Saint Louis University Journal of Health Law & Policy

Volume 13
Issue 2 *Gender Identity, Sexual Violence, and Diseases of Despair: Legal Obstacles & Solutions*

Article 8

6-12-2020

The Importance of Standardized Data Collection and Reporting in Improving Medical Care for Immigration Detainees

Allison Michelle Bowen

THE IMPORTANCE OF STANDARDIZED DATA COLLECTION AND REPORTING IN IMPROVING MEDICAL CARE FOR IMMIGRATION DETAINEES

ABSTRACT

The provision of substandard medical care for immigration detainees has become somewhat of a norm for some time now. From October 1, 2003 to June 5, 2017, alone, there were a total of 172 deaths in ICE custody. This number is only rising as the number of detainee beds increases and ICE continues to not be held accountable. Presently, there lacks a mechanism for oversight and accountability of ICE. This Comment suggests that requiring standardized data collection and reporting efforts is a crucial first step towards improving the medical care for immigration detainees and creating a mechanism for oversight and accountability over ICE.

I. INTRODUCTION

Eighty-five miles northeast of Los Angeles, in the Mojave Desert, sits the rural town of Adelanto, California.[1] The small town of Adelanto has a population of about 34,000 people.[2] However, it is also home to nearly 10,000 incarcerated people who are split between an immigration detention center, a county jail, a state prison, and a nearby federal prison.[3] The Adelanto Detention Facility (ADF), which can house up to 1,940 detainees, is currently tied with the Stewart Detention Center for the title of largest privately run United States Immigration and Customs Enforcement (ICE) detention center in the U.S.[4] The following paragraphs detail some experiences detainees have had at ADF.

On March 4, 2012, Fernando Dominguez-Valdivia, a fifty-eight-year-old Mexican national, died from pneumonia in ICE custody.[5] Mr. Dominguez-Valdivia contracted pneumonia during his eighty-two days in detention at ADF and died from what the Office of Detention Oversight (ODO) described as an "unacceptable level of medical care."[6] Mr. Dominguez-Valdivia was taken to the hospital twice over a three month timespan leading up to his death after his complaints of dizziness.[7] The summary of the death review in the 2012 ODO inspection reveals several egregious errors committed by the staff, including "'failure to perform proper physical examinations in response to symptoms and complaints, failure to pursue any records critical to continuity of care, and failure to facilitate timely and appropriate access to offsite treatments.'"[8] Further, the summary concludes that Mr. Dominguez-Valdivia's death "'could have been prevented and that [he] received an unacceptable level of medical care while detained.'"[9]

Forty-four-year-old Raul Ernesto Morales-Ramos entered ICE custody in 2011, and he was detained for four years at the Theo Lacy Facility before he was transferred to ADF on May 6, 2014.[10] "Two independent medical experts,

1. Sarah Tory, *'If you don't want us, tell us to go back': The Making of a California Prison Town,* HIGH COUNTRY NEWS (May 15, 2017), https://www.hcn.org/issues/49.8/how-adelanto-came-to-host-californias-biggest-immigration-detention-facility.

2. *QuickFacts: Adelanto City, California*, U.S. CENSUS BUREAU, https://www.census.gov/quickfacts/adelantocitycalifornia (last visited May 26, 2020).

3. Alice Speri, *At Largest ICE Detention Center in the Country, Guards Called Attempted Suicides "Failures"*, INTERCEPT (Oct. 11, 2018), https://theintercept.com/2018/10/11/adelanto-ice-detention-center-abuse/.

4. *Id.*

5. *Fatal Neglect: How ICE Ignores Deaths in Detention*, AM. C.L. UNION 16 (Feb. 24, 2016), https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnijc.pdf.

6. *Id*.

7. *Id*.

8. *Id.* at 17.

9. *Id.*

10. U.S. IMMIGRATION & CUSTOMS ENF'T, DETAINEE DEATH REVIEW-RAUL ERNESTO MORALES-RAMOS JICMS #201505282 (2015); *Systemic Indifference: Dangerous & Substandard*

analyzing ICE's investigation for Human Rights Watch, agreed that he likely suffered from symptoms of cancer starting in 2013, but that the symptoms essentially went unaddressed for two years, until a month before he died."[11] Furthermore, the ODO's death review recognized a "critical lapse in care" that occurred when he was first referred for a follow-up related to gastrointestinal symptoms in April 2013 and the consultation never occurred.[12] Then, when he was transferred, there was no documentation of his previous symptoms.[13] After nine months and several visits with "registered nurses after submitting several sick call requests for body aches, weight loss, pain in his joints, knees, and back, and diarrhea," Mr. Morales-Ramos' submitted a grievance on February 2015, in which he wrote: "To who receives this. I am letting you know that I am very sick and they don't want to care for me. The nurse only gave me ibuprofen and that only alleviates me for a few hours. Let me know if you can help me."[14] He was seen a few days later by a nurse practitioner who documented that his symptoms were resolved, but he quickly complained again, and another nurse saw him and noted that he had a distended abdomen but did not detect a mass.[15] Mr. Morales-Ramos was finally seen by a doctor four days later.[16] The doctor "told ODO that at that visit Morales-Ramos had 'the largest [abdominal mass] she had ever seen in her practice,' which was 'notably visible through the abdominal wall.'"[17] He was scheduled for a colonoscopy that took place about a month later and resulted in complications.[18] Mr. Morales-Ramos died three days later.[19] Two medical experts concluded that more attentive medical treatment could have led to quicker detection when it was still treatable.[20]

Jose Manuel Azurdia Hernandez, a fifty-four-year-old Guatemalan, was transferred to ADF on June 22, 2015.[21] He spent a total of six months in detention prior to a series of medical care lapses that led to his death on

Medical Care in US Immigration Detention, HUM. RTS. WATCH 1 (May 2017), https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_0.pdf [hereinafter *Systemic Indifference*].

11. *Systemic Indifference*, *supra* note 10, at 1.
12. *Id.* at 38.
13. *Id*.
14. *Id.* at 39.
15. *Id*.
16. *Systemic Indifference*, *supra* note 10, at 39.
17. *Id.*
18. *Id*.
19. *Id*.
20. *Id.* at 39–40.
21. U.S. IMMIGRATION & CUSTOMS ENF'T, DETAINEE DEATH REVIEW-JOSE MANUEL AZURDIA-HERNANDEZ JICMS #201602241 (2015).

December 23, 2015.[22] On December 19, 2015, around 9 a.m., another detainee informed an officer that "Mr. Azurdia was sick and wanted to see a medical caregiver."[23] The officer checked on Mr. Azurdia, said he seemed normal and then later heard him vomiting.[24] A licensed vocational nurse came into the housing unit about thirty minutes later, and the officer informed her that Mr. Azurdia was sick and vomiting.[25] "According to the officer, the nurse responded 'by saying she did not want to see Azurdia because she did not want to get sick.' This began a series of delays in Mr. Azurdia receiving attention for what turned out to be a fatal heart attack."[26] All three expert physicians who participated in the review by several advocacy groups agreed that Mr. Azurdia's death was likely preventable.[27]

Other deaths at ADF include: thirty-two-year-old Juan Pablo Flores-Segura; thirty-two-year-old Osmar Epifanio Gonzalez Gadba; fifty-five-year-old Sergio Alonso Lopez; and forty-six-year-old Vicente Caceres-Maradiaga.[28] This means that seven deaths have occurred at ADF over a five-year period. Human Rights Watch (HRW) found that poor care contributed or led to death, or dangerous practices or serious violations of detention standards were documented in review, or both were involved; the seventh case did not have a published death review at the time of the report.[29]

ADF is not the only facility contracted with ICE that has these issues. Stories like those discussed above which involve deaths related to delayed, denied, or substandard care occur far too frequently. In the words of the now former Homeland Security Secretary, Kirstjen Nielson, "one death is too many."[30] However, from October 1, 2003 to June 5, 2017, there were a total of 172 deaths in ICE custody.[31] A 2018 report conducted by HRW, the American Civil Liberties Union (ACLU), the National Immigration Justice Center (NIJC), and

22. *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention*, HUM. RTS. WATCH 15 (June 20, 2018), https://www.hrw.org/sites/default/files/report_pdf/us0618_immigration_web2.pdf [hereinafter *Code Red*].

23. *Id*.

24. *Id*.

25. *Id*.

26. *Id.*

27. *Code Red,* at 22.

28. *Id.* at 68, 72.

29. *Id.*

30. Lisa Riordan Seville et al., *22 Immigrants Died in ICE Detention Centers During the Past 2 Years*, NBC NEWS (Jan. 6, 2019), https://www.nbcnews.com/politics/immigration/22-immigrants-died-ice-detention-centers-during-past-2-years-n954781.

31. U.S. IMMIGRATION & CUSTOMS ENF'T, LIST OF DEATHS IN ICE CUSTODY, OCT. 2003–JUNE 2017 (2017), https://www.ice.gov/doclib/foia/reports/detaineedeaths-2003-2017.pdf; *Deaths in Adult Detention Centers*, AM. IMMIGR. LAW. ASS'N, https://www.aila.org/infonet/deaths-at-adult-detention-centers (last visited May 26, 2020) (reporting twelve deaths in 2018, nine in 2019, and eleven in 2020).

the Detention Watch Network concluded that twenty-three of the fifty-two deaths reviewed by ICE since March 2010 involved medical care lapses.[32] Further, at the time of the report, ICE had reported the deaths of twelve people in ICE custody in 2017, which was "more than any other fiscal year since 2009."[33] Thus, while the Department advocates that even one death is too many, the situations described above occur far too frequently and the conditions are getting increasingly worse.

As these conditions continue to worsen, it becomes more apparent that serious reform is necessary to improve conditions for immigration detainees. This Comment suggests that standardized data collection is a crucial first step to ensuring enforcement and accountability and will hopefully serve as a tool to prevent repeated failures that contribute to detainee deaths. Further, a necessary component of creating effective policies is to first allow for standardized data collection so policymakers can better understand the magnitude of the issues facing immigration detainees.

This Comment proceeds as follows: Part II outlines the current status of detention and data collection efforts. Part III briefly introduces the legal framework for immigration detention and discusses the departments and standards involved in ICE detention. This part also highlights shortcomings of these departments and their efforts to enforce the standards. Lastly, this part briefly highlights recent congressional efforts to address the many issues related to immigration detention. Part IV introduces essential components of a proposed solution and illustrates the importance of standardized data collection.

II. FACTUAL BACKGROUND

A. Current Status of Detention

The stories discussed above are continuously exacerbated by an increasing number of individuals in detention. Between 1994 and 2018 "the average daily population of detained noncitizens increas[ed] from fewer than 7,000 during fiscal year 1994 to 39,322 during fiscal year 2018."[34] This number is likely to continue to rise as Congress recently released the FY 2019 Department of Homeland Security (DHS) budget which allows for 52,000 detention beds, 49,500 adult beds and the remainder family beds.[35] Additionally, the number of bookings reported by ICE in 2018 increased 22.5% from 2017; the total number

32. *Code Red*, *supra* note 22, at 3. It is also important to note that ICE reported a total of seventy-four deaths over that time frame and only released fifty-two death reviews at the time of the report. *Id.*

33. *Id.* at 39.

34. Detention Oversight, Not Expansion Act, S. 2849, 115th Cong. § 2(1) (2018).

35. U.S. DEP'T OF HOMELAND SEC., BUDGET IN BRIEF, FISCAL YEAR 2019 4 (2019), https://www.dhs.gov/sites/default/files/publications/DHS%20BIB%202019.pdf.

of people booked in 2018 was 396,448.[36] The average length of detention was between 72 and 114 days, depending on the status of their removal order.[37] However, ICE reported that the average length of stay in 2018 was 48.8 days.[38] Similar to other statistics related to detention, the reported average length of stay has increased in recent years, from 37.5 days in FY 2014 to 48.8 days in FY 2017.[39]

The roughly 40,000 immigrants are likely detained in one of five types of facilities ICE uses for detention: (1) Service Processing Center (SPC); (2) U.S. Marshals Service Inter-governmental Agreement (USMS IGA); (3) Contract Detention Facility (CDF); (4) Inter-governmental Service Agreement (IGSA); or (5) Dedicated Inter-governmental Service Agreement (DIGSA).[40] Each type of facility is owned and operated by different entities, which further complicates oversight and accountability. SPCs house the lowest proportion of detainees (3,263 average daily population (ADP) detainees in FY 2017) and are owned by DHS and operated by contracted detention staff.[41] USMS IGAs are facilities that are contracted by the U.S. Marshals Service and are the next smallest housing an ADP of 6,756.[42] CDFs house an ADP of 6,818 and are owned and operated by private companies that contract with ICE.[43] The two largest are IGSAs and DIGSAs; IGSAs are local and county jails (ADP 8,778) and DIGSAs are facilities solely dedicated to housing ICE detainees (ADP 9,820).[44] The vast majority of detained individuals (seventy-one percent in 2017) are held in private prisons.[45] Furthermore, "[a]n average of more than 15,000 people daily were held in 33 jails where local governments signed contracts with the federal government . . . and then subcontracted facility operations to private, for-profit

36. *ERO FY18 by the Numbers*, U.S. IMMIGR. & CUSTOMS ENFORCEMENT, https://www.ice.gov/features/ERO-2018.

37. U.S. COMM'N ON CIVIL RIGHTS, STATUTORY ENFORCEMENT REPORT: THE STATE OF CIVIL RIGHTS AT IMMIGRATION DETENTION FACILITIES 9 (2015).

38. U.S. DEP'T OF HOMELAND SEC., U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT BUDGET OVERVIEW: FISCAL YEAR 2019 CONGRESSIONAL JUSTIFICATION 4 (2019) (classifying detainees as "all convicted criminal aliens prior to removal"). The differences in these numbers may come from different classifications of detainees.

39. *See id.* at 12. It is also interesting to note that ICE's target for average length of stay was exceeded every year after 2014.

40. OFFICE OF INSPECTOR GEN., OIG-18-67, ICE'S INSPECTIONS AND MONITORING OF DETENTION FACILITIES DO NOT LEAD TO SUSTAINED COMPLIANCE OR SYSTEMIC IMPROVEMENTS 1 (2018) [hereinafter OIG-18-67].

41. *Id*.

42. *Id*.

43. *Id*.

44. *Id.*

45. Tara Tidwell Cullen, *ICE Released Its Most Comprehensive Immigration Detention Data Yet. It's Alarming.*, NAT'L IMMIGRANT JUST. CTR. (Mar. 13, 2018), https://immigrantjustice.org/staff/blog/ice-released-its-most-comprehensive-immigration-detention-data-yet.

companies."[46] These facilities each have their own contracts, are held to one of four ICE standards, and some have to balance standards governing convicted criminals with the ICE standards.[47]

B. Current Data Collection

Many of the current data collection efforts are related to financial metrics, and there is limited evidence of some medical-related metrics. Several reports have been conducted regarding ICE budgetary data, which emphasize the utility of data collection. For instance, a 2014 report by the U.S. Government Accountability Office (GAO) identifies an issue in data collection regarding costs and operations.[48] "ICE also identified challenges in tracking and maintaining complete data on all costs or expenditures associated with individual facilities, including costs for medical care and transportation, for example."[49] A 2018 report by GAO identifies some improvements by ICE in creating cost data collection tools, but it also points out some inaccuracies.[50] Specifically related to detainee medical care, GAO published a report in 2016 outlining some limitations of current reporting practices.[51] For example, the report states that ICE uses "seven oversight mechanisms to assess facility compliance with medical care detention standards and to inspect the quality of medical care at facilities."[52] However, GAO found that "ICE does not utilize the data gathered through these mechanisms in a way that examines overall trends in medical care deficiencies."[53] GAO concluded that this was a limitation and stated that "[c]onducting analysis of oversight data over time, by detention standards, and across facilities, consistent with internal control standards, could strengthen ICE's ability to manage and oversee the provision of medical care across facility types."[54] Thus, it appears that ICE is collecting some data; however, due to a lack of transparency, it is difficult to determine what information is being collected. It is clear that as of 2016, the data were not being used to indicate trends.

46. *Id.*

47. *See generally id.*

48. *See generally* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-153, IMMIGRATION DETENTION: ADDITIONAL ACTIONS NEEDED TO STRENGTHEN MANAGEMENT AND OVERSIGHT OF FACILITY COSTS AND STANDARDS 13–24 (2014) [hereinafter GAO-15-153].

49. *Id.* at 17.

50. *See generally* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-18-343, IMMIGRATION DETENTION: OPPORTUNITIES EXIST TO IMPROVE COST ESTIMATES 13–18 (2018).

51. *See generally* U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-16-231, IMMIGRATION DETENTION: ADDITIONAL ACTIONS NEEDED TO STRENGTHEN MANAGEMENT AND OVERSIGHT OF DETAINEE MEDICAL CARE (2016) [hereinafter GAO-16-231].

52. *Id.* at 55.

53. *Id.* at *GAO Highlights*.

54. *Id.*

Specific to medical care, there is evidence that the system ICE utilizes, MedPAR, actually hinders ICE's ability to use the data in a meaningful way that allows for identification and assessment of trends for detainees.[55] Specifically, GAO's report states that the MedPAR system does not currently allow "officials to search for or identify types of procedures or off-site medical care visits that were requested, approved, or denied."[56] This further places limitations on ICE's ability use the data. Without useful data, ICE can neither adequately nor efficiently determine or allocate necessary resources.

These issues and limitations of current practices make it difficult to fully determine the scope of the problems occurring within the detention centers. The Chief Medical Informatics Officer at Intermountain Healthcare in Utah, Stan Huff, stated "You can't take proper care of patents if you don't document care."[57] For instance, GAO recognizes the significance of collecting better data and believes that an improvement in this area could lead to more consistency in approvals and in denials. Further, GAO states that "[t]his is important because MedPAR approvals and denials are primarily based on the professional judgment of the reviewer—there is currently no specific written clinical guidance on which to base approval decisions, according to IHSC officials."[58]

Further limitations are apparent in the data collection efforts ICE Health Services Corps (IHSC) is currently undertaking. IHSC collects some data and conducts quality improvement audits across the nineteen IHSC-staffed facilities.[59] If IHSC finds that the compliance rates across all facilities fall below ninety percent, then each clinic is required to conduct additional studies about the issue.[60] In turn, these studies help IHSC determine best next steps to address the issue, such as creating a new administrative process or creating a new medical care intervention.[61] While this is refreshing, it only applies to about fifty-seven percent of the average daily population in 2015.[62] Additionally, there seems to be an overall focus on individual facilities than comparison across facilities.[63] Without comparison data, GAO states ICE

> is not well-positioned to assess the medical care performance of facilities over time, by contracted standards, or by facility type[,] thereby[] limiting ICE's ability to plan and manage overarching changes to detainee medical care.

55. *Id.* at 18.

56. GAO-16-231, *supra* note 51, at 18.

57. Darius Tahir, *'Black hole' of Medical Records Contributes to Deaths, Mistreatment at the Border*, POLITICO (Dec. 1, 2019), https://www.politico.com/news/2019/12/01/medical-records-border-immigration-074507.

58. GAO-16-231, *supra* note 51, at 18.

59. *Id*. at 26.

60. *Id.* at 26–27.

61. *Id*. at 27.

62. *Id*. at 26.

63. *See generally id*. at 27.

> Expanding analysis of oversight data across facilities would strengthen ICE's ability to manage and oversee the provision of medical care across facility types.[64]

Lastly, complaints are maintained by different sectors, kept in separate systems, and typically "not tracked or analyzed for trending purposes."[65] There is only one group that is required to report their complaints, the Office for Civil Rights and Civil Liberties (CRCL).[66] This again creates issues for determining the scope of issues faced by detainees.

III. LEGAL BACKGROUND

A. Legal Framework for Detention

Pursuant to 8 U.S.C. § 1226(a), the United States Attorney General has the authority to arrest and detain aliens.[67] The detention of immigrants is supposed to be administrative instead of punitive.[68] There are both constitutional and administrative standards that apply to immigration detention. First, detained immigrants are afforded certain constitutional rights,[69] including protections under the Fifth and Eighth Amendments.[70] Second, there are a number of administrative standards created by ICE that outline further administrative requirements, which include the provision of adequate medical care.[71] The current legal framework complicates accountability and enforcement efforts because it utilizes multiple different standards and includes too many departments.

1. Utilization of Multiple Standards Is Confusing and Complicates Accountability & Enforcement Efforts

Currently there is a lack of unified standards and regulations, which creates confusion and makes it difficult for entities to hold facilities accountable. There are four standards used in ICE-contracted facilities: (1) the 2000 National Detention Standards (NDS); (2) the 2007 Family Residential Standards; (3) the 2008 Performance-Based National Detention Standards (PBNDS); and (4) the

64. *Id.* at 28.

65. GAO-16-231, *supra* note 51, at 33.

66. *Id.* at 33–34.

67. 8 U.S.C. § 1226(a) (2016).

68. Brianna M. Mooty, *Solving the Medical Crisis for Immigration Detainees: Is the Proposed Detainee Basic Medical Care Act of 2008 the Answer*, 28 L. & INEQ. 223, 227 (2010).

69. *See id.* at 227–232 (providing a history of case law regarding immigrant detainees' constitutional rights).

70. *Id.* at 227–28.

71. *Detained and Denied: Health Care Access in Immigration Detention*, N.Y. LAW. FOR PUB. INT. 4 (2017), https://nylpi.org/wp-content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report_2017.pdf.

2011 PBDNS.[72] The largest number of facilities, 115, still follow the NDS, but they only detain 17.6% of the ADP.[73] Facilities housing the largest percent of ADP (62.3%) adhere to the 2011 PBDNS.[74] However, NIJC received a list of facilities and standards through a Freedom of Information Act request and found that "[o]nly 65 percent of ICE's adult detention centers are contractually bound by one of the agency's three sets of detention standards."[75] Further, the highest percentage of facilities (35%) are contractually obligated to follow the NDS, and 20% follow the 2011 PBNDS.[76] Even more concerning is that "[s]ome contracts only bind jail operators to the vaguely worded 'minimum service standards,' 'local standards,' or to 'COR Detention Standards' which refer to the Contracting Officer Representative and pertain to enforcement of the technical aspects of a facility's contract rather than conditions inside the jail."[77] However, regardless of the standards listed in the contractual agreement with ICE, ICE states that all "facilities are inspected under one of the three sets of ICE standards."[78] NIJC reports that 45% of inspections used the NDS.[79] Furthermore, GAO reported that ICE only applied the 2011 PBNDS to 15% of the facilities.[80] This suggests that it is important to understand how each standard addresses medical care.

First, the NDS section on medical care was the first standard for detention facilities. The NDS states that "[e]very facility will provide its detainee population with initial medical screening, cost-effective primary medical care, and emergency care."[81] Like later standards, NDS requires an initial medical and mental health screening for new arrivals and a second screening within fourteen days of arrival.[82] In addition to medical screenings, the NDS requires an initial dental screening within fourteen days of arrival.[83] The NDS also requires each facility have "a mechanism that allows detainees the opportunity to request health care services provided by a physician or other qualified medical officer

72. GAO-16-231, *supra* note 51, at 9. Please note that since writing this, ICE revised their standards in late 2019. *See 2019 National Detention Standards for Non-Dedicated Facilities,* U.S. IMMIGR. & CUSTOMS ENFORCEMENT (Dec. 19, 2019), https://www.ice.gov/detention-standards/2019.

73. *Id.*

74. *Id.*

75. Tidwell Cullen, *supra* note 45.

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *See* GAO-15-153, *supra* note 48, at 28.

81. U.S. IMMIGRATION & CUSTOMS ENF'T, INS DETENTION STANDARD: MEDICAL CARE 1 (2000) [hereinafter INS DETENTION STANDARD: MEDICAL CARE].

82. *Id.* at 3.

83. *Id.* at 4.

in a clinical setting."[84] This mechanism involves a procedure that request slips be received by medical facility in a timely manner and a regularly scheduled time for what is called "sick call."[85] Sick call is a time "when medical personnel will be available to see detainees who have requested medical services."[86] The NDS breaks down minimum standards for sick call based on number of detainees; for example, the minimum standard for facilities with fifty to 200 detainees is three days per week.[87] In general, the NDS provides for the provision of very basic medical care.

Next, the 2008 PBNDS built on the NDS and experiences learned over eight years. Like the NDS, the 2008 PBNDS requires medical, mental health, and dental screenings for each detainee.[88] A key difference between the two standards is that the 2008 PBNDS lays out specific requirements for each of the screenings.[89] Further, one of the biggest additions to the 2008 PBNDS is the inclusion of expected outcomes for the standards. There are thirty-eight expected outcomes for the medical care standard.[90] A few expected outcomes are: "[d]etainees will have access to a continuum of health care services, including prevention, health education, diagnosis, and treatment" and "[d]etainees will have access to specified 24-hour emergency medical, dental, and mental health services."[91] Another change from the NDS is the scope of the medical care standard. The 2008 PBNDS states that the standard "ensures that detainees have access to emergent, urgent, or non-emergent medical, dental, and mental health care."[92] Overall, the 2008 PBNDS is much more extensive than the NDS.

Lastly, the 2011 PBNDS is the most updated standard and builds on the extensive revisions conducted in the 2008 PBNDS. Accordingly, the 2011 PBNDS outlines the expected outcomes its standards are expected to accomplish. The 2011 PBNDS "ensures that detainees have access to appropriate and necessary medical, dental, and mental health care, including emergency services."[93] The standard applies to SPCs, CDFs, and state or local government facilities that contract with Enforcement and Removal Operations (ERO) through Intergovernmental Service Agreements to hold detainees for more than seventy-two hours.[94] The 2011 PBNDS added the inclusion of

84. *Id.* at 5.

85. *Id.*

86. INS DETENTION STANDARD: MEDICAL CARE, *supra* note 81, at 5.

87. *Id.*

88. U.S. IMMIGRATION & CUSTOMS ENF'T, ICE/DRO DETENTION STANDARD: MEDICAL CARE 11 (2008).

89. *See id.* at 11–14.

90. *See id.* at 1–3.

91. *Id.* at 1–2.

92. *Id.* at 1.

93. U.S. IMMIGRATION & CUSTOMS ENF'T, PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011 257 (2016).

94. *Id.* at 1.

optimal levels of compliance for the standards.[95] An example of an expected outcome under the 2011 PBNDS is that "[d]etainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment."[96] The corresponding optimal provision states "[m]edical facilities within the detention facility shall achieve and maintain current accreditation with the standards of the National Commission on Correctional Health Care, and shall maintain compliance with those standards."[97] Regarding medical care, the standards outline that:

- Detainees shall be able to request health services on a daily basis and shall receive timely follow up.
- A detainee who is determined to require health care beyond facility resources shall be transferred in a timely manner to an appropriate facility.
- 24-hour emergency medical and mental health services shall be available to all detainees.
- Detainees with chronic conditions shall receive care and treatment as needed, which includes monitoring of medications, diagnostic testing, and placement in chronic care clinics.
- Prescriptions and medications shall be ordered, dispensed, and administered in a timely manner and as prescribed by a licensed healthcare professional.[98]

If followed, the standards should allow for the provision of decent health care. However, many government agencies and advocacy groups have suggested the standards are rarely followed. For example, the U.S. Commission on Civil Rights report from 2015 stated that the "standards do not have enforcement mechanisms, [and] facilities are not held accountable when they fail to maintain or meet these standards."[99] Thus, while the standards may be sufficient, the lack of enforcement negatively impacts the provision of medical care to detainees. Enforcement is further complicated by the existence and simultaneous use of four different standards.

2. Too Many Departments Involved in Oversight Further Complicates Accountability & Enforcement Efforts

The large number of departments involved in immigration also adds to the complexity and further complicates enforcement and accountability efforts. The three overarching federal agencies are DHS, the Department of Health and

95. *Id.* at i.

96. GAO-15-153, *supra* note 48, at 45 (internal quotations omitted).

97. *Id.*

98. U.S. COMM'N ON CIVIL RIGHTS, STATUTORY ENFORCEMENT REPORT: THE STATE OF CIVIL RIGHTS AT IMMIGRATION DETENTION FACILITIES 30 (2015).

99. *Id.* at 25.

Human Services (HHS), and the Department of Justice (DOJ). For the purposes of this Comment, the focus will be on DHS. Within DHS, there are several other components and offices involved in immigration, including ICE.[100] Under ICE are several more departments, including ERO, ODO, IHSC.[101]

a. ERO and ODO Facility Inspections Are Insufficient

ERO is charged with "ensuring sane and humane conditions of confinement for detained aliens in ICE custody, including the provision of reliable, consistent and appropriate health services."[102] In an attempt to enforce the standards and fulfill its duties, ERO contracts with a third party, Nakamoto Group, Inc. (Nakamoto), to conduct inspections of all the types of facilities that hold ICE detainees for more than seventy-two hours.[103] These inspections are conducted typically conducted annually and are used to "determine compliance with 39 to 42 applicable detention standards."[104] A 2018 report from the Office of Inspector General (OIG) states that "Nakamoto inspected or re-inspected 103 facilities in 2015, 83 facilities in 2016, and 116 facilities in 2017."[105] Additionally, ERO has a Detention Monitoring Program. Through this program, select facilities have onsite Detention Service Managers (DSMs) who are tasked with monitoring compliance with ICE detention standards.[106] "In December 2017, 35 DSMs monitored compliance with ICE detention standards at 54 facilities holding more than 70 percent of detainees."[107] These facilities are still inspected by Nakamoto and the ODO.

ODO inspections "aim to provide ICE executive leadership with an independent assessment of detention facilities."[108] Roughly once every three years, ODO conducts inspections of seventy-two-hour facilities that hold more than ten detainees. The inspection schedule is determined "based on staffing budget, agency priorities, and special requests by ICE leadership" and is adjusted "based on perceived risk, ICE direction, or national interest."[109] The ODO inspections determine compliance with fifteen to sixteen core standards.[110]

100. *Id.* at 12. This discussion is limited to ICE, but DHS also includes the Customs and Border Protection and Citizenship and Immigration Services.

101. *Id.* at 12–14. There are several other departments under ICE, but the discussion is limited to these three because of their roles in the provision and enforcement of medical care standards.

102. DETAINEE HEALTH CARE FY 2015 FACT SHEET, U.S. IMMIGRATION & CUSTOMS ENF'T, https://www.ice.gov/factsheets/dhc-fy15 (last visited Sept. 11, 2018) [hereinafter DETAINEE HEALTH CARE FY 2015 FACT SHEET].

103. OIG-18-67, *supra* note 40, at 2.

104. *Id.*

105. *Id.*

106. *Id.* at 3.

107. *Id.*

108. *Id.*

109. *Id.*

110. OIG-18-67, *supra* note 40, at 3.

In 2018, the OIG conducted a report on ICE inspection mechanisms to determine "whether ICE's immigration detention inspections ensure adequate oversight and compliance with detention standards."[111] OIG also evaluated the post-inspection follow-up procedures to determine if the deficiencies identified were corrected. The report concluded that neither type of inspection (ERO or ODO) "ensures consistent compliance with detention standards or comprehensive correction of identified deficiencies."[112] OIG specifically found that Nakamoto inspections were too broad, practices were not consistently thorough, inspectors did "not fully examine conditions or identify all deficiencies," and ICE's guidance was unclear.[113] Further, while the OIG found ODO's processes to be more effective, OIG also found that these inspections were too infrequent.[114] Even if the inspections were flawless, ICE "does not adequately follow up on identified deficiencies or systematically hold facilities accountable for correcting deficiencies."[115] Moreover, OIG conducted an inspection of five detention facilities in 2006 and later found in 2017 that some of the same problems still persisted.[116]

The OIG and several advocacy groups have also highlighted many alarming discrepancies in the inspections and reporting. The 2018 OIG report provides an example that "for the same 29 facilities ODO and Nakamoto inspected, ODO's teams found 475 deficiencies while Nakamoto teams reported 209 deficiencies. Given that ODO looks at 15 to 16 standards and Nakamoto inspects 39 to 42 standards, the much larger number of deficiencies identified by ODO is surprising."[117] Further, OIG found several inaccuracies and misrepresentations in Nakamoto's reports to ERO.[118] Additionally, a 2018 HRW report highlights how ICE death reviews are often not included in later ODO inspection results.[119] Similarly, when a death has occurred in a facility, the report will often indicate substandard medical care as a potential cause, and yet the facility will pass the inspection with flying colors.[120] This is a potentially deadly oversight. If the conditions that led to a first death are not properly addressed, then more deaths might occur. These issues are substantial and need to be addressed properly. However, without a proper idea of the scope of these issues, it is difficult to implement effective policies.

111. *Id.*
112. *Id.* at 4.
113. *Id.*
114. *Id.*
115. OIG-18-67, *supra* note 40, at 4.
116. *Id.* at 4–5.
117. *Id.* at 7–8.
118. *Id.* at 9–10.
119. *See generally Code Red*, *supra* note 22, at 10.
120. *Id.* at 12.

b. IHSC Detention Role

IHSC "provides and coordinates the primary health care services for detainees in ICE custody."[121] IHSC provides direct care to detainees in some facilities and provides case management and oversight for some other facilities.[122] ICE states that IHSC provided direct care to 13,500 detainees in twenty-one facilities and provided oversight for an additional 15,000 detainees in 119 non-IHSC staffed facilities.[123] Private facilities contract with outside medical providers for the provision of medical care for detainees. This means that there are different providers across many facilities, which again makes it difficult from an accountability and enforcement standpoint.

B. Current ICE Reporting Efforts

Recently, there has been a congressional push toward increasing the data collection efforts of ICE. As a part of the DHS appropriations for FY 2017, Congress required that within ninety days of enactment that ICE submit a comprehensive plan for immigration data improvement,[124] and Congress mandated that the plan include an action plan, a staffing plan, and an estimate of necessary funding to implement the plan.[125] Moreover, Congress withheld $25,000,000 from ICE until it released the plan, which further demonstrates Congress' commitment to bettering data collection.[126] Based on Senate Report 114-264 and the Comprehensive Plan for Immigration Data Improvement created by DHS and ICE, it appears that the focus of the newly required data collection is "to track progress, justify resource needs, identify gaps, and assess effectiveness, particularly in the area of border security and immigration enforcement."[127]

Pursuant to its duties as required by the appropriations bill, ICE released its comprehensive plan for improving data collection. One of the first steps ICE took was to create a Chief Data Officer position.[128] Much of the rest of the plan concerned DHS missions and ICE goals for improving national security.[129] The plan included no mention of medical or health related needs. However, this

121. DETAINEE HEALTH CARE FY 2015 FACT SHEET, *supra* note 82.

122. *ICE Health Services Corps: Overview*, U.S. IMMIGR. & CUSTOMS ENFORCEMENT (Feb. 26, 2019), https://www.ice.gov/ice-health-service-corps.

123. *Id.*

124. Consolidated Appropriations Act of 2017, Pub. L. No. 115-31, § 212(a), 131 Stat. 135, 412 (2017).

125. *Id.* at 412–413.

126. *Id.*

127. S. REP. NO. 114-264, at 4–5 (2016).

128. *See generally* U.S. IMMIGRATION & CUSTOMS ENF'T, COMPREHENSIVE PLAN FOR IMMIGRATION DATA IMPROVEMENT: FISCAL YEAR 2017 REPORT TO CONGRESS 10 (2018) (discussing the creation of the position and the roles of the new Information Governance Division).

129. *See generally id.* at ii, 8–9.

report remains relevant because it demonstrates the current recognition and support for improved data collection as it relates to immigration.

C. Relevant Attempts to Target the Flaws

Over the past decade, there have been a few attempts to reform the detention system by addressing some of the flaws outlined above. Many of the reforms concern the size of the detention population, the requirements for asylum, and family separation. A few bills concern access to health care and some highlight need for data collection. While none of the bills have passed, they are important because they indicate what policymakers find important.

The Detainee Basic Medical Care Act of 2008 (H.R. 5950) was introduced on May 1, 2008,[130] and a companion bill (S. 3005) was introduced in the Senate on May 12, 2008.[131] The bill summary provided by Congress states that the Act directs

> (1) the Secretary of Homeland Security to establish procedures for the delivery of medical and mental health care to all immigration detainees in Department of Homeland Security (DHS) custody; and (2) that such procedures address all detainee health needs, including primary care, emergency care, chronic care, prenatal care, dental care, eye care, mental health care, medical dietary needs, and other medically necessary specialized care.[132]

This Act was supported by several immigrant rights groups, including the ACLU.[133] It was also supported by the American Bar Association, which was a contributor to the development of the original ICE Detention Standards, NDS, that took effect in 2001.[134] While the bill received a lot of support, it also had its opponents. Some groups and individuals describe the bill as not enough alone to solve the issue of substandard care in detention centers.[135] Many groups outline general recommendations, including the ACLU.[136] Additionally, a law review article written in 2010 addresses some of the shortcomings of the act.[137]

130. Detainee Basic Medical Care Act of 2008, H.R. 5950, 110th Cong. § 1 (2008).

131. Detainee Basic Medical Care Act of 2008, S. 3005, 110th Cong. § 1 (2008).

132. *H.R. 3923 - Death for Detained Immigrants Act of 2017: Summary*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/house-bill/3923 (last visited Feb. 2, 2020).

133. *Applauds Senator Menendez for Introducing Vital Legislation*, AM. CIVIL LIBERTIES UNION (May 13, 2008), https://www.aclu.org/news/aclu-welcomes-detainee-basic-medical-care-act.

134. WILLIAM H. NEUKOM, AM. BAR ASSOC., PROBLEMS WITH IMMIGRATION DETAINEE MEDICAL CARE (June 4, 2008).

135. *See generally id*. (describing additional measures that should be adopted); Mooty, *supra* note 68, at 240–47 (referring to the Detainee Basic Medical Care Act of 2008 as "bare bones legislation.).

136. *See Code Red*, *supra* note 22, at 4–6; *Systemic Indifference*, *supra* note 10, at 8–9.

137. Mooty, *supra* note 68, at 226, 240–47.

The Dignity for Detained Immigrants Act of 2017 was introduced in the House (H.R. 3923), and a related bill was introduced in the Senate (S. 3112).[138] The bill mandates that DHS provide standards for each facility that meet at least the requirements outlined out by the American Bar Association's Civil Immigration Detention Standards and create a cause of action for those who are injured due to a violation of a standard during their detention.[139] Further, the bill summary states that "[t]he bill: (1) provides for facility oversight and transparency, (2) phases out the use of private detention facilities and jails for such aliens, and (3) revises procedures for detaining aliens."[140] The bill died after introduction in the House.[141] Since the bill has died, a number of additional cosponsors have come forward in support of the bill; the original total was forty-six and now it is up to 120.[142]

In 2018, the Detention Oversight, Not Expansion Act, or DONE Act (S. 2849), was introduced in the Senate,[143] and an identical bill (H.R. 5820) was introduced in the House.[144] Basically, the bill sought to increase oversight of current detention standards, not expand the number of facilities.[145] The increased oversight involves additional inspections and "investigations focused on health, safety, and due process concerns at immigration detention facilities, including: (i) deaths in custody; (ii) detainee access to medical and mental health care, including pregnant women and other vulnerable populations; (iii) sexual assault and harassment; and (iv) compliance with legal visitation and access requirements."[146] Additionally, there are reporting requirements for both the OIG and the CRCL that mandate the release of aggregate data regarding complaints.[147]

138. *H.R. 3923 - Death for Detained Immigrants Act of 2017: Related Bills*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/house-bill/3923/related-bills (last visited Feb. 2, 2020).

139. Dignity for Detained Immigrants Act of 2018, H.R. 3923, 115th Cong. §§ 2, 4 (2017).

140. *H.R. 3923 - Death for Detained Immigrants Act of 2017: Summary*, *supra* note 132.

141. *H.R. 3923 - Death for Detained Immigrants Act of 2017: Actions Overview*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/house-bill/3923/actions?KWIC View=false (last visited May 26, 2020).

142. *H.R. 3923 - Death for Detained Immigrants Act of 2017: Cosponsors*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/house-bill/3923/cosponsors (last visited Feb. 2, 2020). The number of co-sponsors was last updated March 2, 2019.

143. *S. 2849 - DONE Act: Actions*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/senate-bill/2849/actions?KWICView=false (last visited Feb. 2, 2020).

144. *S. 2849 - DONE Act: Related Bills*, CONGRESS.GOV, https://www.congress.gov/bill/115th-congress/senate-bill/2849/related-bills (last visited Feb. 2, 2020).

145. *S. 2849: DONE Act*, AM. IMMIGR. LAW. ASS'N, https://www.aila.org/infonet/s-2849-done-act (last visited Feb. 2, 2020).

146. Detention Oversight, Not Expansion Act, S. 2849, 115th Cong. § 5(a)(1)(C) (2018).

147. *Id.* § 5(e).

Most recently, several bills regarding immigration have been introduced as a result of the Trump administration's "zero tolerance" policy and the government shutdown. Many of the laws introduced after the DONE Act concern prohibiting family separation and changing the asylum system.[148] However, in the 2017 Senate Report (S. Rept. 114-264) for the DHS Appropriations bill (S. 3001), Congress recognized the need for DHS to improve its data collection. The report states:

> The Committee charges the Department [of Homeland Security] to better assess its needs and demonstrate its effectiveness through data and metrics. To that end, this bill and report include specific direction to track progress, justify resource needs, identify gaps, and assess effectiveness, particularly in the areas of border security and immigration enforcement.[149]

From this report, it is clear that Congress recognizes the significance of data collection. However, it seems that most of the data collection tools Congress recommends seem to focus more on national security data than treatment of immigrants. Nonetheless, Congress, at the very least, acknowledges the usefulness of proper data, which can easily translate to the need for data collection for detainees.

IV. ANALYSIS

The previous sections outline many of the problems outlined by immigrants' rights advocacy groups and government oversight agencies, highlight how this problem is worsening over time as we continue to expand immigrant detention, and introduce some attempts at targeting the problems. This section attempts to build on those reports and proposals to provide a solution moving forward. This solution involves components of current and proposed legislation.

A. Congress Should Mandate Standardized Data Collection for ICE

1. Importance of Data Collection Generally

The importance of standardized data collection has been shown numerous times in health care and in evidence-based policymaking in general. For instance, the public health sector has witnessed a trend towards evidence-based interventions and policymaking. One report states that evidence "can make a difference to policy making by:

- achieving recognition of a policy issue (the first step in the policy-making process);

148. *See generally What's Happening in Congress: Pending Legislation*, AM. IMMIGR. LAW. ASS'N, https://www.aila.org/advo-media/whats-happening-in-congress/pending-legislation (last visited Feb. 2, 2020).

149. S. REP. NO. 114-264, at 4 (2016).

- informing the design and choice of policy (to analyze the policy issue);
- forecasting the future (forecasting models to assess how a policy can influence both short- and long-term outcomes);
- monitoring policy implementation (to assess the expected results of a policy decision); and
- evaluating policy impact (to measure the impact of a policy)."[150]

This list highlights the significance of evidence throughout the policymaking process. Not only are evidence and data collection crucial to recognition of the problem, but they are also important tools for evaluating the impact of a policy after it has been implemented. Furthermore, if consistent data were collected before and after policy implementation, then studies could be conducted to demonstrate the impacts of such policy.

2. ACA as Current Legislation Focused on Data Collection

The Patient Protection and Affordable Care Act (ACA) recognizes the importance of data collection. Prior to the passage of the ACA in 2010, there was an absence of standardized data collection in health care, which "inhibited uniform reporting and tracking of health disparities data."[151] The Institute of Medicine (IOM) released two landmark reports that "identified multiple factors slowing progress toward the elimination of health disparities among racial and ethnic minority groups."[152] These reports showed a "concern about the lack of consistency and granularity in the collection of data on racial and ethnic minorities" and "emphasized that the lack of standardized data relevant to race, ethnicity, and language diminished the likelihood that effective actions could be identified to reduce specific health disparities."[153] Additionally, the reports recommended standardization of data collection.[154] As a result of these reports, the ACA recognized data collection as a tool for tracking and understanding health disparities and created new data standards under section 4302 of the ACA.

Section 4302 of the ACA "focuses on the standardization, collection, analysis and reporting of health disparities data."[155] This section requires HHS to "establish data collection standards for race, ethnicity, sex, primary language,

150. *Evidence-Informed Policy Making: The Role of Monitoring and Evaluation,* NAT'L COLLABORATING CENT. FOR METHODS & TOOLS 1, 1, https://www.nccmt.ca/registry/resource/pdf/82.pdf (last updated Aug. 28, 2017).

151. Rashida Dorsey et al., *Implementing Health Reform: Improved Data Collection and the Monitoring of Health Disparities,* 35 ANN. REV. PUB. HEALTH 123, 124 (2014).

152. *Id.* at 124–125.

153. *Id.* at 125.

154. *Id.*

155. U.S. DEP'T HEALTH & HUMAN SERVS., HHS IMPLEMENTATION GUIDANCE ON DATA COLLECTION STANDARDS FOR RACE, ETHNICITY, SEX, PRIMARY LANGUAGE, AND DISABILITY STATUS 1 (2011).

and disability status."[156] HHS responded by creating a set of data collection standards, allowing public comment, and publishing the final set of data collection standards and supporting guidance.[157] Congress needs to similarly require DHS, specifically ICE, to implement standardized data collection.

Many of the circumstances leading to the creation and inclusion of data collection standards in the ACA to improve health disparities are similar to the circumstances surrounding immigration detainees' access to health care. About thirty years prior to the passage of the ACA, researchers discussed how health disparities impact health outcomes and realized the need for understanding the scope of the issue. Presently, there is over a decade's worth of research and advocacy work suggesting the need for improved medical care for detainees. However, most of the data suggesting the existence of substandard medical care come from detainee death reviews published by ICE, lawsuits, media coverage of deaths, and random reports released by OIG and GAO. This means that data collected in many of these reports could be outdated and potentially unrepresentative of the true scope of the issues, which is especially worrisome when considering that ICE death reviews are essentially ICE conducting reviews on itself. Thus, in order to create informed policy that effectively targets the issues of substandard medical care, data collection will be crucial.

3. Components Related to Data Collection in Recent Proposed Legislation

Recall that many of the proposed bills contain requirements for reporting related to transparency and oversight, which can be viewed as a form of data collection. One of the most extensive examples of this is found in the Dignity for Detained Immigrants Act of 2017 (Dignity Act).

The Dignity Act has several provisions that concern reporting. First, the Dignity Act requires OIG to perform unannounced inspections of each facility and make the reports publicly available on the DHS website.[158] The Dignity Act also requires DHS to conduct investigations into the death of an immigrant in custody that includes a "root cause analysis that identifies any changes to policies or practices that could reduce the probability of such an event in the future."[159] Similar to the requirement for investigations of facilities, death investigations must be made publicly available.[160] ICE does currently release death reviews and notifies Congress, non-governmental organization stakeholders, and the media; however, it appears that this is just "agency

156. *Id.*
157. *Id*. at 2.
158. H.R. 3923, 115th Cong. § 3(a)(1) (2017).
159. *Id.* § 3(b).
160. *Id.*

policy."[161] Regardless, there is no statutory provision requiring elements of a detainee death review. Additionally, the Dignity Act requires DHS to conduct an annual report that identifies each facility found to not be in compliance with the standards, any actions taken to comply with the standards, and whether remedial actions were successful in bringing the facility into compliance.[162] Another new requirement added in the Dignity Act is the creation of a "Facilities Matrix" that is publicly available on the DHS website and is updated monthly.[163] The matrix must include eight factors for each facility, including: the number of beds available in each facility disaggregated by gender; whether it is in compliance; the nature of the facility's contract; and the average number of days an immigrant is detained at the facility.[164] Most importantly, there is a requirement for information to be collected and maintained for detainees in DHS custody. The information to be collected is: gender and age; date detained; whether the individual is a vulnerable person or primary caregiver; provision authorizing detention; location where detained; any transfers and transfer reasons; status and basis of removal proceedings; initial custody determination and any review, date and reason for release or removal; and whether the individual is subject to final order of removal.[165] While this information does not concern medical care directly, it offers a foundation for beginning a more robust data collection process for immigration detainees.

None of the recent proposed legislation directly mandates specific requirements for medical care reporting. In addition to the foundation laid by general reporting requirements, there need to be requirements that include data related to lapses in care and contributing factors to substandard medical care. For instance, data to be collected could include the following: length of time between detainee medical complaint and when they are seen; illnesses diagnosed at time of initial screening; illnesses diagnosed during detention; qualifications of providers in detention center; and number of providers disaggregated by profession and specialty. These are just a few ideas, but if collected, policymakers and advocacy groups could begin to understand the scope of the issues in detention centers.

161. *Death Detainee Report*, U.S. IMMIGR. & CUSTOMS ENFORCEMENT, https://www.ice.gov/death-detainee-report (last updated Feb. 26, 2020).

162. H.R. 3923, § 3(c)(1)–(3).

163. *Id.* § 3(e).

164. *Id.* The other factors are: "[t]he name and location of each facility[,] . . . [w]hether the facility houses adults, children, or both[,] . . . [w]hether it is a seventy-two-hour facility or longer than seven days[,] . . . [and] the average number of detainees for current year and preceding month disaggregated by gender and classification." *Id.* § 3(e)(1)–(2), (4)–(5).

165. *Id.* § 3(g)(1)–(10).

B. Other Significant Components of the Solution

Several of the proposed bills and reports outline many different ways to reform immigration detention. The following sections outline a few of the proposals that could serve as additional components of the solution.

1. Halt the Expansion of ICE Detention

Many of the proposed bills and reports conducted by immigrants' rights groups support the need for halting expansion efforts. The DONE Act could serve as the basis for this component. The DONE Act states that DHS "may not use any Federal funds for the construction or expansion of immigration detention facilities."[166] Furthermore, the DONE Act requires DHS to submit a report to Congress that details "how the number of immigration detention beds will be deceased to 50 percent of the [current] number."[167] The bill also allows for DHS to submit a written justification for additional immigration detention space.[168] These actions have the potential to greatly improve medical care for the remaining detainees, as there would be fewer detainees to care for overall.

2. Create a Statutory Minimum Standard of Care

The standards currently utilized by ICE involve provisions for minimum standards of care in immigration detention facilities, but there is no statutory minimum standard of care. The absence of a statutory requirement allows ICE too much flexibility in determining the standard of care it deems sufficient. ICE should neither to determine its own standards nor have the duty to hold itself accountable for those standards. There needs to be a minimum standard of care created by Congress with the help of advocacy organizations. For this statutory minimum, the Detainee Basic Medical Care Act of 2008 provides a useful foundation that Congress could build upon and use in conjunction with any findings from the past decade.

The Detainee Basic Medical Care Act of 2008 creates a statutory minimum standard for medical and mental health treatment and creates reporting requirements. The minimum standards include provisions for both medical screenings and examinations, as well as continuity of care. The medical screenings and examinations provision require DHS to design procedures that ensure that each immigration detainee receives a comprehensive medical and mental health intake screening and examination by a qualified health professional, is allowed to continue taking prescribed medications unless a qualified health care professional decides upon an appropriate alternative, and gives priority release consideration to a detainee with a serious medical or

166. S. 2849, 115th Cong. § 4(a) (2018).
167. *Id.* § 4(b)(1).
168. *Id.* § 4(c)(1).

mental health condition.[169] Most of these minimum standards are reflected in the 2011 PBNDS that have been adopted by DHS. However, as outlined above, the standards are inadequately enforced, and some facilities' contracts only require an older, outdated standard. A solution to the inadequate enforcement of these standards is for Congress to create a statute that creates minimum standards of care, like the Detainee Basic Medical Care Act of 2008.

3. Create Statutory Provisions Requiring DHS to End Contracts with Non-Compliant Facilities

Reports have revealed that even facilities that violate standards have continued to receive passing inspections and continue to contract with ICE. Just like most other entities that receive funding from the federal government, the facilities should be held accountable for deficiencies. For this component, the DONE Act offers a relevant proposal. It has a provision relating to termination of a contract, which states that "[i]f a facility is deemed less than adequate in the 2 most recent inspections, audits, or investigations conducted by the [OIG] . . . [DHS] shall not continue to contract with such facility."[170] The definition of "less than adequate" needs to be added to this provision to ensure uniformity and clarity. Nonetheless, the DONE Act serves as a good example of proposed legislation that could be used as a component for the overall solution.

4. Increase Mechanisms for Oversight and Transparency

The need for better oversight and transparency is abundantly clear through the repeated inadequacies of ICE enforcement efforts. For instance, consider the deficiencies exposed in the inspections. GAO reported that

> ICE ERO and ODO inspection reports differed in the extent to which they found deficiencies in medical care for the same facilities, including facility inspection reports in which only ERO found deficiencies, facility reports in which only ODO found deficiencies, and reports in which both ERO and ODO found deficiencies but the specific deficiencies differed. For example, at one IGSA, ODO found that the facility was not properly safeguarding detainee medical information, as all facility staff had access to each detainee's medical intake form. At this same facility, ICE ERO did not find any deficiencies related to medical care.[171]

GAO identified the lack of enforcement mechanisms as one of the reasons for these deficiencies. Thus, a solution for addressing these deficiencies is to increase ICE enforcement capacity, create accountability mechanisms for ICE through Congress, and increase transparency.

169. H.R. 5950, 110th Cong. § 2(b) (2008).
170. S. 2849 § 5(d).
171. GAO-15-153, *supra* note 48, at 47.

The Done Act also has provisions relating to oversight and transparency. The DONE Act provisions on oversight mandate that the OIG conduct: (1) unannounced annual inspections; (2) audits to ensure compliance with national standards pursuant to other federal laws; and (3) investigations focused on health, safety, and due process concerns, including deaths, access to medical and mental health care, sexual assault and harassment and compliance with visitation requirements.[172] Additionally, the inspections should be measured against the American Bar Association's Civil Detention Standards and ICE standards.[173] At the conclusion of the inspections, audits, and investigations, DHS must make the results publicly available.[174] In addition to publicly releasing results, the OIG and the CRCL must "submit a report to the appropriate congressional committees that summarizes the results" of (1) any inspection, audit, or investigation within sixty days, as well as quarterly release aggregate data on its website regarding complaints lodged about or from an immigration detention facility; (2) the actions taken in response to such complaints; and (3) any investigation outcomes that resulted.[175]

5. Other Solutions

There are numerous other proposals that could improve care received by immigrants in detention. A 2018 report conducted by HRW calls on Congress to ensure that IHSC is the sole and direct provider at all immigration detention facilities, even those that are privately-run and IGSAs.[176] The same report also recommends that Congress "[a]ppoint an independent medical oversight board with jurisdiction over the quality of medical and mental health care in ICE detention composed of medical doctors and advocates at the national level and require ICE and its contractors to begin implementing local medical oversight boards at individual detention facilities."[177]

IV. RECOMMENDATION

As demonstrated above, many of the reports and proposed bills offer recommendations on how to better the detention system. Some of these recommendations include decreasing the number of individuals detained, creating a federal minimum standard of care, creating a cause of action for violation of standards, and increasing oversight and accountability. Since the situation is critical and lives are at stake, short-term policies should be implemented to attempt to better conditions. These policies should be created by

172. S. 2849 § 5(a)(1).
173. *Id.* § 5(a)(2).
174. *Id.* § 5(a)(4).
175. *Id.* § 5(c)(1)(A)–(B).
176. *Code Red*, *supra* note 22, at 4.
177. *Id.*

looking to the prison standards and working with health care providers and advocacy groups to determine the best short-term options. A potential starting place could be The Dignity for Detained Immigrants Act of 2017 that was introduced in the House (H.R. 3923). It created a lot of attention before the newly elected members of Congress were sworn in. Now that the House has more Democrats, there is a higher likelihood of a bill like this succeeding. The bill should be modified and reintroduced. Prior to the long-term implementation of any of these proposals, a proposal should be created that mandates standardized data collection in ICE detention facilities. Public health officials and health care providers should be included in the discussion to determine appropriate metrics to be collected for best results. If these measures are taken, hopefully the substandard medical care that was received by individuals like Fernando Dominguez-Valdivia, Jose Manuel Azurdia Hernandez, Raul Ernesto Morales-Ramos, and at least twenty others will be a thing of the past.

V. CONCLUSION

As the number of immigrants continues to grow, the corresponding need for reform in ICE detention becomes more apparent. This need is well documented by advocacy groups, scholars, and federal governmental agencies. In response to the need, Congress has proposed several pieces of legislation aimed at reforming the various issues referenced in this Comment. There needs to be a push for standardized data collection to help improve the conditions within detention facilities. Data collection is crucial to determining the scope of the issue, creating policy, implementing policy, and evaluating the policy. It is clear that immigration is currently a key political issue, which means there may be an opportunity for the passage of such necessary legislation, or at the very least, a spur of discussions between policymakers. Not only is this crucial for ICE, but it is also essential that a similar push occur for CBP, and DHS as a whole. In December 2018, two children (eight-year-old Felipe Alonso-Gomez and seven-year-old Caal Maquin) died in CBP custody.[178] This is the real border crisis. Individuals are dying in ICE and CBP custody at an alarming rate. Transparent and standardized data collection metrics need to be implemented immediately so that researchers may quickly begin to understand the scope of the problem

178. Chanelle Diaz, *The Real Border Crisis: Medical Neglect of Migrants in Detention Centers,* STAT (Jan. 10, 2019), https://www.statnews.com/2019/01/10/medical-neglect-migrants-detention/. *See also* Andrew Meehan, *Statement by U.S. Customs and Border Protection*, U.S. CUSTOMS & BORDER PROTECTION (Mar. 30, 2019), https://www.cbp.gov/newsroom/speeches-and-statements/statement-us-customs-and-border-protection (calling for congressional action to assist CBP in caring for those in its custody and referring to the current situation as a 'humanitarian crisis'").

and policymakers can work to effectively address the problem before any more lives are lost due to substandard medical care in immigration detention centers.

ALLISON MICHELLE BOWEN*

*Juris Doctor, Saint Louis University School of Law (anticipated 2021); Master of Public Health, Saint Louis University College for Public Health and Social Justice (anticipated 2021); Bachelor of Arts in Urban Studies and Political Science/International Studies, Rhodes College (2016). This Comment is published with enormous gratitude to my supportive parents, Pamela and Matthew Spencer; my grandparents, Bonnie and Forrest Smith; my boyfriend, Matthew Vavrek; my little sister, McKenna Morris; and my friends for all their advice and laughter. I would also like to thank my mentor, Professor Elizabeth Pendo, and the rest of the faculty of the Center for Health Law Studies for their expertise, advice, and feedback throughout the writing process and throughout my law school career. Lastly, I would like to thank the *Saint Louis University Journal of Health Law & Policy* for teaching me and allowing me to grow while offering many new friendships and lots of laughter.