May 15, 2015

Sarah Saldaña
Director, U.S. Immigration and Customs Enforcement
U.S Immigration and Customs Enforcement
500 12th St., SW
Washington, D.C. 20536

John Roth Inspector General, Department of Homeland Security 245 Murray Lane SW Washington, DC 20528-0305

Megan H. Mack Officer for Civil Rights and Civil Liberties U.S. Department of Homeland Security Building 410, Mail Stop #0190 Washington, D.C. 20528 crcl@dhs.gov

Dear Director Saldaña, Inspector General Roth and Officer Mack:

We, the undersigned Southern California legal service providers and human rights organizations, write to express our deep concerns about the quality of health care provided to immigration detainees at the Adelanto Detention Center operated by GEO Group Inc. in Adelanto, California.

Since the facility first opened in 2011, GEO consistently has denied or delayed necessary medical and mental health treatment to Adelanto detainees, placing their physical and mental well-being at significant risk. These failures have directly led to the death of at least one detainee, Fernando Dominguez, and there are significant questions regarding whether the recent death of Raul Ernesto Morales-Ramos was due to the facility's failure to diagnose and treat his intestinal cancer. To ensure that no further detainees' lives are placed at unnecessary risk, we urge ICE to act immediately to address the systemic health care deficiencies at Adelanto, and to halt the planned expansion of the facility.

GEO is obligated to provide comprehensive, necessary and appropriate medical and mental health care services to the detainees at the Adelanto facility. Under ICE's Performance Based National Detention Standards ("PBDNS")—to which GEO has contracted to adhere—GEO must "ensure[] that detainees have access to appropriate and necessary medical, dental and mental

¹ ICE's Office of Professional Responsibility determined that Mr. Dominguez's death was caused by "egregious errors committed by ACF medical 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 off-site treatments. ODO concluded the detainee's death could have been prevented and that the detainee received an unacceptable level of medical care while detained at ACF." *See* http://www.ice.gov/doclib/foia/odo-compliance-inspections/adelantoCorrectionalFac_Adelanto-CA-Sept_18-20-2012.pdf.

² Kate Linthicum, "Salvadoran immigrant held at Adelanto ICE facility dies," LA Times, April 7, 2015, *available at* http://www.latimes.com/local/lanow/la-me-ln-detainee-death-20150407-story.html

health care, including emergency services." Facilities are required to provide a "comprehensive" range of medical, dental and mental health screening and care, "timely responses to medical complaints," and "professional language services necessary for detainees with limited English proficiency." The PBNDS includes detailed rules governing the provision of health care services to ensure that these goals are met.

However, all too often, GEO has failed to live up to these standards. As organizations who work directly with individuals detained in Adelanto, we have first-hand experience with numerous cases of medical neglect, and seen how detainees' health has suffered as a result. These cases demonstrate a pattern and practice of substandard care including:

- Extended delays in responding to detainee requests for medical treatment;
- Repeated failures by medical staff to use language services to communicate with non-English speakers;
- Over-medication of detainees with mental disabilities:
- Use of shackles during appointments with psychiatrists;
- Lack of continuity of care for arriving and departing detainees with chronic conditions;
- Unwarranted limits on access to necessary medical treatment, supplies and services;
- Delayed or denied care for serious conditions and diseases in cases where the detainees' removal is alleged to be imminent;
- Denial of necessary care, or misdiagnoses, for detainees with serious conditions and diseases.

These systemic breakdowns have led to numerous cases in which Adelanto detainees' health was placed at unnecessary risk. We here summarize a small sample of the cases we have documented in the past few years:

- Denial of care to a detainee with Hepatitis C because "his length of stay was uncertain";
- Denial of a medically-necessary helmet for a detainee with severe epilepsy who is prone to violent seizures:
- Denial of treatment to a detainee with a serious hip infection because "it was too expensive" and that ultimately developed into a life-threatening condition that required a 6-week hospitalization;
- Failure to perform diagnostic tests on a detainee suffering from extreme headaches, dizziness and temporary losses of vision;
- Denial of meal accommodations and sufficient pain medication for a detainee suffering from a severe form of sickle-cell anemia;
- Denial of surgery to correct mobility issues in a stroke victim's arm;
- Failure to sanitize catheters that medical staff required a partially paralyzed, wheel-chair bound detained to recycle, resulting in a urinary tract infection and hospitalization;
- Denial of back surgery for a detainee with a slipped disc because "the injury occurred in prison," and his "stay at Adelanto will be brief";
- Delayed treatment for a detainee with a severe case of valley fever after he had informed medical staff that his condition requires regular monitoring and specialized care.

³ PBDNS § 4.3.I, available at http://www.ice.gov/doclib/detention-standards/2011/medical_care.pdf

⁴ PBNDS § 4.3.V.A.

⁵ See generally PBDNS § 4.3.

We have brought many of these cases, as well as other instances of substandard care, to the attention of the ICE Los Angeles Field Office and Assistant Field Office Director at Adelanto. While ICE has taken action to address several of the individual cases, the ongoing number and severity of cases involving inadequate care make clear that there are underlying systemic deficiencies that remain unresolved. Simply put, ICE has failed to conduct sufficient oversight of the medical care at Adelanto and to fulfill its obligation to ensure the health and safety of the immigration detainees housed there.

GEO's failure to provide adequate medical care at Adelanto, unfortunately, should not come as a surprise. In 2012, twenty-six members of Congress requested an investigation of the GEO-operated Broward Transitional Center in Florida after hearing reports of inadequate medical care for detained immigrants. The same year, the Department of Justice released a report finding "systematic, egregious, and dangerous practices," including inadequate medical care, at a GEO facility in Mississippi. At another GEO facility in Pennsylvania, seven people died in less than two years, with several resulting in lawsuits alleging that the facility failed to provide adequate medical care. In 2011, GEO was held civilly liable in a wrongful death action brought by the estate of an inmate at a GEO facility in Oklahoma. There are dozens more suits ranging from allegations of inmate death to abuse to medical neglect that have been filed against GEO, many of which are settled before trial. Most recently, in March 2015, GEO was found negligent in an Australian prisoner's death.

GEO's demonstrated track record of providing deficient care at Adelanto and these other facilities make clear that it is currently incapable of ensuring the health and safety of Adelanto detainees. In light of this history, we are particularly troubled that ICE has announced plans to expand the available bed space at Adelanto by 640 beds (for a total of approximately 1,940) and for the first time may house women and LGBTQ individuals at the facility—vulnerable populations that require specialized health care services. If GEO is incapable of providing adequate care to the male detainees currently in its custody, how can it be trusted to provide new, specialized care to such vulnerable populations?

We therefore urge ICE to immediately intervene to ensure the health and safety of the current and future detainees housed at Adelanto. First, ICE should either take over the provision of

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⁶ Letter from Congressional Members Demanding an Investigation of Broward Transitional Center, Sept. 13, 2012 (noting, among other reports, that a woman "was returned to her cell on the same day she had emergency ovarian surgery and that she suffered bleeding and inadequate follow-up care").

⁷ Department of Justice: Civil Rights Division, *Investigation of the Walnut Grove Youth Correctional Facility*, 20-33, Mar. 20, 2012, *available at* http://www.justice.gov/crt/about/spl/documents/walnutgrovefl.pdf

⁸ See Alex Rose, "A changing of the guard at county prison," Daily Times News, Jan. 4, 2009, available at http://www.delcotimes.com/general-news/20090104/a-changing-of-the-guard-at-county-prison.

⁹ Estate of Ronald S. Sites, deceased v. The GEO Group, Inc., available at http://www.sec.gov/Archives/edgar/data/923796/000119312513087892/d493925d10k.htm.

¹⁰ Private Corrections Working Group/Private Corrections Institute: List of GEO Group Lawsuits, *available at http://www.prwatch.org/news/2013/09/12255/violence-abuse-and-death-profit-prisons-geo-group-rap-sheet#sthash.WHKaqen8.dpuf.*

¹¹ See Ray Downs, "Judge Says GEO Group Negligent in Australian Prisoner's Brutal Death," Broward-Palm Beach New Times, Mar. 31, 2015, available at http://www.browardpalmbeach.com/news/judge-says-geo-group-negligent-in-australian-prisoners-brutal-death-6920957.

health care at the facility or take immediate steps to improve GEO's practices, including by appointing an independent investigator to inspect GEO's health care policies and practices, developing recommendations to improve the quality of care at the facility, and overseeing the implementation of those recommendations.¹²

Second, ICE should immediately halt its plans to expand the detention population at Adelanto, including the transfer of women and LGBTQ individuals, because GEO has failed to establish that it is capable of providing adequate care.

We look forward to your prompt attention to these serious issues. We request a meeting with ICE and DHS CRCL to discuss our concerns and what steps ICE plans to take to address them. Please notify us by May 25 with proposed dates for the meeting. Should you have any questions, please contact Michael Kaufman, Staff Attorney at the ACLU of Southern California at mkaufman@aclusocal.org or (213) 977-5232 or Christina Fialho, Co-Executive Director of Community Initiatives for Visiting Immigrants in Confinement (CIVIC) at CFialho@endisolation.org or 385-212-4842.

Sincerely,

ACLU of Southern California
American Immigration Lawyers Association, Southern California Chapter CARACEN
Community Initiatives for Visiting Immigrants in Confinement (CIVIC)
Defund Detention in Adelanto
National Day Labor Organizing Network
National Immigration Law Center
Public Counsel
Public Law Center
USC Gould School of Law, Immigration Clinic

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¹² While ICE conducts routine compliance inspections at the facility, it is clear that more robust oversight is urgently needed. Those reviews have failed to adequately investigate GEO's medical care practices and overlooked the serious systemic problems at the facility.

CC:

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