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May 15, 2008

The Honorable Michael Chertoff
Secretary
U.S. Department of Homeland Security
Washington, DC 20528

Dear Secretary Chertoff:

On May 11, 2008, the Washington Post published the first article ("System of Neglect") in a four-part series concerning the newspaper's investigation into the provision of medical care at immigration detention facilities across the country. According to the article, "[t]he investigation found a hidden world of flawed medical judgments, faulty administrative practices, neglectful guards, ill-trained technicians, sloppy record-keeping, lost medical files and dangerous staff shortages." The article stated that poor medical care may have contributed to the deaths of at least 30 detainees in the custody of Immigration and Customs Enforcement (ICE), and there is evidence that infectious diseases such as tuberculosis and chicken pox are spreading inside ICE detention facilities.

According to the Post, its investigation was based in part on "thousands of pages of government documents," including "autopsy and medical records, investigative reports, notes, internal e-mails, and memorandums." A review of a small selection of these documents, which have been posted on the newspaper's website, is of great concern to us. Among other things, they indicate that immigration detainees are receiving sub-standard medical care and that your department has failed to address complaints and concerns from detainees and on-site medical care providers.

Given these concerns, we request that you provide to us, within 5 days of the date of this letter, complete and unredacted copies of all documents submitted to the Washington Post relating to the provision of medical and mental health care to immigration detainees. In addition, we request that you provide to us, within 14 days of the date of this letter, the following documents:

1. Any and all documents (including, but not limited to, medical records, requests for medical or mental health care, treatment authorization requests, grievances,

correspondence, e-mails, memoranda, notes, field guidance, incident reports, internal investigations, case summaries, autopsy reports, and death certificates) relating to detainees who have died in ICE custody since October 1, 2002.

2. Any and all Immigration and Customs Enforcement (ICE) and Division of Immigration Health Services (DIHS) policies, protocols and procedures regarding the delivery or withholding of medical and mental health care to detainees in ICE custody, including, but not limited to, the use of Treatment Authorization Requests (TARs) and the factors to be considered in deciding whether to grant or deny such requests.

3. Any and all documents (including, but not limited to, complaints, grievances, correspondence, e-mails, memoranda, notes, and field guidance) relating to concerns or complaints by ICE or DIHS employees or contractors, detainees in ICE custody, or persons advocating on their behalf, regarding the provision or withholding of medical or mental health care to detainees in ICE custody.

4. Any and all documents (including, but not limited to, reports, assessments, analyses, reviews, audits, correspondence, e-mails, memoranda, notes, and field guidance) relating to the costs and savings associated with the provision or withholding of medical and mental health care to detainees in ICE custody.

5. Any and all documents (including, but not limited to, reports, assessments, analyses, reviews, audits, correspondence, e-mails, memoranda, notes, and field guidance) relating to any investigations or evaluations of medical or mental health care provided to detainees in ICE custody.

6. Any and all documents (including, but not limited to, reports, assessments, analyses, reviews, audits, correspondence, e-mails, memoranda, notes, and field guidance) relating to medical staffing levels—including, but not limited to, that of physicians, psychiatrists, psychologists, pharmacists, dentists, mid-level providers, nurses, social workers and other staff—at facilities used to hold detainees in ICE custody.

7. A detailed explanation of the annual expenditures by ICE and DIHS relating to the provision of medical and mental health care to detainees in ICE custody from FY 2001 to FY 2007.

Additionally, we have concerns over an ICE-disseminated "Fact Sheet," entitled "Mortality Rates at ICE Detention Facilities." *Attached as Appendix A.* We are particularly concerned about the validity of ICE's claim that "[t]he number of deaths per 100,000 is dramatically lower for ICE detainees than for U.S. prisons and jails and the general U.S. population as a whole." It is our understanding that ICE's figures do not account for age, length

of time in detention, or other factors necessary to make accurate comparisons. *See Letter from New York University School of Medicine, attached as Appendix B.* For example, without standardizing length of detention, ICE could detain 300,000 people per year for one day each and compare their crude death rates to a prison population of 300,000 people detained for a full year. Such comparisons are meaningless. Consequently, we ask that you also provide for fiscal years 2003 through 2007 a detailed explanation, with supporting data, of:

8. the morbidity rate of detainees in ICE custody;

9 the mortality rate of detainees in ICE custody (expressed as x number of deaths per 100,000 detainees per full year of detention);

10. the morbidity and mortality rates of detainees in ICE custody, factoring in length of time in custody (0-60 days, 61-120 days; 121-180 days; 181-240 days, etcetera up to five years.);

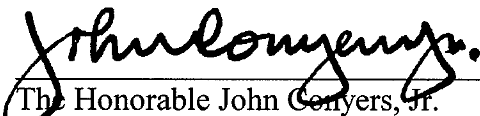
11. the morbidity and mortality rates of detainees in ICE custody, adjusted for age of the detainees (0-18 years, 19-25 years, 26-30 years, 31-35 years, etcetera up to 100 years of age);

12. the morbidity and mortality rates of detainees in ICE custody, adjusted for age of the detainees and for disease prevalence and incidence;

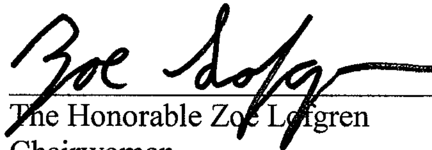
With respect to the documents and information requested above, "detainees in ICE custody" shall mean all persons in ICE custody under U.S. immigration law, regardless of whether the relevant detention facility is operated by ICE or by another entity through a contract or other agreement. With respect to documents requested in items 1 through 6, please provide all documents from October 1, 2002 to the present.

Thank you for your immediate consideration of this very important matter.

Sincerely,



The Honorable John Conyers, Jr.
Chairman
Committee on the Judiciary



The Honorable Zoe Lofgren
Chairwoman
Subcommittee on Immigration, Citizenship, Refugees, Border Security, & International Law

cc: The Honorable Lamar Smith
The Honorable Steve King
Assistant Secretary Julie Myers

Office of Public Affairs
U.S. Department of Homeland Security

U.S. Immigration and Customs Enforcement

Fact Sheet

May 2008
Contact: ICE Public Affairs
(202) 514-2648

Mortality Rates at ICE Detention Facilities

U.S. Immigration and Customs Enforcement, Office of Detention and Removal (DRO) takes great care to ensure the safety and well being for each of the hundreds of thousands of individuals who come through our detention facilities each year. ICE has put processes in place with the U.S. Public Health Service, Division of Immigration Health Services (DIHS) medical professionals to provide care for all those detained, including those who may encounter a medical emergency while in custody. Though the ICE detainee population has increased by more than 30% since 2004, the mortality rate has actually declined. The number of deaths per 100,000 is dramatically lower for ICE detainees than for U.S. prisons and jails and the general U.S. population as a whole.

Detainee deaths over the past five years, showing the relative decline as a percentage of total detained population for the same time period

Calendar Year	Death Frequency
2004	29
2005	15
2006	16
2007	7
2008 (To Date May 2, 2008)	4
Total	**71**

Detainee Population and Detainee Deaths

DRO Detainee Populations; Detainee Deaths

Fiscal Year	Population
2004	231,804
2005	234,198
2006	254,383
2007	311,213

Fiscal Year	Deaths
2004	25
2005	16
2006	17
2007	11

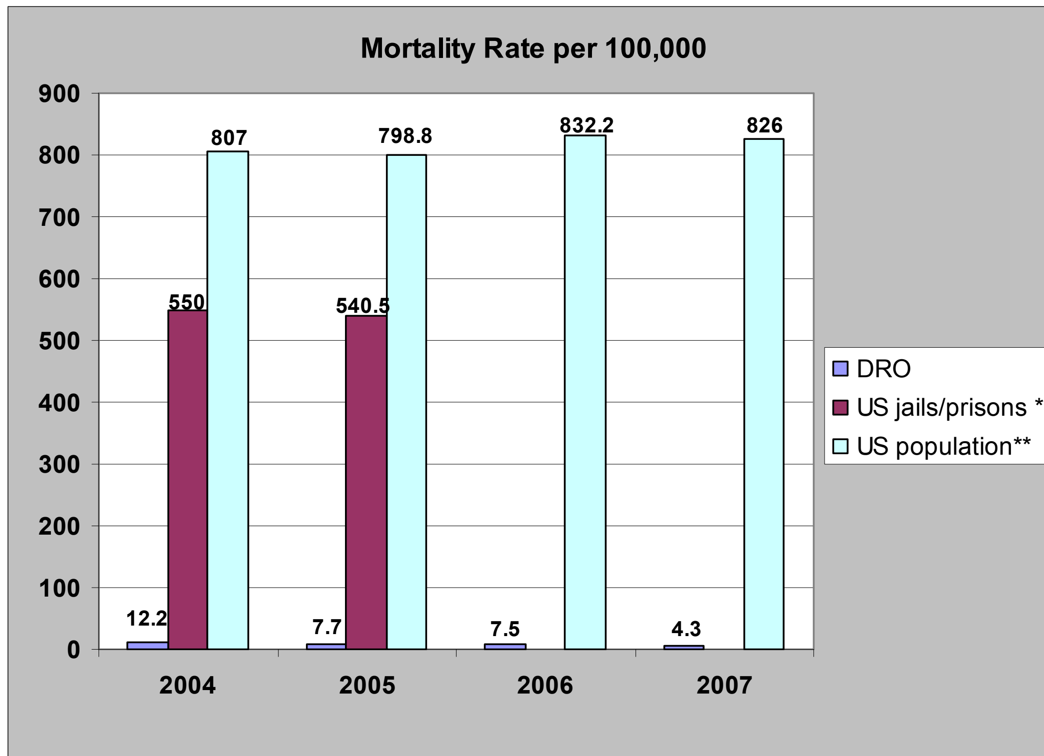
Comparison of spending on detainee medical services over the past five years

Note: *In FY 2001-2003 under Legacy INS, costs to operate the health care program and pay community service providers for*

FISCAL YEAR	PROGRAM OPERATIONS	MEDICAL CLAIMS	TOTAL
2001*	$ 55,493,356	$ -	$ **55,493,356**
2002*	$ 56,608,879	$ -	$ **56,608,879**
2003*	$ 30,065,834	$ 20,000,000	$ **50,065,834**
2004	$ 33,851,607	$ 40,443,028	$ **74,294,635**
2005	$ 39,777,000	$ 30,672,928	$ **70,449,928**
2006	$ 43,310,792	$ 30,301,850	$ **73,612,642**
2007	$ 60,900,000	$ 30,714,307	$ **91,614,307**
TOTAL	$ **320,007,468**	$ **152,132,113**	$ **472,139,581**

detainee claims were combined in the Operations and Maintenance budget. The Veterans Administration/Financial Services Center began servicing ICE during the mid-point of FY 2003.

Comparison of death rates in ICE custody with those of other U.S. prisons, jail systems



ICE/DRO sites showed estimated death rates per 100,000 detainees for fiscal years 2004, 2005, 2006 and 2007 are 12.2, 7.7, 7.5, and 4.3, respectively.

In comparison, according to Bureau of Justice Statistics, other U.S. prisons and jails statistics have reflected that for calendar years 2004 and 2005, its detainees in prisons and jails showed estimated death rates per 100,000 detainees are 550 and 540.5, respectively; in the general U.S. population, estimated age-adjusted death rates per 100,000 population for calendar years 2004, 2005, 2006, and 2007 are 801, 798.8, 832.2, and 826, respectively.

The implication is that while the ICE detainee population has increase by more than 30% since 2004, the mortality rate has actually declined. The number of deaths per 100,000 is dramatically lower for ICE detainees than for the population is U.S. prisons and jails and the general public as a whole.

DIHS health care numbers for fiscal year 2007

In fiscal year (FY) 2007, DIHS staff had 711,719 detainee visits (a 45% increase over FY 06).

These visits included:

- 16,885 dental visits
- 23,224 mental health visits
- 56,828 short stay unit visits
- 190,883 chronic disease visits
- 87,017 physical exams
- 97, 620 sick call visits and
- 703,319 pill line distributions

DIHS also completed 131,792 chest X-rays during intake screening

DIHS filled 210,182 prescriptions

There were 967 hospital admissions (about a 108% increase from that of FY06)

Additional breakdown of chronic disease-related visits:

- 6,264 hypertension
- 3.614 diabetes
- 1,521 TB/INH
- 1,302 asthma
- 565 HIV/AIDS
- 559 seizure

To address the needs of the growing number of detainees, the psychologists and social workers of DIHS have provided 31,697 different types of psychological services and/or patient contacts that impact detainees in a positive manner.

In the last 12 months, DIHS psychologists and social workers have been successful in managing a daily population of between 1,350 to 2,160 detainees with serious mental illnesses. In that time frame, there have been no suicides.

BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE

New York University School of Medicine

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Response to Immigration and Customs Enforcement Fact Sheet on Detainee Deaths

Homer D. Venters, M.D., Allen S. Keller, M.D.

May 12, 2008

The following points represent a critical appraisal of the Fact Sheet released by Immigration and Customs Enforcement (ICE) dated May 2008 which pertains to detainee deaths. We are concerned this Fact Sheet has a number of shortcomings in its assessment of the quality of its own system of health care.

1. Mortality is a poor method to determine health and healthcare delivery in a transitional population. Because death is rare and detention is short (usually < 1 year), mortality will under-represent problems with health care delivery among ICE detainees. Morbidity is a better measure of the efficacy of ICE healthcare since by ICE estimates (testimony by Gary Mead); at least 25% of detainees suffer from chronic diseases such as diabetes and hypertension. Consequently, complications from poorly controlled chronic disease, such as diabetes or hypertension are types of measures that are more sensitive.

2. The ICE fact sheet is titled 'Mortality Rates at ICE detention Facilities' but it presents crude death rate, not a true mortality rate. A genuine measure of mortality rate would be presented as x number of deaths per 100,000 detainees per year of detention. This allows standardization across length of detention. Without this standardization, ICE could detain 300,000 people per year for one day each and compare their crude death rates to a prison population of 300,000 people detained for a full year. Such a comparison is meaningless.

3. In addition to lacking standardization, comparison of ICE detainees to prisoner populations are problematic because prisoners are incarcerated for much longer periods of time than ICE detainees are held. Prison research has shown that mortality rates increase with time of incarceration. For instance, the DOJ report on medical causes of death in state prisons (NCJ 216340, 2007) found that the age adjusted mortality rate of prisoners who had served more than 5 years was triple that of prisoners incarcerated for less than 5 years. For heart disease, the single greatest cause of death in this population, mortality was 47 per 100,000 in the < 5 year group and 150 per 100,000 in the > 10 year group. Here, 'mortality rate' is an appropriate term since most prisoners are incarcerated for the full 12 months of any given year.

4. Comparison of crude death rates among ICE detainees to population mortality rates for other groups is confusing without adjustment for age and burden of disease. This is generally accomplished using standardized mortality rates where death rates are adjusted for age (greater in the general population) or disease prevalence and incidence (greater in both the general population and definitely the prison population). On page 3 of the ICE document, ICE and prison death rates are presented alongside 'age adjusted' data for the U.S. population. No information is provided about what age stratum of the U.S. population this is and no mention is made of any age adjustment for the ICE or prisoner data, which unless they are coincidentally that same cannot be accurately compared.

5. If the quality of ICE healthcare is at issue, then even morbidity may under-represent adverse effects of this system. As with mortality, shorter detentions will tend to produce fewer adverse events, Given acceleration of expedited removal and accompanying shortening of average length of detention, one would expect a decrease in the crude death rate (number of detainees who die per 100,000) without a any change in mortality rate (number of detainees who die per standardized years of detention). As the subject of interest becomes shorter over time (such as shortening length of detention), the standard epidemiologic response is to look afterwards, at both short and long term mortality and morbidity. For instance, a NEJM article last year reported a dramatic increase in mortality among prisoners within the first 2 weeks of their release. The ICE system is quite different but as detention time shortens, the likelihood is that adverse events caused by the system will occur afterwards.

6. ICE has made the argument that sufficient care is provided to detainees based on the expenditure of $100 million annually and the delivery of a certain number of visits and procedures. These figures are difficult to asses without comparison. For example, when compared to Rikers Island Jail in New York City, which has an annual and daily census roughly ½ that of ICE, approximately the same is spent on health care by each institution for their detainees. Unlike ICE, Rikers is able to provide mammograms, pap smears and other standard health screening. The Fact sheet also shows an increase in

spending by ICE on medical care. Was the increase in proportion with the marked increase of individuals in detention (correcting for inflation as well)? Furthermore, what proportion of this is spent on direct care?

7. There is no information provided about the number of mental health or dental visits in terms of follow up versus initial visit. For mental health, what % of visits were for ongoing counseling/care and what % of patients responded to therapies or interventions?

8. Regarding the number of sick call visits, this doesn't provide information about whether or not there was a delay from when the request was made until the individual was seen (which was an important concern in the death reported in the New York Times Article where the individual died from an intracranial bleed.) Furthermore, this case also highlights concerns previously raised about the misuse of segregation in a 2003 report "From Persecution to Prison: The Health Consequences of Detention for Asylum Seekers." (Physicians for Human Rights, Bellevue/NYU Program for Survivors of Torture: available at www.phrusa.org). The individual was agitated/confused and later unresponsive. Rather than receiving a thorough neurologic evaluation, he was put in segregation which led to delay in his care.

9. The ICE fact sheet mentions that no suicides occurred in the past 12 months. What was the incidence of previous suicides? In the 2003 PHR/Bellevue-NYU Report, there were documented instances in which detainees would not report suicidal thoughts or other depressive symptoms for fear of segregation.

Please do not hesitate to contact us with questions about this subject.

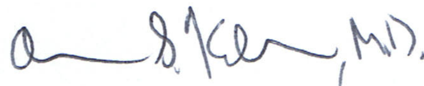
Sincerely,

Homer D. Venters, M.D.

Attending Physician, Bellevue/NYU Program for Survivors of Torture

Public Health Research Fellow, U.S. Centers for Disease Control

e-mail: Homer.Venters@nyumc.org



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