mixture of federal, state, local, and private facilities. It uses five Federal Bureau of Prisons facilities to hold approximately 3% of the detainees¹⁰⁶ and seven private facilities¹⁰⁷ found primarily along the southern border.¹⁰⁸ The private facilities are typically the largest ones available and hold upwards of 17% of ICE's immigration detainees.¹⁰⁹ Finally, ICE has established "intergovernmental service agreements" (ISAs) with over 350 state and local facilities¹¹⁰ throughout the United States.¹¹¹ Because there are significantly more ISA facilities than any other type, they hold approximately 67% of the detainee popula-

¹⁰⁴ Detention Management, *supra* note 4.

¹⁰⁵ Ford Fessenden, Nina Bernstein & Matthew Bloch, *A Growing Detention Network*, N.Y. TIMES, http://www.nytimes.com/interactive/2008/12/26/us/1227_DETAIN.html (last visited Feb. 13, 2009).

¹⁰⁶ Detention Management, *supra* note 4.

¹⁰⁷ *Id.*

¹⁰⁸ Fessenden, Bernstein & Bloch, *supra* note 105.

¹⁰⁹ Detention Management, *supra* note 4.

¹¹⁰ *Id.*

¹¹¹ Fessenden, Bernstein & Bloch, *supra* note 105.

tion.¹¹²

It is not uncommon for a detainee to be shuffled through a variety of detention facilities. ICE states that its purpose for routinely moving detainees is to ensure that overcrowding does not become a problem at any detention facility.¹¹³ ICE also states that detainees may be moved among facilities based on the healthcare resources available for addressing specific immigrant needs.¹¹⁴ Thus, even if an immigrant is initially assigned to an ICE-owned detention facility, it is likely that he or she will be held at other facilities, as well. This makes the healthcare standards at each type of facility an important consideration for those concerned with medical care afforded to detainees.

B. ICE-Contracted Facilities¹¹⁵

In direct contrast to the ICE-owned facilities, the ISAs and private facilities are rarely designed with the intention of housing immigrant detainees. Typically, they are built to hold convicted criminals and accept the ICE detainees as a way of making money or paying off debts.¹¹⁶ The need to supplement their inmates to achieve financial success only arose in the 1980s. During that time, private companies and poor communities anticipated an increase in prisoners from the “war on drugs” and began building more facilities than ever before.¹¹⁷ As competition for prisoners grew among the facilities, more and more of them began contracting to hold ICE’s detainees in

¹¹² Detention Management, *supra* note 4.

¹¹³ Washington Post Detainee Health Care Series - Day 2, U.S. Immigration and Customs Enforcement, http://www.ice.gov/pi/wash_post_myth_fact2.htm (last visited Oct. 18, 2009) [hereinafter ICE and Washington Post Day 2].

¹¹⁴ *Id.*

¹¹⁵ Information on how a facility qualifies to be a provider to ICE is currently unavailable. It appears that ICE acquires its facilities in the same manner as most government agencies – via a Request for Proposal as outlined in the Federal Acquisition Regulations. For an example of an RFP from ICE, *see* Federal Business Opportunities, Contract Detention Facility, Las Vegas, Nevada, https://www.fbo.gov/index?s=opportunity&mode=form&id=10d5cccbb88fa90d51f71f832439e271&tab=core&_cview=1 (last visited May 6, 2009).

¹¹⁶ *City of Immigrants*, *supra* note 1. For example, the Donald Wyatt Facility in Rhode Island began accepting detainees to pay off the \$106 million loan it had taken out to pay for expansion and refinancing. *Id.*

¹¹⁷ *Id.*

addition to the criminals that the facilities were initially built to hold. Today, each ISA and private facility houses anywhere from a handful to over 1,000 immigrant detainees.¹¹⁸

IV. The Standards of Detainee Medical Care

Although the average length of detention for immigrants in 2007 was 37.5 days, the length of stay can vary dramatically by case.¹¹⁹ Because removal proceedings include a hearing before an immigration judge, the right to appeal to the Board of Immigration Appeals, and in some cases the right to appeal to the U.S. Circuit Court of Appeals, certain removal cases - and thus some periods of detention-are significantly lengthier than others.¹²⁰ Therefore, the question of medical care can become extremely important, especially to those immigrants who find themselves in detention for months or even years.

The Division of Immigration Health Services (DIHS) is responsible for providing medical care to detainees, including the care mandated by the below standards.¹²¹ DIHS provides the majority of services for detainees housed in centers that it staffs; it also oversees the financial authorizations for any needed off-site specialty or emergency care.¹²² DIHS is considered ICE's authority for all medical issues,¹²³ although ICE is the party responsible for drafting and monitoring the standards discussed below. This section first examines the 2000 Standards before analyzing the 2008 Standards and how they present solutions to the earlier version's deficiencies.

¹¹⁸ Fessenden, Bernstein & Bloch, *supra* note 105.

¹¹⁹ ICE and New York Times, *supra* note 3.

¹²⁰ *Id.* See also Immigrants Face Long Detention, Few Rights, Associated Press, Mar. 15, 2009, available at <http://www.msnbc.msn.com/id/29706177/> (providing examples of immigrant detention stays ranging from several months to several years).

¹²¹ Health Care, *supra* note 41. DIHS had previously been a subdivision of the Department of Health and Human Services, but was detailed to ICE via a memorandum of agreement between the two agencies in October of 2007. *Id.*

¹²² Health Care, *supra* note 41.

¹²³ *Id.*

A. *The 2000 National Detention Standards*

In 2000, the INS published the National Detention Standard to specify appropriate living conditions for immigration detainees.¹²⁴ The stated purposes were to “facilitate consistent conditions of confinement, access to legal representation, and safe and secure operations” and to establish “consistency of program operations and management expectations, accountability for non-compliance, and a culture of professionalism.”¹²⁵ These standards set forth both mandatory and recommended procedures for facilities to follow.¹²⁶ The entirety of the 2000 Standards are mandatory for the ICE-owned and private facilities. Some of the standards are also mandatory for the state and local facilities, while others are guidelines that the ISAs can either follow or adopt alternatives that meet or exceed the listed standards.¹²⁷ According to ICE, these standards “surpass industry standards in their stringency and commitment to detainee health and comfort.”¹²⁸

1. *The Actual Standards*

The 2000 Standards state that immigrants in all facilities must have “access to medical services that promote detainee health and general well-being.”¹²⁹ Facilities must provide “initial medical screening, cost-effective primary medical care, and emergency care” as well as arrange for “specialized health care, mental health care, and hospitalization within the local community.”¹³⁰ Additionally, facilities must employ a medical staff that is large enough to perform

¹²⁴ Immigration Detention Facilities, U.S. Immigration and Customs Enforcement, <http://www.ice.gov/pi/dro/facilities.htm> (last visited Oct. 18, 2009) [hereinafter *Facilities*].

¹²⁵ Detention Management, *supra* note 4.

¹²⁶ *Id.*

¹²⁷ 2000 Standards, *supra* note 7.

¹²⁸ ICE Op-ed, *supra* note 5. For a partial comparison of the 2000 Standards to the American Correctional Association’s Performance-Based Standards for Adult Local Detention Facilities and to the Office of the Federal Detention Trustee’s Federal Performance-Based Detention Standards Review Book, *see* OIG Policies, *supra* note 9, at 51-55.

¹²⁹ 2000 Standards, *supra* note 7.

¹³⁰ *Id.*

basic exams and treatment for all detainees.¹³¹

Initial screening of new arrivals in every facility should include an interview about and observation of the detainee's potential suicide risk and possible mental disabilities, including mental illness and mental retardation.¹³² A full health appraisal must be conducted on every detainee within fourteen days of their arrival at the facility.¹³³

Each facility should have "request slips" for detainees to request healthcare services from a physician.¹³⁴ Each facility should have a regularly scheduled "sick call" where physicians are available to address medical requests.¹³⁵ Sick calls must occur at least once a week for facilities with less than fifty detainees, three times a week for those with 50-200 detainees, and five days a week for those with over 200 detainees.¹³⁶ Also, each facility must have a "written plan for the delivery of twenty-four hour emergency health care when no medical personnel are on duty at the facility, or when immediate outside medical attention is required."¹³⁷

Detention staff in all facilities must be trained to respond to emergencies within four minutes.¹³⁸ Their training must include recognition of the signs of potential health emergencies and appropriate responses, the use of first aid and cardiopulmonary resuscitation, how to obtain emergency medical assistance, the signs of mental illness, and what the facility plans are for safely transferring detainees to off-site emergency facilities.¹³⁹ Additionally, if a facility officer is unsure about whether emergency health care is needed, he must im-

¹³¹ 2000 Standards, *supra* note 7.. The standards do not specify how a facility must determine whether its medical staff is large enough to perform these services. This decision appears to be left to the facility administrator. *Id.*

¹³² *Id.*

¹³³ *Id.*

¹³⁴ *Id.*

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ 2000 Standards, *supra* note 7.

¹³⁸ *Id.*

¹³⁹ *Id.*

mediately contact a healthcare provider or on-duty supervisor.¹⁴⁰

ICE-owned and private facilities must maintain accreditation by the National Commission on Correctional Health Care.¹⁴¹ Additionally, they must attempt to achieve accreditation with the Joint Commission on Accreditation of Health Care Organizations.¹⁴² Only health care providers and officers in these facilities can deliver medication.¹⁴³ Otherwise, the standards for these facilities and ISAs are nearly identical for practical purposes—the differences that exist are minimal.

2. *An Analysis of the Standards*

Although a cursory look at the 2000 Standards suggests that they appropriately cover medical care needs for detainees, a closer look at them reveals significant gaps. One of the major problems is that the standards rarely addressed outcomes – they simply provided steps that must be followed. For instance, although the standards state that a detainee can request medical attention by filling out a request slip and by receiving medical care on sick days, they do not provide any requirements that the care received actually correct the problem, that any follow-up treatment is provided, or that the detainee can ask for a second evaluation if he or she disagrees with the first.

Also, although the standards state that arrangements must be made for specialized healthcare and hospitalization in the local community, nothing mandates when these arrangements must be made. Facilities are not clearly told what qualifies as a health need that warrants such care; it appears that the facilities are left to make that decision on their own. This is particularly problematic when combined with the explicit limitation that the medical care be “cost-effective.” These combined requirements create a serious potential for facilities to choose cost-savings over a diligent and proactive approach to medical needs.

¹⁴⁰ 2000 Standards, *supra* note 7.

¹⁴¹ *Id.*

¹⁴² *Id.*

¹⁴³ *Id.*

Another serious problem arises from the medical screening. The initial exam is only required to cover potential mental illness and suicide risk. An immigrant can be held in detention for two weeks before any physical examination is conducted. This creates the potential for any detainee needing medical care upon entrance to suffer unnecessarily until that physical exam is conducted. Even an immigrant with a known condition who was already receiving treatment or medication before entering detention might be forced to wait those two weeks before anyone in the detention facility is even made aware of his or her needs.

The limited sick call days create yet another potential problem. For smaller facilities, these can occur as rarely as once a week. Although true emergencies are to be addressed immediately, anyone who has been sick with the flu or other painful but non-life-threatening illnesses knows that an entire week without medical care can be an extremely difficult period to endure.

Thus, although much of the debate over detainee medical care surrounds the appropriate application and enforcement of the required standards, it is nonetheless clear that the 2000 Standards themselves left significant room for criticism.¹⁴⁴ In light of these potential problems, it is especially promising to see that the 2008 Standards appear to appropriately address each of these deficiencies.

B. The 2008 Performance Based National Detention Standards

The 2008 Standards are the new ICE-written rules that facilities are currently in the process of adopting.¹⁴⁵ As with the 2000 Standards, they are all mandatory for ICE-owned and private facilities; although some are only guidelines for ISAs, the majority of the standards are also mandatory for those facilities.¹⁴⁶ Because these standards have not been fully implemented in all facilities, it is too early to determine if they will provide a comprehensive answer to some of the problems with the 2000 Standards. Facially, at least,

¹⁴⁴ For an additional critique of the 2000 Standards, see Brane & Lundholm, *supra* note 10, at 161-64.

¹⁴⁵ Facilities, *supra* note 124.

¹⁴⁶ 2008 Standards, *supra* note 8.

they do appear to provide a significantly improved approach to detainee healthcare.

The difference between the new requirements and the 2000 Standards is largely one of attitude – the 2008 Standards provide a performance-based format that starts “with a focus on the results or outcomes the required procedures are expected to accomplish.”¹⁴⁷ As opposed to the 2000 Standards that purely provide for required behaviors, the 2008 Standards include “the expected outcomes each detention standard is intended to produce,” as well as “the prescribed expected practices” for how to accomplish those outcomes.¹⁴⁸

The general purpose of the standards was also expanded – rather than simply ensuring access to medical services, the new standards ensure detainees “have access to emergent, urgent, or non-emergent medical, dental, and mental health care that are within the scope of services provided by the DIHS, so that their health care needs are met in a timely and efficient manner.”¹⁴⁹ In addition to adding such clarity to the approach that facilities should take in providing medical care, the 2008 Standards list “expected outcomes” that include items such as: initiating requests for health services on a daily basis; ensuring continuity of care “from admission to transfer, discharge, or removal, including referral to community-based providers when indicated;” and providing pregnancy testing and pregnancy management services for female detainees.¹⁵⁰

In contrast to the 2000 Standards that only required observation about potential suicide risks upon arrival and did not require a full health appraisal until two weeks after arrival, the 2008 Standards demand an initial medical, dental, and mental health screening within twelve hours of arrival.¹⁵¹ This initial screening should include a determination of current illness and health problems, a pain assessment, an analysis of the possibility of pregnancy, and an evaluation regarding past or recent sexual victimization.¹⁵² An additional new feature

¹⁴⁷ Detention Management, *supra* note 4.

¹⁴⁸ *Id.*

¹⁴⁹ 2008 Standards, *supra* note 8.

¹⁵⁰ *Id.*

¹⁵¹ *Id.*

¹⁵² *Id.*

of the 2008 Standards is that a detainee in ICE custody for over a year must be provided an age-and gender-appropriate health exam at least annually or more often, if needed.¹⁵³

Another major difference in the 2008 Standards concerns the regulation of sick call procedures. The 2000 Standards required regularly scheduled sick calls that varied from once a week to five days a week depending on the size of the facility. The 2008 Standards instead require an “unrestricted opportunity to freely request health care services” and guarantee that all requests will be addressed within forty-eight hours and any emergencies addressed immediately by medical personnel.¹⁵⁴

One final major improvement in the 2008 Standards is that detainees are provided with the opportunity to seek independent medical exams from private doctors.¹⁵⁵ To do so, immigrants request such an exam from the Field Officer Director, who is ordered to approve the request unless it presents an unreasonable security risk.¹⁵⁶ Although the costs must be borne by the detainee, this nonetheless presents a valuable tool for immigrants who feel they are not receiving proper medical attention from those at their detention facility.¹⁵⁷

In short, the new standards appear to fully address the primary criticisms that could have been levied against the 2000 Standards.¹⁵⁸ The first prong of the investigation into detainee medical healthcare can therefore be disposed of relatively simply. There may have been a variety of opinions on whether the prior standards were

¹⁵³ 2008 Standards, *supra* note 8.

¹⁵⁴ *Id.*.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ Minimal academic literature exists at this point regarding the 2008 Standards; however, others have already begun to recognize the potential improvements that the new standards present. See Dana O’Day-Senior, Note, *The Forgotten Frontier? Healthcare for Transgender Detainees in Immigration and Customs Enforcement Detention*, 60 HASTINGS L.J. 453, 464-66 (2008) (finding that the new standards promote greater uniformity between facilities, contain “much more specific” requirements, and clearly address many of the concerns raised about the 2000 Standards); Papst, *supra* note 10, at 279-82 (acknowledging some improvements but arguing that other problems still exist).

appropriate or not;¹⁵⁹ however, that debate is likely to become moot after full adoption of the 2008 Standards. The significantly more difficult questions will still remain – even if the standards themselves are appropriate, will they be effectively followed? Will the type of facility affect how adequately they are adhered to? Does the current system of monitoring sufficiently ensure compliance? These are the questions that we must turn to next.

V. Adherence to the Standards

Controversy surrounding adherence to the medical standards is particularly acute. Immigrants and advocates strongly argue that facilities fail to provide the care required by the 2000 Standards. If that is true, then the improvements in the 2008 Standards will provide little practical assistance to detainees. ICE, however, maintains just as forcefully that its facilities do follow the required standards and that it effectively monitors them to ensure such compliance. This section looks first at the allegations in general and then at ICE's response to such claims. After looking at several case studies and actual statistics, it concludes by arguing that despite a handful of clear and blatant violations, immigrant detention facilities do generally appear to follow the medical care requirements.

A. Immigrant Allegations Regarding the Failure to Follow Standards

Immigrant advocates claim that detainees face several consistent healthcare deficiencies while in custody.¹⁶⁰ When viewed in

¹⁵⁹ For a discussion on how ICE's alleged failure to enforce the 2000 Standards results in "agency action unlawfully withheld" under the Administrative Procedure Act, *see* Neeley, *supra* note 10.

¹⁶⁰ For details on many of the complaints alleged by advocates, *see* Homer D. Venters, M.D., Attending Physician, Statement on Immigration Detainee Health Care, Hearing on Problems with Immigration Detainee Medical Care (June 4, 2008), *available at* judiciary.house.gov/hearings/pdf/Venters080604.pdf [hereinafter Venters]; Laura Rotolo, Access to Medical Care for Persons Detained by Immigration and Customs Enforcement in Massachusetts, American Civil Liberties Union of Massachusetts (December 2008), <http://www.aclum.org/ice/medical.php> (follow Download hyperlink) (last visited Mar. 25, 2008) [hereinafter ACLU Mas-

light of the standards discussed *supra*, these complaints clearly fall into the category of improper application of the standards. For instance, immigrants claim that after submitting a request for medical attention, it can be upwards of several weeks before they receive any response.¹⁶¹ This would be in direct contradiction to even the 2000 Standards' requirement of addressing all sick call forms on the designated sick day, which should occur a minimum of once of week. The 2008 improvements, requiring the forms to be addressed within forty-eight hours, will not help if the facilities do not actually follow those requirements. Similarly, detainees complain of delays in receiving necessary medications or changes in medications.¹⁶² The promise of improved treatment can only help detainees if the treatment is actually provided.

Another common complaint is poor record-keeping practices, including the unavailability of sick call forms.¹⁶³ Promising "unrestricted access" to requests for medical care and requiring sick call forms to be addressed in forty-eight hours will not help an immigrant if his or her detention facility denies access to filling out such forms.

A third major complaint is irregular intake medical screenings.¹⁶⁴ Despite the very minimal requirements in the 2000 Standards for the initial health screening, immigrants and their advocates claim that even this is often not provided. In support of their allegations, they point to a DHS report on five facilities that found only one complied with the initial health screening standards and only three complied with the physical exam requirements.¹⁶⁵ Again, al-

sachusetts]; Cheryl Little, Executive Editor of the Florida Immigrant Advocacy Center, Written Testimony Before the Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law Committee on the Judiciary House of Representatives (October 4, 2007), *available at* judiciary.house.gov/hearings/pdf/Little071004.pdf [hereinafter Little].

¹⁶¹ Sunita Patel & Tom Jawetz, Conditions of Confinement in Immigration Detention Facilities, American Civil Liberties Union (2007), <http://www.aclu.org/immigrants/detention/30261pub20070627.html#attach>; *see also* ACLU Massachusetts, *supra* note 160, at 6-7.

¹⁶² Patel & Jawetz, *supra* note 161; ACLU Massachusetts, *supra* note 160, at 7.

¹⁶³ Patel & Jawetz, *supra* note 161, at 6.

¹⁶⁴ *Id.*

¹⁶⁵ Patel & Jawetz, *supra* note 161, at 6; OIG Treatment, *supra* note 9, at 3-4.

though the 2008 Standards promise much more effective intake exams, those will only assist immigrants if the facilities actually perform them.

A final complaint, much publicized by recent advocate and media reports,¹⁶⁶ involves appropriate investigations into cases of immigrants who died in detention. From 2003 to May 2008, eighty-three immigrants died while in custody.¹⁶⁷ After-the-fact medical analysis by advocate-hired physicians suggested that thirty of these deaths could have been prevented had facilities provided the detainees with appropriate medical care.¹⁶⁸

Advocates charge that deaths in detention are particularly problematic because there is no government body responsible for accounting for such detainee deaths.¹⁶⁹ Additionally, there is no requirement that ICE or any other agency publicly report the deaths, nor is any independent inquiry or investigation required.¹⁷⁰ While ICE does investigate detainee deaths, advocates charge that voluntary investigative policies leave too much to the agency's discretion and allow ICE to transfer or deport witnesses before any investigations occur.¹⁷¹

Despite ICE's policy to investigate deaths that occur during detention,¹⁷² family members, advocacy groups, and media reporters claim they are often the only ones trying to follow up on such deaths.¹⁷³ They find this particularly burdensome because many

For more info on the contents of this report, see Section V.F1., *infra*.

¹⁶⁶ See Section V.A., *infra*.

¹⁶⁷ Nick Miroff, *ICE Facility Detainee's Death Stirs Questions*, THE WASH. POST, Feb. 1, 2009, at C1, available at http://www.washingtonpost.com/wp-dyn/content/article/2009/01/31/AR2009013101853.html?sub=AR&sid=ST2009013101877&s_pos=.

¹⁶⁸ *Id.*

¹⁶⁹ ACLU, *supra* note 24; Nina Bernstein, *Few Details on Immigrants Who Died in Custody*, N.Y. TIMES, May 5, 2008, at A1, available at http://www.nytimes.com/2008/05/05/nyregion/05detain.html?_r=1 [hereinafter *Few Details*].

¹⁷⁰ *Few Details*, *supra* note 169.

¹⁷¹ *Id.*

¹⁷² See Section V.C., *infra*.

¹⁷³ ACLU, *supra* note 24.

family members fear immigration authorities because of their own problematic status; additionally, families often lack access to lawyers or are geographically located very distant from the facility where the immigrant died.¹⁷⁴

B. ICE's Arguments Supporting Proper Adherence to the Standards

In published statements, ICE has directly addressed many of the allegations detailed above. For instance, in response to the accusations of untimely sick call treatment, ICE states that sick call requests are “prioritized 24/7 based on urgency of need for medical treatment,” are “triaged daily and scheduled accordingly,” and that “those in need of immediate treatment are seen right away” while “lower priority cases are scheduled as appropriate.”¹⁷⁵ Also in response to complaints about the lack of timely off-site care, ICE states that detention facilities forward those requests to an ICE administrator who responds within seventy-two hours of receipt.¹⁷⁶ If the request is for urgent care, ICE states that their policy is to ensure the medical care is provided first and adjudicate the administrative aspects of the request after treatment has occurred.¹⁷⁷ Furthermore, ICE adamantly rejects charges that it refuses medical care for the purpose of saving money.¹⁷⁸ Although some advocates argue that ICE directs off-site hospitals to minimize costs, ICE denies that it has such control. Instead, it asserts that if a detainee is hospitalized at an off-site treatment facility, that hospital “assumes medical decision-making authority including the patient’s drug regimen, lab tests, x-rays and treatments.”¹⁷⁹

ICE combats charges of improper medical intake screenings by providing statistics about its detainees. Nearly 1.5 million immigrants traveled through detention facilities from the time ICE was created in 2003 through May 2008.¹⁸⁰ According to ICE, each detai-

¹⁷⁴ *Few Details*, *supra* note 169.

¹⁷⁵ ICE and Washington Post Day 1, *supra* note 5.

¹⁷⁶ *Id.*

¹⁷⁷ *Id.*

¹⁷⁸ ICE and Washington Post Day 3, *supra* note 44.

¹⁷⁹ ICE and New York Times, *supra* note 3.

¹⁸⁰ *Id.*

nee received a comprehensive health screening and care management by DIHS, at a cost of over \$360 million.¹⁸¹ In 2007 alone, ICE spent almost \$100 million providing medical care to detainees—double the funding spent by ICE’s predecessor five years earlier.¹⁸² Twenty-four percent of these incoming detainees were diagnosed and treated for pre-existing chronic conditions.¹⁸³ These services were particularly important, according to ICE, because many who entered detention did not have medical insurance; detention was thus the first time they received preventative care following their entry into the United States.¹⁸⁴

Statistics also bolster ICE’s defense against claims that high detainee death rates have resulted from facilities failing to follow its medical standards.¹⁸⁵ Detainee deaths have fallen nationwide since 2004¹⁸⁶ despite ICE’s detainee population increasing by over 30%.¹⁸⁷ Fatality rates among ICE detainees are lower than those of the U.S. prison population.¹⁸⁸ In 2005, for example, U.S. prison and jail inmates died at a rate of 540.5 per 100,000.¹⁸⁹ The general U.S. population saw deaths that year at a rate of 798.8 per 100,000.¹⁹⁰ Detainee deaths, by contrast, dropped from a 2004 rate of 10.8 to a 2005 rate of only 6.8 per 100,000.¹⁹¹ By 2007, ICE’s death rate fell to 3.5 per 100,000 while the U.S. general population rate rose to 826 per 100,000.¹⁹² Thus, from 2004 to 2007, detainee death rates fell from 10.8 to 3.5 per 100,000 and remained consistently lower than those in the general and prison populations.

¹⁸¹ ICE and New York Times, *supra* note 3.

¹⁸² ICE Op-ed, *supra* note 5; Mead, *supra* note 36.

¹⁸³ *Id.*

¹⁸⁴ *Id.*

¹⁸⁵ See Venters, *supra* note 160, at 2-3 (critiquing the statistical analysis used by ICE).

¹⁸⁶ Miroff, *supra* note 167; ICE and New York Times, *supra* note 3; Mortality Rates, *supra* note 11.

¹⁸⁷ ICE and New York Times, *supra* note 3; Mortality Rates, *supra* note 11.

¹⁸⁸ Miroff, *supra* note 167; ICE and New York Times, *supra* note 3; Mortality Rates, *supra* note 11.

¹⁸⁹ ICE Op-ed, *supra* note 5; Mortality Rates, *supra* note 11.

¹⁹⁰ Mortality Rates, *supra* note 11.

¹⁹¹ ICE Op-ed, *supra* note 5; Mortality Rates, *supra* note 11.

¹⁹² *Id.*

Regarding investigations and notice to families, ICE's stated policy is to "immediately notify the next of kin or the consular official from the respective country."¹⁹³ Additionally, ICE's Office of Professional Responsibility (OPR) is directed to review the circumstances of every death to determine if a more in-depth investigation is needed.¹⁹⁴ OPR also informs the DHS's Office of the Inspector General (OIG) of all detainee deaths, regardless of reason, in order to assure proper record-keeping and accountability.¹⁹⁵

C. ICE's Arguments Supporting Proper Monitoring of the Standards

As discussed *supra* in Section IV, ICE has established a variety of detention standards that apply to its facilities. While all are mandatory for ICE-owned and private facilities, some are optional for the state and local contracted facilities.¹⁹⁶ However, as explained previously, the majority of the important provisions are mandatory to all facilities. ICE must therefore monitor all of its facilities—both owned and contracted to ensure all detainees are receiving treatment that follows the standards it publishes.

ICE has taken a variety of steps to ensure that its facilities comply with the established standards.¹⁹⁷ First, in February 2007, ICE implemented the Detention Facilities Inspection Group (DFIG) under the auspices of the ICE Office of Professional Responsibility.¹⁹⁸ DFIG is mandated to provide objective oversight and independent validation of detention facility inspections.¹⁹⁹ Furthermore, it conducts immediate focused reviews of any serious incidents that occur.²⁰⁰

¹⁹³ ICE and New York Times, *supra* note 3.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* This is a relatively recent development. ICE published a memo on March 13, 2008 directing its agents to report detainee deaths to OIG immediately, with additional details on each incident to be provided by the following business day. OIG Policies, *supra* note 9, at 13-14.

¹⁹⁶ 2000 Standards, *supra* note 7.

¹⁹⁷ *Orantes-Hernandez v. Gonzalez*, 504 F.Supp.2d 825, 863-64 (C.D. Cal. 2007) (discussing the procedures used by ICE during its facility reviews).

¹⁹⁸ ICE and Washington Post Day 1, *supra* note 5.

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

To ensure even greater objectivity in monitoring, ICE contracted with two private, independent companies in October 2007.²⁰¹ Creative Corrections, Inc. places full-time quality assurance professionals at the forty largest detention facilities.²⁰² The smaller facilities receive quality checks on a rotational basis.²⁰³ The Nakimoto Group provides full-time professionals to inspect each ICE facility on an annual basis.²⁰⁴ As Section VI establishes, ICE has taken even more steps in recent months to expand its monitoring capabilities and ensure those charged with such an important task remain independent of political or organizational bias.

If, and when an inspector detects a breach of the established standards, the potential compliance lapse results in the implementation of a corrective action plan with a follow-up review in ninety days.²⁰⁵ If the identified problems have not been resolved by the ninety day check-up, ICE will either remove the detainees at that time or decline to renew the contract.²⁰⁶ Between 2007 and 2008, two facilities failed to come into compliance after their ninety day check-up, resulting in ICE taking further steps against those facilities.²⁰⁷ As discussed below in Section V.D.2., it also took such measures against the Donald Wyatt Detention Facility in late 2008.

Monitoring also results in employee termination, if such is appropriate. For instance, the OPR received 409 allegations of improper detainee treatment for fiscal years 2003 through 2006.²⁰⁸ It found seven of these violations to be substantiated by evidence that would cause a reasonable person to conclude that the misconduct had actually occurred.²⁰⁹ Out of those cases, four employees were terminated and the other three were still under investigation at the time ICE reported these figures.²¹⁰ Thus, ICE claims that its responses to

²⁰¹ ICE and Washington Post Day 1, *supra* note 5.

²⁰² ICE Op-ed, *supra* note 5.

²⁰³ *Id.*

²⁰⁴ ICE and Washington Post Day 1, *supra* note 5.

²⁰⁵ ICE Op-ed, *supra* note 5.

²⁰⁶ *Id.*

²⁰⁷ *Id.*

²⁰⁸ Stana, *supra* note 9, at 6.

²⁰⁹ *Id.*

²¹⁰ *Id.* at 7.

allegations of misconduct work in conjunction with its regular monitoring inspections to provide safe and responsible conditions for detainees.

D. Case Studies with ICE-Acknowledged Violations

In some of the more publicized cases of detainee deaths, ICE's subsequent investigations have revealed that the facilities did in fact fail to follow the required standards of medical care. Two such cases are detailed below. The importance of these cases is in understanding the types of situations in which ICE admits to violations; furthermore, they are important in understanding the various ways in which ICE responds to findings of violations.

1. Abdeulaye Sall

A Guinean immigrant, Abdeulaye Sall, had worked as a taxi-cab mechanic in Washington, D.C. for seventeen years when his employer agreed to sponsor him for legal permanent residence status.²¹¹ Although he had no prior criminal record, his application alerted ICE to the existence of a prior deportation order that had been issued against him years before.²¹² ICE arrested him at his immigration lawyer's office and began removal proceedings.²¹³

At the time of his arrest, Sall had been taking medication for a serious kidney ailment.²¹⁴ He was assigned to the Piedmont Regional Jail in Farmville, Virginia,²¹⁵ where he informed the staff that he had diabetes.²¹⁶ Despite noting this on his initial medical intake

²¹¹ Nina Bernstein, *New Scrutiny as Immigrants Die in Custody*, N.Y. TIMES, June 26, 2007, available at <http://www.nytimes.com/2007/06/26/us/26detain.html> [hereinafter *New Scrutiny*].

²¹² *New Scrutiny*, supra note 211.

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ The Piedmont Regional Jail is a 780-bed jail run by the governments of six Virginia counties that usually houses approximately 300 immigration detainees. Nina Bernstein, *Another Jail Death, and Mounting Questions*, N.Y. TIMES, Jan. 28, 2009, at A14, available at http://www.nytimes.com/2009/01/28/us/28detain.html?_r=1 [hereinafter *Another Death*].

²¹⁶ *New Scrutiny*, supra note 211.

form, the staff failed to refer him to a provider for medication or treatment of the disease.²¹⁷ His symptoms rapidly worsened until his death of kidney failure in December 2006.²¹⁸ He was fifty years old.²¹⁹

Two days after his death, ICE initiated an investigation and found that the facility violated a number of the 2000 Standards.²²⁰ For instance, the medical staff did not conduct the required physical examination on Sall during his initial fourteen days of detention.²²¹ On one occasion, the medical clinic's nurse failed to inform the medical director of Sall's concerns about his medication and about his swelling feet.²²² The facility had no records indicating that any healthcare provider saw him in response to his second sick call slip regarding the swollen feet.²²³ ICE also found that on the day of his death, employees "stood around for approximately one minute" after he was found unconscious before they tried to revive him.²²⁴

In all, ICE's investigation revealed that the "facility ha[d] failed on multiple levels to perform basic supervision and provide for the safety and welfare of ICE detainees."²²⁵ It also found that the facility's staff "did not follow established policy, procedure, and practice" and that the "medical health care unit [did] not meet minimum ICE standards."²²⁶ While ICE did complete its investigation and acknowledged the facility's failures, the agency did not remove any of its detainees or stop sending new detainees there. Significant criticism of this decision arose late last year, when another immigrant

²¹⁷ After Action Review Death of Abdeulaye Sall A # 70 306 018 4, Dept. of Homeland Security Immigration and Customs Enforcement (2006), *available at* http://graphics8.nytimes.com/packages/pdf/nyregion/2009/20090128_DETAIN_R_EPORT.pdf [hereinafter Sall Review].

²¹⁸ *Another Death*, *supra* note 215; Miroff, *supra* note 167.

²¹⁹ Miroff, *supra* note 167.

²²⁰ Sall Review, *supra* note 217, at 2-6.

²²¹ *Id.*

²²² *Id.* at 3.

²²³ *Id.*

²²⁴ *Id.* at 4.

²²⁵ *Id.* at 6.

²²⁶ *Id.*

died in this facility's custody.²²⁷

2. *Hiu Lui Ng*

A more recent case involved a thirty-four year old computer engineer who came to the United States from Hong Kong at the age of seventeen.²²⁸ He had overstayed his visa and was in the process of applying for legal permanent residence status through his citizen wife when he was detained for the visa overstay.²²⁹

After spending almost a year in various immigration detention facilities,²³⁰ Ng arrived at the Donald W. Wyatt Detention Facility in Central Falls, Rhode Island (Wyatt Facility) in July 2008.²³¹ He died there a month later from liver cancer and a fractured spine that had gone undiagnosed despite his allegedly constant complaints.²³²

ICE's investigation into Ng's death revealed that he was de-

²²⁷ See Section V.F2., *infra*.

²²⁸ Nina Bernstein, *U.S. Issues Scathing Report on Immigrant Who Died in Detention*, N.Y. TIMES, Jan. 16, 2009, at A14, available at <http://www.nytimes.com/2009/01/16/us/16detain.html?fta=y> [hereinafter *Scathing Report*]; Nina Bernstein, *Detention Center Facing Inquiry Will Get No More Immigrant Detainees*, N.Y. TIMES, Dec. 6, 2008, at A17, available at <http://www.nytimes.com/2008/12/06/nyregion/06detain.html?fta=y> [hereinafter *No More Detainees*].

²²⁹ *Scathing Report*, *supra* note 228; *No More Detainees*, *supra* note 228. He was arrested at immigration headquarters in Manhattan when he arrived there to complete the final interview needed to receive legal permanent residence status. *Id.*

²³⁰ *Scathing Report*, *supra* note 228.

²³¹ *Id.* ICE had contracted with the 642-bed Wyatt Facility to house approximately 200 of its detainees. *No More Detainees*, *supra* note 228. The facility is owned by Central Falls Detention Facility Corporation, a quasi-public body. Wyatt Detention Facility, Mission, <http://www.wyattdetention.com/index.cfm?L1=1&L2=3> (last visited Feb. 20, 2009). As with many contracted facilities, it was initially built not for detainees, but instead to house medium to maximum-security pre-trial adult male inmates for the U.S. Marshals Service. Wyatt Detention Facility, About Us, <http://www.wyattdetention.com/index.cfm?L1=1> (last visited Feb. 20, 2009); see also Section III.B., *supra*.

²³² *Scathing Report*, *supra* note 228; Hilary Russ, *Federal Immigration Officials Terminate Contract with RI Detention Facility After Inmate Death*, A.P., Jan. 15, 2009, available at <http://www.cis.org/griffith/morningnews11609>.

nied proper medical care.²³³ The report found that jail supervisors effectively prevented him from meeting with his lawyer by refusing him use of a wheelchair when he was unable to walk to the meeting.²³⁴ The more serious violation, however, involved his inability to walk from his cell to the van that would carry him to ICE headquarters for a meeting about his pending appeal.²³⁵ Instead of assisting him or providing him a wheelchair, the warden directed guards and medical staff to drag him to the van, which they did while he screamed in pain.²³⁶ This was in clear violation of the jail's policy that banned the use of force on detainees.²³⁷ Although the Wyatt Facility announced it would be punishing seven of its employees and despite the fact that all of the above actions were captured on the surveillance video cameras installed throughout the facility,²³⁸ the jail's spokesman informed reporters that "[w]e will steadfastly maintain that we had nothing to do with the detainee's death."²³⁹

After its investigation, ICE ended its contract with the Wyatt Facility.²⁴⁰ The agency stated that it would not send any more detainees there and that it stationed detention-management experts to "directly monitor conditions at Wyatt" and take "all reasonable steps to ensure the safety and well-being of the 153 remaining detainees" until those detainees could be moved to another facility.²⁴¹ In addition, ICE asked the Boston, Massachusetts U.S. Attorney's Office to review the case for the possibility of criminal charges.²⁴²

²³³ *Scathing Report*, *supra* note 228; Russ, *supra* note 232.

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ *Id.*

²³⁷ *Id.*

²³⁸ *Id.*; Russ, *supra* note 232.

²³⁹ *Scathing Report*, *supra* note 228.

²⁴⁰ *No More Detainees*, *supra* note 228.

²⁴¹ *Id.* (quoting Richard Rocha, an ICE spokesman).

²⁴² *Scathing Report*, *supra* note 228. Prosecutors later declines to bring criminal charges, stating that no laws had been broken. See Eric Tucker, *RI Prosecutors: No Charges Over Detainee Death*, A.P., Jan. 26, 2009, available at http://www.google.com/hostednews/ap/article/ALeqM5i1AbYR9TNu9BRajYH0Mm7P_P_4WAD95V866G0.

E. Case Studies with Disputed Violations

Although the above cases show that ICE does investigate detainee deaths and has acknowledged violations of its medical standards, there are other instances where the agency adamantly disagrees with allegations of abuse. These cases provide a direct contrast to ICE's response in the above situations.

1. The University of Arizona Study

On January 13, 2009, the Southwest Institution of Research on Women and the James E. Rogers College of Law, both of the University of Arizona, released a report stating that the 300 women held at immigration detention centers in their state faced dangerous delays in health care and widespread mistreatment.²⁴³ They conducted the study from August 2007 to August 2008 and focused on three private and ISA facilities in the state.²⁴⁴ The study examined a variety of cases, including the two detailed below.

One immigrant, who had been detained for violating the INA by committing a nonviolent crime, allegedly complained of extreme abdominal pain for almost six months before receiving a hospital ultrasound that revealed a cyst the size of a "five month old fetus."²⁴⁵ According to the woman's lawyer, immigration officials immediately released the woman from custody in order to avoid paying for her medical care.²⁴⁶

Another immigrant, detained because she had received a criminal conviction for the use of a fake credit card, spent five weeks in detention.²⁴⁷ She was six months pregnant and had been diagnosed with an ovarian cyst, but was allegedly forced to use a top bunk while being denied sonograms and prenatal vitamins for the du-

²⁴³ Dan Frosch, *Report Faults Treatment of Women Held at Immigration Centers*, N.Y. TIMES, Jan. 21, 2009, at A23, available at http://www.nytimes.com/2009/01/21/us/21immig.html?_r=1.

²⁴⁴ *Id.*

²⁴⁵ *Id.*

²⁴⁶ *Id.*

²⁴⁷ *Id.*

ration of her stay.²⁴⁸

The study concluded that immigration authorities were too aggressive in detaining women who did not pose a flight risk.²⁴⁹ It also found that women detainees are often refused proper prenatal care and treatment for cancer, ovarian cysts and other serious medical problems.²⁵⁰ Although the analysis was based solely on accounts given by detainees and their lawyers, the study found such accusations corroborated a “pattern of endemic mistreatment” of women at immigration centers across America.²⁵¹

ICE responded to the study by stating it was narrow and unsubstantiated.²⁵² The agency criticized the analysis because it used only information received from detainees and their advocates.²⁵³ In response to the story of a woman being released after receiving an ultrasound, ICE stated the report was the first time they had been informed of the woman’s problems.²⁵⁴

2. *Yong Sun Harvill*

Yong Sun Harvill emigrated from Korea as the wife of an American soldier in 1975.²⁵⁵ Within a year of her arrival, she received her first cancer diagnosis.²⁵⁶ Repeated surgeries and radiation treatments since then have damaged her leg, causing her to rely on a leg pump to boost circulation and minimize swelling.²⁵⁷ She entered detention in this condition, after ICE began removal proceedings on

²⁴⁸ *Frosch, supra note 243*

²⁴⁹ *Id.*

²⁵⁰ *Id.*

²⁵¹ *Id.* For more discussion on healthcare concerns specifically related to women, see Little, *supra note 160*, at 6-9.

²⁵² *Id.*

²⁵³ *Id.*

²⁵⁴ *Id.*

²⁵⁵ Amy Goldstein & Dana Priest, *In Custody, In Pain*, WASH. POST, May 12, 2008, at A1, available at http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d2p1.html (hereinafter *In Custody*). She never applied for citizenship, although she retained her legal permanent residence status. *Id.*

²⁵⁶ *In Custody, supra note 255*.

²⁵⁷ *Id.*

her because of a prior conviction for buying stolen jewelry.²⁵⁸

Shortly after her detention began, ICE moved her to an Arizona facility that they stated was better suited to providing her the medical care she needed.²⁵⁹ Her initial intake examination at that facility detailed numerous issues, such as her history of sarcoma, hepatitis C, high blood pressure, nosebleeds, panic attacks, and lymphedema.²⁶⁰ Several weeks after that, ICE moved her to another Arizona facility that has no permanent doctor on its staff.²⁶¹ Her medical care became allegedly insufficient during her stay at that facility.²⁶² It did not provide her with a leg pump or allow her family to send her the one she owns.²⁶³ Another lump in her leg began growing, just like the one she had with her previous cancer, but she received no biopsy for it.²⁶⁴ Doctors at a local hospital told her she needed a separate biopsy to determine if spots on her liver were tumors, but she never received it.²⁶⁵ Although the hospital did perform a biopsy of her uterus for a different problem, the biopsy occurred three months after the doctors had initially ordered it.²⁶⁶ She did not receive the results for two months, at which time she learned there were polyps in her uterus that needed to be removed.²⁶⁷ Four months after that, the removal surgery had still not occurred.²⁶⁸

ICE explained the move from the first Arizona facility to the second by stating that the first facility was not equipped to provide long-term medical care for female detainees.²⁶⁹ It acknowledged that no physician was scheduled full-time for the second facility that she

²⁵⁸ *In Custody*, *supra* note 255.

²⁵⁹ Little, *supra* note 160, at 2-3. Specifically, ICE claimed that there were no facilities in Florida capable of accommodating her needs. *Id.*

²⁶⁰ *Id.*

²⁶¹ *Id.*

²⁶² *In Custody*, *supra* note 255.

²⁶³ *Id.*

²⁶⁴ *Id.*

²⁶⁵ *Id.*

²⁶⁶ *Id.*

²⁶⁷ *Id.*

²⁶⁸ *In Custody*, *supra* note 255.

²⁶⁹ *Id.*

was moved to,²⁷⁰ but claimed that Harvill “received appropriate medical care at [the second facility] with physician oversight.”²⁷¹ It has consistently declined to comment specifically on any of her allegations, most likely because of a lawsuit she filed against ICE in June 2008.²⁷² The lawsuit resulted in Harvill’s release from detention.²⁷³ Under the terms of the settlement, Harvill released ICE from future claims even if doctors determine that her care in detention contributed to her ailing health.²⁷⁴ The settlement contained “no admission of any liability whatsoever” on the part of ICE, whose spokeswoman states that “a careful review of Ms. Harvill’s medical records reveals that she consistently received a high level of medical care for myriad pre-existing ailments while she was in ICE custody. Any claim to the contrary is simply not borne out by the records.”²⁷⁵

²⁷⁰ Specifically, the second facility’s medical clinic is “staffed with a Health Services Administrator (HSA), two Mid-Level Providers (MLPs) such as a Nurse Practitioner and Physician’s Assistant, a Pharmacist, one Pharmacy Technician, six Registered Nurses (RNs), four Licensed Practical Nurses (LPNs), one Administrative Assistant and four Medical Records Technicians (MTRs). While not on site full time, there is also a Physician, a Psychiatrist and a Psychologist that provide services to the detainees at Pinal County [the facility] on a regular basis. In addition, the Medical Clinic has full laboratory capabilities as well as a fully staffed pharmacy on site. Further, the facility does rely on specialists in the local area.” ICE and Washington Post Day 2, *supra* note 113.

²⁷¹ *In Custody*, *supra* note 255.

²⁷² The suit alleged that the agency’s top administrator and other officials denied Harvill her basic human needs, inflicted unnecessary pain and suffering on her, and put her at substantial risk of physical injury, illness, and premature death. Amy Goldstein & Dana Priest, *Lawsuit Leads to Release of Immigrant*, THE WASH. POST, July 3, 2008, at A02, available at <http://www.washingtonpost.com/wp-dyn/content/story/2008/07/02/ST2008070203668.html>.

²⁷³ *Id.*

²⁷⁴ *Id.* Other terms of the settlement include allowing Harvill to remain in the United States until the later of two years or the resolution of her pending immigration case. ICE retains the ability to deport her or refer her removal after that time. *Id.*

²⁷⁵ *Id.*

F. An Analysis of Whether the Standards are Adhered to and Monitored

The case studies above demonstrate that ICE has been willing to recognize certain facility failures. They also show that ICE does not always agree with allegations levied by immigrants and their advocates. One way to help settle the question of whether ICE effectively monitors its facilities is to look at objective reports by the OIG and the U.S. General Accountability Office (GAO). These reports, combined with an analysis of the above cases and statistics, suggest that the recent changes made by ICE will allow the agency to properly monitor its facilities for compliance with the updated standards. On August 9, 2009, ICE announced major reform initiatives, which improve its monitoring capabilities even further. With such a framework now in place, it is likely that the country will see ICE conduct a comprehensive evaluation of the circumstances surrounding the death of Guido R. Newbrough, the most recent detainee to die amid allegations of adherence and monitoring failures.

1. The Analysis, In General

Two objective reports issued by the OIG regarding medical care for detainees suggest that problems existed in how facilities adhered to the 2000 Standards and how ICE monitored those facilities. However, these reports are dated and reflect the state of adherence and supervision that occurred prior to multiple procedural changes by ICE. The findings, taken in light of ICE's subsequent improvements, actually bolster support for the belief that the standards should be properly monitored and adhered to today. Additionally, the GAO has found that medical and monitoring failures are neither "persistent" nor "pervasive," further strengthening this argument.

The first OIG report, issued in December 2006, analyzed the healthcare services provided at five detention facilities. It found that several of the facilities failed to comply with intake screening procedures and that there were problems regarding the timeliness of responses to sick call requests.²⁷⁶ Although many advocates continue to

²⁷⁶ OIG Treatment, *supra* note 9, at 3-4.

point to this report,²⁷⁷ ICE has since taken steps to ensure that these problems were adequately addressed. For instance, ICE reviewed its quality assurance reports to ensure they effectively evaluated the medical intake screenings.²⁷⁸ It also assessed whether it needed to change the standards to provide better guidance on timely responses. The 2008 Standards demonstrate how ICE incorporated this change into its policies.²⁷⁹ Finally, the report noted that ICE's monitoring had not effectively uncovered these problems and recommended changes to the monitoring program.²⁸⁰ ICE agreed,²⁸¹ the increased monitoring standards discussed in Section V.C., reflect the high priority ICE has since placed on this aspect of detainee healthcare.

The second report was published more recently, in June 2008, but reflected data collected in prior years.²⁸² After reviewing two immigrant deaths, the medical care standards, and agency monitoring reports, the OIG concluded that although there were certain compliance problems, ICE had adhered to important portions of the standards and the reviewed deaths were a result of serious pre-existing medical conditions rather than a failure to follow the standards.²⁸³ Although the report found that previous monitoring had not been effective, it acknowledged that such failures had occurred before ICE developed the Detention Facilities Inspection Group or hired the two private monitoring companies discussed in Section V.C.²⁸⁴ The OIG made several suggestions for improved monitoring, including providing more details when assigning scores to facilities and using better sampling in its reviews.²⁸⁵ ICE largely agreed with the recommendations and stated that its recent improvements and the 2008 Standards should address the majority of the problems indicated.²⁸⁶ In light of OIG's recognition that ICE has since taken steps to increase its abili-

²⁷⁷ See Section V.A., *supra*.

²⁷⁸ OIG Treatment, *supra* note 9, at 6.

²⁷⁹ See Section IV.B., *supra*.

²⁸⁰ OIG Treatment, *supra* note 9, at 36.

²⁸¹ *Id.*

²⁸² OIG Policies, *supra* note 9.

²⁸³ *Id.* at 1.

²⁸⁴ *Id.* at 19-20.

²⁸⁵ *Id.* at 21-25.

²⁸⁶ *Id.* at 26-29.

ty to monitor the detention facilities,²⁸⁷ it appears that the primary concerns noted in the OIG report have been efficiently and adequately addressed. Furthermore, the OIG recognized that the specific goals provided in the 2008 Standards should assist facilities in following those standards with more success than that achieved under the 2000 Standards.²⁸⁸

Finally, testimony given in June 2008 by GAO's Director of Homeland Security and Justice Issues lends support to ICE's claims of effective monitoring. The agency reviewed twenty-three detention facilities and found noncompliance in three of those locations.²⁸⁹ Even in the three facilities with problems, however, the GAO found no "pervasive or persistent pattern[s] of noncompliance" with the medical standards.²⁹⁰ Additionally, the GAO analyzed ICE's monitoring of the facilities. Within the year prior to the agency's research, ICE had actively reviewed approximately 90% of its detention facilities²⁹¹ and found four instances of noncompliance with its medical standards.²⁹² Although the GAO found a higher percentage of violations than ICE, the important thing to note is that the results of ICE's monitoring were at least relatively on par with those of the GAO. Considering all the monitoring improvements made since that time, it is quite likely that ICE's activities today would uncover at least as many violations as the GAO, were the study to be repeated.

²⁸⁷ *Id.* at 4.

²⁸⁸ *Id.* at 29-31.

²⁸⁹ Stana, *supra* note 9, at 3. The GAO's review covered six specific medical care standards - whether (1) the required range of medical and mental health services were available, (2) detainees received the initial medical screening upon admission and the complete physical exam within 14 days of admission, (3) detainees were able to request medical services, (4) specialized medical and mental health services could be arranged if necessary, (5) suicide prevention procedures and facilities were available, and (6) a plan for 24-hour emergency care was available. *Id.* at 2.

²⁹⁰ *Id.* at 3.

²⁹¹ *Id.* at 4. According to its regulations, ICE must inspect each facility on an annual basis.

²⁹² *Id.* at 5. The noncompliance included failing to provide sick call request forms in Spanish, failing to maintain medical records on site, failing to obtain informed consent from a detainee before prescribing psychiatric medication, and failing to have medical staff on site to screen detainees arriving after 5:00 p.m. *Id.*

Therefore, the objective reports on ICE's medical care standards demonstrated problems that have since been remedied. The remaining information available for analyzing detainee healthcare comes from biased sources—immigrants and the immigration agency itself. Information from these sources must be examined carefully when drawing conclusions about the current state of medical care. Advocates argue that multiple compliance problems exist, including slow treatment, problems with paperwork, and a lack of information regarding detainee deaths. In many instances, advocates allege blatant violations of both human rights and of ICE's standards.²⁹³ ICE has moved to address many of the alleged compliance problems. For instance, it has set up its own internal monitoring system as well as hired two separate private firms to provide more effective and continuous monitoring. Its statistics show that detainee deaths have dropped sharply despite the rapid rise in the number of detainees for which it is responsible.

Additionally, ICE has developed a track record of investigating detainee deaths and acknowledging when there have been violations. As a result of its investigations, ICE has taken a variety of measures against the offending facilities, including ending its contracts and removing its detainees.²⁹⁴ ICE demonstrated a similar proactive approach to the OIG recommendations; the agency has proven its willingness to accept faults and enact measures to counter problems when it finds them. It is particularly important to recognize this attitude in light of the instances where ICE and immigrant advocates disagree about the quality of care provided to detainees. Although there may be no true way to determine which party is in the right, it cannot be said that ICE has never accepted responsibility for detainee deaths. Based on its track record of acknowledging failures, its recent emphasis on adherence and monitoring, its new 2008 Standards, and the statistics regarding detainee deaths, it would be reasonable to assume that ICE is speaking the truth in the disputed cases. This becomes important when considering new deaths, like that of Guido R. Newbrough.

²⁹³ See Section V.E., *supra*.

²⁹⁴ See Section V.C. and V.D.2., *supra*.

2. The Analysis, As Applied to the Case of Guido R. Newbrough

At the time of this writing, the most recent detainee death occurred on November 27, 2008 at the Piedmont Regional Jail in Farmville, VA²⁹⁵-the same facility where Abdeulaye Sall died in 2006.²⁹⁶ Guido R. Newbrough, the son of a German mother who married an American Air Force sergeant, lived forty-two of his forty-eight years in the United States.²⁹⁷ However, because his step-father never formally adopted him when he was a child and his mother only naturalized several years ago,²⁹⁸ he did not possess American citizenship at the time of his 2002 criminal conviction for aggravated sexual battery.²⁹⁹ He served eleven months in jail and was later detained in February 2008 in a program known as Operation Coldplay.³⁰⁰ That program, conducted jointly by ICE and the Virginia State Police, focused on identifying, arresting, and beginning removal proceedings for immigrants with prior sex-related criminal convictions.³⁰¹

According to his family, Guido Newbrough began complaining of extreme pain several weeks before his death.³⁰² Inmates claim that he had been sobbing through the night for two weeks before Thanksgiving.³⁰³ At lunch, shortly before the holidays, Newbrough

²⁹⁵ *Another Death*, *supra* note 215; Miroff, *supra* note 167.

²⁹⁶ *See* Section V.D1., *supra*.

²⁹⁷ *Another Death*, *supra* note 215.

²⁹⁸ *Id.*

²⁹⁹ Newbrough was arrested for molesting his girlfriend's four-year-old daughter and presented an Alford plea for taking "indecent liberties with a minor" and aggravated sexual battery. *Id.*; Miroff, *supra* note 167. Newbrough's immigration suit was pending appeal at the time of death. He assigned error to the judge's ruling that he had failed to derive U.S. citizenship from his stepfather. *Another Death*, *supra* note 215.

³⁰⁰ *Another Death*, *supra* note 215; Press Release, U.S. Immigration and Customs Enforcement, ICE, Virginia Attorney General Announce Arrests of 171 Criminal Alien Sex Offenders in Virginia (Feb. 20, 2008), *available at* <http://www.ice.gov/pi/news/newsreleases/articles/080220richmond.htm> [hereinafter Virginia Arrests].

³⁰¹ Virginia Arrests, *supra* note 300. Operation Coldplay is thus another example of how ICE and local enforcement agencies are working together to increase the number of immigrants being removed from the United States.

³⁰² *Another Death*, *supra* note 215.

³⁰³ *Id.*

informed his guards that he could not rise from the table because he was in too much pain.³⁰⁴ The guards then allegedly threw him to the floor and dragged him by his leg to an isolation room.³⁰⁵ He died shortly thereafter from a virulent staph infection related to endocarditis, which is an infection of the heart valves.³⁰⁶ According to advocates, such infections are typically cured by antibiotics;³⁰⁷ with proper treatment, the death rate is under 25%.³⁰⁸

The jail's superintendent denies wrongdoing on the part of his staff, stating that "[t]here is no medical negligence and there is no agency that can say anybody died of medical negligence."³⁰⁹ The superintendent furthermore stated that inmate and family members' claims that Newbrough was held in isolation after being dragged from the lunchroom were "100 percent incorrect."³¹⁰

ICE launched an investigation to determine if the facility followed proper medical standards,³¹¹ although it initially denied reports that it was removing any detainees from the Farmville facility.³¹² As of the date that this paper was written, the investigation was still ongoing, but ICE had already announced that it had stopped sending new detainees there.³¹³ As a result, the number of detainees had fallen from 330 at the time of Newbrough's death to fifty-three in February 2009.³¹⁴

³⁰⁴ *Another Death*, *supra* note 215; Miroff, *supra* note 167.

³⁰⁵ *Id.*

³⁰⁶ *Id.*

³⁰⁷ Miroff, *supra* note 167.

³⁰⁸ *Another Death*, *supra* note 215.

³⁰⁹ Jamie C. Ruff, *Man's Death at Farmville Detention Center Brings Criticism*, RICHMOND TIMES-DISPATCH, Feb. 26, 2009, available at http://www.timesdispatch.com/rtd/news/state_regional/article/JAIL26_20090225-220613/216066/.

³¹⁰ Miroff, *supra* note 167.

³¹¹ Nick Miroff & Josh White, *ICE Halts Detentions at Va. Facility After Death*, WASH. POST, Feb. 20, 2009, at B01, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/02/19/AR2009021901816.html>.

³¹² *Another Death*, *supra* note 215.

³¹³ Ruff, *supra* note 309; Miroff & White, *supra* note 311.

³¹⁴ Miroff & White, *supra* note 311.

ICE has refused to comment on when its investigation will be complete or on what actions it might take should the facility be found at fault.³¹⁵ However, some things appear clear. Instead of ignoring the problem, ICE began an investigation almost immediately. Even before they finished the investigation, ICE agents began taking steps to ensure the protection of detainees. The agency has maintained silence regarding responsibility in Newbrough's death, but that is only proper while the investigation is still pending. The fact that ICE has already stopped sending detainees to the facility supports the argument that the agency – while it may have had monitoring failures in the past – is currently taking its responsibility for detainee health very seriously. The most likely outcome of this situation, if there was negligence on the part of the facility, is that ICE will acknowledge it and continue taking steps to prevent similar future problems.

VI. Recommendations

Proper medical healthcare is a serious issue for immigrants and the agency that oversees their detention. It has become an especially explosive concern with the rapidly rising number of detainees. In recent years, ICE has seen a vast increase in the number of pending removal cases. This increase can be explained by three primary changes – Congressional decisions that have enlarged the number of ways an immigrant becomes eligible for removal, an increased focus on removal by ICE, and the expanding interest that state and local enforcement agencies have put on removal. Because many immigrants are detained pending removal, the number of immigrant detainees has increased dramatically. ICE is unable to detain all of these immigrants in its own facilities, so it has increased its use of contracted private and local government detention facilities.

To ensure detainee health at all facilities, ICE publishes standards governing medical care. The initial standards, written in 2000, left many potential problems open. Most noticeably, a facility could comply with the standards simply by following required steps rather than focusing on whether the immigrant actually obtained the desired

³¹⁵ Miroff & White, *supra* note 311.

medical result. The more recent standards have closed the most blatant loopholes; by directing facilities to focus on the outcome rather than a rigid step-by-step process, the 2008 Standards change the emphasis of the care providers. Facilities are currently in the process of transitioning over to these 2008 Standards. If they are adhered to, the vast majority of detainee complaints about healthcare should be effectively addressed.

However, such success assumes that the facilities will comply with the 2008 Standards and that ICE will monitor them in a way that ensures effective compliance. This assumption must be probed more fully before it can be accepted. Immigrant advocates argue that compliance is a major problem, pointing to repeated complaints from detainees that their medical care is delayed or that they are unable to attain care in the first place. ICE responds by explaining some of the delays, disputing others, and offering statistics that show how detainee deaths are dropping significantly despite the massive increase in immigrant detention rates. Simply looking at such disputed allegations would provide little guidance in determining whether compliance really does occur.

Case studies, however, provide more assistance. In several recent instances, ICE's internal investigations have revealed and acknowledged compliance problems at certain facilities. The agency may dispute other charges, but it has not failed to accept responsibility in some cases. This recognition bolsters ICE's credibility in the disputed situations. Additionally, although objective OIG and GAO reports have also found compliance problems, those reports admit that the problems had occurred before ICE made important procedural changes to prevent any reoccurrences. ICE's changes have come from its own initiatives as well as in response to the OIG reports, whose criticisms the agency largely accepted. Although the argument could not have been supported several years ago, today it appears that ICE has an effective system in place to ensure compliance with its standards. Because the standards have been vastly improved, its monitoring system has been heavily reinforced, and its detainee death rates consistently lowered, ICE has recently demonstrated that it does have the ability to provide adequate health and medical care to the immigrants in its custody.

Compelling support for this position can be found in ICE's most recent policy change. On August 6, 2009, the agency announced a series of major reforms targeted towards further improvements in its immigrant detainee system.³¹⁶ First, ICE will be creating an Office of Detention Policy and Planning (ODPP) to focus on designing a detention system custom tailored to ICE's needs.³¹⁷ ODPP will be focusing on seven specific areas that will each have designated progress benchmarks.³¹⁸ One of the seven areas is health care management³¹⁹ and an expert in healthcare administration will be hired as part of ODPP's staff.³²⁰ Second, ICE will appoint 23 detention managers to work in the facilities housing over forty percent of the detainees.³²¹ These managers will be responsible for monitoring the facilities and ensuring appropriate detention conditions.³²² As such, they represent yet another means ICE will have of ensuring compliance with the 2008 Standards. Finally, ICE will also be establishing an Office of Detention Oversight (ODO).³²³ It will be tasked with inspecting facilities and neutrally investigating detainee grievances.³²⁴ Although contracted facilities were generally required under the 2000 and 2008 Standards to meet or exceed the healthcare requirements, advocates often alleged that the facilities chose not to do so and that ICE either condoned such failures or remained ignorant of them. Because these new reforms place a heavy emphasis on monitoring and inspection, they should serve to resolve many such

³¹⁶ ICE Announces Major Reforms to Immigration Detention System, U.S. Immigration and Customs Enforcement (August 6, 2009), <http://www.ice.gov/pi/nr/0908/090806washington.htm> (last visited October 7, 2009) [hereinafter ICE Reforms].

³¹⁷ *Id.*; 2009 Immigration Detention Reforms, U.S. Immigration and Customs Enforcement (August 6, 2009), http://www.ice.gov/pi/news/factsheets/2009_immigration_detention_reforms.htm (last visited October 8, 2009) [hereinafter 2009 Reforms].

³¹⁸ ICE Reforms, *supra* note 316.

³¹⁹ *Id.*

³²⁰ 2009 Reforms, *supra* note 317.

³²¹ ICE Reforms, *supra* note 316.

³²² *Id.*

³²³ *Id.*

³²⁴ *Id.* ODO employees will be located in regional offices so that they will be capable of conducting random inspections more frequently. 2009 Reforms, *supra* note 317.

allegations by greatly increasing compliance rates. Further analysis of how these changes support the proposition that ICE is assuming responsibility for improving its detainee healthcare system must be reserved for a future day.

At this time, it is recommended that ICE and immigrant advocates recognize the significance of the 2008 Standards. The impact that the Standards can have upon detainee healthcare is substantial. ICE must acknowledge that following required steps by rote will never guarantee that a detention facility is successfully providing medical assistance to detainees. ICE's adoption of the 2008 Standards suggests that it has accepted this critical deficiency in the 2000 Standards and taken active measures to correct it. Today, ICE is in the process of requiring all facilities that it owns or has contracted with to "focus on the results or outcomes the required procedures are expected to accomplish."³²⁵ In turn, immigrants and their advocates should become familiar with the new protections offered by the 2008 Standards. By effectively citing to the 2008 Standards, immigrant advocates can now demand facilities do more than simply rely upon compliance with the steps outlined in the 2000 Standards. Today, the facilities are required to focus on the results; immigrant advocates must have working knowledge of the 2008 Standards to ensure that the facilities do so.

Additionally, it is recommended that ICE continue to take steps towards bolstering its capability to monitor facilities for adherence to the 2008 Standards. Creating the Detention Facilities Inspection Group and contracting with independent monitoring companies are respectable first steps. The August 6, 2009 reforms provide even more substantive changes to ensure effective monitoring. However, having this improved framework of monitoring is only a partial answer. The agency must actually follow through with the monitoring capabilities that it now possesses and is in the process of refining. Detention facilities that have been found non-compliant with the required standards must be met with serious and consistent results. The immigrant detainee healthcare system cannot afford another repeat of the Abdeulaye Sall–Guido Newbrough situation.³²⁶

³²⁵ Detention Management, *supra* note 4.

³²⁶ See Sections V.D.1. and V.F.2., *supra*, for a discussion of how both detai-

ICE must not continue contracting with facilities found to be in blatant violation of its 2008 Standards, or there will likely be more occurrences of multiple deaths at the same facilities.

For their part, immigrant advocates cannot rely upon the 2008 Standards and the steps that ICE is taking to monitor its facilities. Attention cannot wane and voices cannot quiet. Advocates must become familiar enough with the 2008 Standards to recognize when the newly afforded protections are not being provided. Demands that ICE properly monitors its facilities must continue. If these steps are taken, it becomes more likely that ICE will continue focusing its efforts on monitoring detention facilities for compliance. If the facilities in turn adhere to the 2008 Standards, then the failures of the 2000 Standards should be corrected. Complete and accurate adherence to the 2008 Standards will result in more immigrant detainees receiving the healthcare that they need while in detention.

VII. Conclusion

Immigrant detention rates are rising rapidly. While concerns about detainee healthcare existed previously, those concerns become even more acute as the number of detainees continues to increase. The 2000 Standards failed in several significant and substantive ways. The 2008 Standards diligently address the worst of those failings. If ICE properly monitors immigrant detention facilities for adherence to the 2008 Standards, the vast majority of detainee healthcare concerns should be sufficiently addressed. Such monitoring appears possible in light of statistics demonstrating lower death rates and changes in ICE policies, including the August 6, 2009 reforms. The quality of immigrant detainee healthcare should increase as more facilities transition to the 2008 Standards.

nees died at the Piedmont Regional Jail in Farmville, VA.