March 3, 2021

Katherine Culliton-Gonzalez
Office of Civil Rights and Civil Liberties
Department of Homeland Security

Joseph Cuffari
Inspector General
Department of Homeland Security

VIA EMAIL crcl@dhs.gov; dhs-oig.officepublicaffairs@oig.dhs.gov

RE: Discriminatory Practices and Deliberate Indifference Related to the Prenatal, Maternal, Gynecological, and Pediatric Medical Needs of Detained Black Women and Young Children at the Karnes County Family Residential Center.

Dear Ms. Culliton-Gonzalez and Mr. Cuffari:

This complaint is filed by RAICES and its partners, the Haitian Bridge Alliance, the Cameroon American Council, and UndocuBlack Network, on behalf of families RAICES has represented during their detention at the Karnes County Residential Center in Karnes City, Texas (“Karnes Family Prison” or “Karnes”) between February 2020 and February 2021.

Since Immigration and Customs Enforcement (“ICE”) began to detain nuclear family units at Karnes in February 2020, RAICES observed several troubling changes in the demographics of the family population at Karnes: 1) an increase in the number of detained pregnant women, particularly women in late stages of pregnancy, even since the start of the COVID-19 pandemic; 2) a disproportionate spike in the number of Black families detained; and 3) an increased number of infants under 1 year, toddlers 1-3 years old, and young children (5 years and under) in detention.

Since February 18, 2020, ICE has detained approximately 43 pregnant women at Karnes, 34 of whom were Black women from Haiti or countries in Africa, including Angola, Cameroon, The Democratic Republic of the Congo, Ghana, and Sierra Leone. On average, the Department of Homeland Security (“DHS”) detained these Black pregnant women for 22 days, and other pregnant women for 20 days. The two pregnant women who ICE detained for the longest period of time were Black Haitian women; one woman who was 8 months pregnant was detained for over 38 days, and another pregnant woman was detained 39 days.

Similarly, since February 18, 2020, ICE has detained approximately 320 young children under 5

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1 Prior to February, 2020, women had not been detained at Karnes since September 2019, and family units with mothers had not been detained at Karnes since July 2018.

2 Tens of other women reported that they had missed periods but had not received results from pregnancy tests, nor alternative explanations or medical attention regarding what else may have caused their menstrual irregularity.
years of age at Karnes. On average, DHS imprisoned these infants, toddlers and young children in its custody for 37 days. Overall, at least 65% of families detained at Karnes were Black families from Haiti and nations in Africa. Given the ambiguities of transnational racial categorizations, these numbers may not capture the full scope of anti-Black racism experienced by families at Karnes.

Since ICE began to detain nuclear families at the Karnes family prison, RAICES has encountered an alarming number of Black families who report that they received wholly substandard medical care while in DHS custody and at Karnes. RAICES has observed, in particular, a pattern of discriminatory practices and deliberate indifference related to the prenatal, maternal, gynecological, and pediatric medical needs of detained Black women and young children at Karnes. Medical care at Karnes is provided by the independent contractor GEO Group (“GEO”). DHS and its private contractors are legally obligated to provide adequate medical care to all individuals in custody and to prevent discriminatory treatment. Based on the information available to RAICES, there has never been an obstetrician-gynecologist (“OBGYN”) at Karnes, although ICE imprisoned women and children there between 2014-2018, and again imprisoned adult women without children between April and September 2019. This complaint outlines 7 specific examples out of the countless experiences that demonstrate these patterns, and makes specific requests for investigation and an adherence to the policies favoring release and the administration of adequate and legally required medical care. The specific cases within this complaint are supported by the attached declarations, including the declaration of Dr. LaTasha Nelson, a board-certified Obstetrician Gynecologist with a board-certified sub-specialty in Maternal Fetal Medicine. See Exh. 1 Declaration of Dr. LaTasha Nelson at 1. Dr. Nelson identified, “a concerning pattern of indifferent treatment...as well as multiple accounts of poor living conditions and substandard medical care.” Id.

The standard of medical care provided at Karnes by the GEO Group does not meet the minimum standard required of ICE pursuant to its constitutional legal obligations, and those under the Flores Settlement Agreement, the Family Residential Standards, governing regulations, and orders from federal judges under cases including Fraihat v. Immigration and Customs Enforcement. Karnes, like other ICE immigration prisons, has a history of inadequate medical treatment that cannot be ignored and which has repeatedly been brought to the attention of both ICE officials at Karnes and to your office. Recent reports

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3 Throughout this complaint, the term “infant” refers to a child up to the age of one year; “toddler” refers to a child between the ages of 1 year and 3 years; and “young child” refers to any child under the age of 5.
4 Specific countries of origin included: Angola, Congo, Cameroon, Democratic Republic of the Congo, Ghana, Nigeria, Sierra Leone.
5 Although this complaint focuses on the circumstances at Karnes since February 18, 2020, RAICES is aware of a history of medical neglect at Karnes. For example, when adult women were imprisoned at Karnes in 2019, at least 15% reported receiving no treatment or insufficient treatment for medical concerns, where 44% of the 820 reported medical concerns were for severe medical issues. 72 of the medical issues reported to RAICES related to OBGYN care, and women received inadequate treatment at least 26% of the time for OBGYN concerns. Major OBGYN medical issues included examples of lack of attention for ovarian cysts, lack of attention to severe bleeding after having suffered a miscarriage, and lack of care for ongoing gynecological issues resultant from sexual assault, among other non-gynecological concerns. RAICES also received ongoing reports of inadequate medical care from women detained at Karnes with their children from 2014-2018. Complaints regarding medical care did not dissipate during the times in which adult men and their sons were detained at Karnes.
6 https://www.aila.org/advo-media/press-releases/2015/deplorable-medical-treatment-at-fam-detention-ctrs/public-version-of-complaint-to-crcl. This complaint documented specific failings in the provision of medical care at the three ICE family prisons, including: (1) instances of medical professionals at the ICE family prisons providing “insufficient information about medical care to mothers and disregard [for] their concerns, the information they
about ICE prisons in Georgia unveil a pattern of medical negligence including subjecting women with similar conditions to those described here to forced hysterectomies. Investigations by CRCL experts have further revealed serious deficiencies resulting in harm to those detained in immigrant family detention. The examples below illustrate that the care at Karnes is part of an overarching pattern of medical neglect for those in DHS custody.

I. Detention Exacerbates and Illuminates the Systemic Anti-Black Racism and Discrimination Inherent in the United States Health Care System

A. In and Out of Detention, Black Women and Children Face Systemic Barriers to Access Adequate Health Care due to Racial Bias Discrimination, with Grave and even Fatal Repercussions

It is well documented that Black people in the United States encounter deliberately restricted access and outright denial of access to health care on account of their race. This disparate treatment is particularly alarming in regards to prenatal and maternal care, and the medical care of Black women and children generally. Racial disparities in pregnancy-related deaths and infant mortality rates are well documented and long-standing truths in the American healthcare system. According to 2019 research published by the Centers for Disease Control (CDC), “Black, American Indian, and Alaska Native women are two to three more times likely to die from pregnancy-related causes than white women.” These infant and pregnancy-related mortality rates sadly shed light on how racism heavily influences medical outcomes.

These disparities have not and do not continue to occur in a vacuum. They are the direct result of long-standing, systemic racism in American society. Sociological studies have found “[t]he sources of these [healthcare] disparities [to be] complex[,] [and] rooted in historic and contemporary inequities.” In addition to disparities in access to affordable health care and medication, bias against minorities and stereotyping on the part of healthcare professionals may negatively interfere in the proper diagnosis and provide and their complaints”; (2) descriptions of “[m]edical staff frequently direct[ing] mothers and children to ‘drink more water’ regardless of the illnesses or injuries presented”; (3) reports that families were made to wait between three to fourteen hours for medical care; and (4) examples of inadequate follow-up treatment. Id. at 1–2.

10 The wide disparity between white and Black rates of infant mortality has been documented since at least 1850, and has only worsened. Linda Villarosa, Why America’s Black Mothers and Babies Are a Life-or-Death Crisis, NY Times (April 11, 2018), available at https://www.nytimes.com/2018/04/11/magazine/black-mothers-babies-death-maternal-mortality.html. In 2018, Black infants in the U.S. were twice as likely to die than white infants. Id. Considering socio-economic status or education levels does nothing to bridge this gap: in fact, a “[B]lack woman with an advanced degree is more likely to lose her baby than a white woman with less than an eighth-grade education.” Id.
treatment of Black patients. Realities of the clinical process only exacerbate the impact of these negative stereotypes. Healthcare professionals often make decisions regarding diagnoses and treatments under tight time limits and with limited access to resources, leading to an over-reliance on stereotypes that can result in negative outcomes and deficient medical treatment. Medical staff and administrators at Karnes are not immune to these realities.

B. The Risks Associated with Inadequate Medical Care for Black Women and Children are Heightened Given the Ongoing Detention of Immigrants During the COVID-19 Pandemic

The COVID-19 pandemic has only heightened concerns about the poor baseline medical care administered within ICE prisons. In March 2020, John Sandweg, former acting director of ICE, joined other advocates in calling for ICE to release all individuals in immigration detention, citing that social distancing and other virus-spreading prevention measures were nearly impossible to implement in detention facilities. Mr. Sandweg emphasized that detention is entirely discretionary in nature and the only way to promote public health and safety would be for DHS to exercise that discretion and release all individuals in its custody. Id. Medical professionals agree with Mr. Sandweg’s assessment. Also in March 2020, a group of medical professionals from the New York Lawyers for the Public Interest Medical Providers Network and Doctors for Camp Closure sent an open letter to ICE encouraging the release of all individuals and families in immigration detention. The letter highlighted how conditions inherent to ICE prisons exacerbate the risks of an already highly contagious virus like COVID-19.

These predictable risks are playing out in real time inside immigration prisons across the country. According to data published by ICE, as of February 11, 2021, there have been 9, 411 confirmed cases of COVID-19 in ICE custody across the country. Karnes has seen 103 confirmed cases since February 2020. Id. ICE has confirmed nine COVID-19 related deaths in its prisons. Id.

The COVID-19 pandemic has only further exacerbated the risks of inadequate medical care for Black mothers and young children detained at Karnes. Aside from the risk of severe illness from

12 For example, studies have shown, after controlling for other demographic factors and medical history, “physicians viewed [B]lack patients, compared with whites, as less kind, congenial, intelligent, and educated, less likely to adhere to medical advice, and more likely to lack social support and to abuse alcohol and drugs.” Understanding Racial and Ethnic Differences in Health in Late Life, available at https://www.ncbi.nlm.nih.gov/books/NBK24692/pdf/Bookshelf_NBK24692.pdf. In addition, racist tropes like the myth of the “bad Black mother” have shaped modern-day health policies and institutions. From the time of slavery forward, Black mothers have been unfairly cast as poor parents and caretakers as a way to explain disproportionately high Black infant mortality rates. For example, nineteenth century census data shows that the deaths of Black infants were often erroneously blamed on the “carelessness” of Black mothers. One writer in the nineteenth century went as far as to baselessly claim that infanticide in the Black community was so commonplace, it was not even considered a crime. Racist tropes like this help promulgate the historical bias against Black patients in the American healthcare system. Dorothy E. Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty 58 (1999).


COVID-19 faced by anyone held in a congregate setting, pregnant women may be at an even higher risk for severe illness compared to the rest of the detained population. Infection by COVID-19 may result in an increased risk for pregnancy-related complications, like preterm birth. Young children may also be at an increased risk for severe illness from COVID-19 because of their immature immune systems. CDC data and numerous reports demonstrate that Black mothers and young children are disproportionately impacted by severe illness related to COVID-19, and that Black children are more likely to be hospitalized for COVID-19 than children of other races. Black people have died at 1.4 times the rate of white people, based on data tracked through February 17, 2021.

II. Since ICE Began to Detain Nuclear Families at Karnes in February 2020, Cases of Medical Neglect of Black Women and Young Children Have Increased

Prenatal, maternal, gynecological, and pediatric care for Black families at Karnes is wholly inadequate. It cannot be overemphasized that the effects of detention are long-lasting, and that when experienced by pregnant women, the effects are compounded. As stated by Dr. Nelson, “any condition that negatively impacts an expecting mother also impacts her developing baby.” See Nelson Decl. at 2. The following constitute only a handful of examples of Black women and young children who have reported receiving discriminatory and inadequate medical care at Karnes. Instances of complaints of substandard medical care by Black families seem to have surpassed the occasional incident, and in recent months have become an alarming pattern of behavior at Karnes. Based on the experiences of the following families, medical care at Karnes can only be described as negligent at best. Karnes medical staff has shown a pattern of indifference to the health complaints and needs of Black mothers and young children, even when the medical needs are severe and potentially life-threatening. These disparities are of particular concern given the increase in numbers of detained pregnant mothers and young children in recent months, and the increase in family units in restrictive Title 42 proceedings. Across the board,

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20 The DHS has expelled families under Title 42 of the U.S. Code since March 21, 2020 and detained family units in Title 42 proceedings at Karnes since approximately July 1, 2020. In Response to a September 4, 2020, order from Federal Judge Dolly Gee in Flores v. Barr, which prohibited the detention of minors in hotels, beginning on approximately October 22, 2020, ICE began to use the Karnes family prison as a central staging ground for Title 42 expulsions of family units. Flores v. Barr, CV 85-4544-DMG (AGRx), Dkt. No: 976 at 17 (C.D. Cal Sept. 4, 2020). The DHS is of the position that individuals and families, including children, in Title 42 proceedings do not have a right to counsel, and implemented restrictive legal visitation policies which minimized access to counsel for families.
these women are not Spanish-speakers and they report inconsistent use of interpreters when speaking with medical staff—including one example below where an interpreter was never used, thus severely diminishing basic access to care. Nearly all of these women had sponsors ready and willing to receive them and assist in their care.

All stories shared below relate to clients who are no longer detained. RAICES and its clients made attempts to access the medical records of pregnant women and young children, including those in this complaint. However, ICE did not provide medical records for nearly all of the cases below, despite an attempt to obtain them by FOIA. See Exh. 10. This in itself reflects the inadequacy of care at Karnes. As noted by Dr. Nelson, “having complete medical records helps ensure continuity of care,” and a lack of access to such records may produce a significant delay in treatment.

A. [Redacted] A# [Redacted] A two-months pregnant Black mother with rheumatism was found unresponsive in her room.

[Redacted] a mother from Ghana, was detained at Karnes for 25 days. See Exh. 2 Declaration of [Redacted]. She was in the first trimester of pregnancy and also breastfeeding a one-year-old infant while detained. She experienced a flare up of her rheumatism at Karnes and at one point was found unresponsive in her room, leading to the family being placed in the medical center for nearly three weeks [Redacted]'s infant was with her unresponsive mother for an unknown period of time, until the family was taken to the medical center where [Redacted]'s husband was with them.

[Redacted] was never provided an interpreter in her language while at Karnes and thus lacked communication with staff in the medical center. She repeatedly had blood drawn and tests performed on her for unknown reasons—at one point, she described having blood drawn on a daily basis without explanation. When RAICES wrote to request the release of this family based on Fraihat and Flores, ICE failed to respond to medical concerns and instead explained the status of the family’s immigration case. See Exh. 3. The family remained detained for approximately three weeks after this exchange.

B. [Redacted] A# [Redacted]. A Black mother suffered a miscarriage in custody and was never provided adequate follow-up medical care at Karnes.

[Redacted] a mother from Ghana detained at Karnes, suffered a miscarriage a few days after entering the U.S. and never received needed follow-up medical care. See Exh. 4, Declaration of [Redacted].

When [Redacted] entered the United States she was about three-months pregnant and immediately reported her medical status to CBP. [Redacted] reported feeling very stressed by the abhorrent conditions in CBP custody. A few days after she was taken into CBP custody, [Redacted] began bleeding and experiencing severe headaches. On or around July 30, 2020, [Redacted]'s pain became so severe CBP officers took her to a hospital where doctors conducted tests and scans. A doctor told [Redacted] she was having a miscarriage and there was nothing they could do, aside from giving her medication for her pain. Despite this physically

at Karnes. This has negatively impacted RAICES’ ability to provide free legal services to detained families under a universal representation model. Meanwhile, ICE’s own reporting indicates that more families than RAICES has been in contact with are detained at Karnes. See ICE Juvenile Coordinator Report, Flores v. Barr, CV 85-4544-DMG (AGRx), Dkt. No: 976 at 17 (C.D. Cal Nov. 16, 2020) Therefore, since March 21, 2020 and especially since October 22, 2020, there may have been additional families not included in this complaint affected by race-based medical neglect including pregnant women and infants.
and emotionally traumatic event, [redacted] was immediately returned into CBP custody. A doctor checked on [redacted] daily and told her her continued bleeding was a normal side effect of a miscarriage, despite [redacted]'s reports of continued extreme pain. A few days later, officers returned [redacted] to a hospital. The doctors at the hospital, again, only provided [redacted] pain medication. Despite her medical condition, and the fact that she was still experiencing extreme pain, [redacted] was then transferred to Karnes.

Once at Karnes, [redacted] reported feeling movement in her stomach and continuing to experience heavy bleeding and debilitating pain. Her prolonged complications never prompted medical providers to identify that [redacted] needed specialty medical care. The Karnes medical staff only provided [redacted] pain medication but told her the facility did not have access to the machine needed to properly examine her. They told her they would facilitate an outside medical appointment for her, but after a week of waiting, she never received any follow-up information. [redacted] remained in detention without explanation. Throughout her detention at Karnes, [redacted] cared for her 16 month old child alone because the facility held her separately from her husband, who was detained in solitary confinement. [redacted] her husband, and her 16 month old child were detained in DHS custody for 19 days.

C. A 1-year-old Black child diagnosed with neonatal asphyxia was never seen by a specialist or provided needed medical care.

A one-year old Black child with severe neurological issues, suffered major complications from her pre-existing respiratory condition while detained at Karnes during a COVID-19 outbreak. See Exh. 5. Declaration of [redacted].

During birth, [redacted] was deprived of oxygen because the umbilical cord was wrapped around her neck, resulting in a diagnosis of neonatal asphyxia. As a newborn, [redacted] spent time in intensive care and on oxygen because of these birth complications. [redacted] regularly went to follow-up appointments with a neurologist in her home country, who monitored her development and breathing. While detained at Karnes, [redacted]’s parents regularly reported to Karnes medical staff that she was ill. She often vomited and was unable to eat. No adequate alternate food was provided by Karnes staff for [redacted]. Despite [redacted]’s parents’ immediate disclosure of all of this information to Karnes medical staff, including provision of their daughter’s prior medical records from their home country, no action was ever taken by Karnes staff to aid [redacted]. Medical staff promised the family that a specialist would examine [redacted] but she was never seen by a specialist, much less the needed neurologist. No doctor ever communicated to [redacted]’s parents about their daughter’s serious health condition. RAICES requested the release of [redacted] and her family given her condition, and made specific requests for the communication of medical information to the family, but to no avail. See Exhibit 6.

Once, [redacted]’s mother went to seek help from Karnes medical staff after her daughter began shaking and vomiting. [redacted] was given a saline drip. When [redacted]’s mother reported her daughter had again vomited and had difficulty breathing, Karnes medical staff insisted she was fine. Shortly after, [redacted] lost consciousness. Karnes medical staff called for an ambulance. Instead of providing [redacted]’s parents with information in their native language, an officer told [redacted]’s mother, in Spanish through her husband who only spoke minimal Spanish, that if she did not calm down they would not allow her to accompany her one-year old child to the hospital. [redacted]’s father was not allowed to accompany his wife and child to the hospital. Once at the hospital, no one communicated to [redacted]’s mother what tests were performed on her young daughter or what medications given to her in a language she could understand. [redacted]’s parents were not provided an explanation of what happened to their
daughter and to their knowledge, [redacted] did not see a specialist. [redacted] and her family were detained in DHS custody for 32 days before being deported without response to the family’s request for release from custody based on [redacted]’s urgent medical needs.

D. [redacted] (A# [redacted]). A 6-month-pregnant mother who reported abdominal pain, vertigo, back pain, and difficulty eating was threatened for voicing her medical needs and detained for over a month.

[redacted], a 6-month-pregnant mother, was detained for 35 days, although she had a sponsor ready and willing to receive her family. See Exh. 7 Declaration of [redacted] When [redacted] sought care for her back pain, abdominal pain, vertigo, and diarrhea, she was only given a vitamin and advice that she should, “not eat a lot.” [redacted] was furthermore threatened with reprisals for seeking care. [redacted] reported a doctor at Karnes told her not only that he could do nothing to help her, but threatened her with psychiatric isolation--he told her, that if she, “was crazy” and kept complaining about her symptoms, she would be placed, “where the crazy people are,” she would not see her children again, and she would be deported to the country from which she had fled. [redacted] was threatened not to speak out about the conditions she experienced at Karnes. [redacted] fell so ill from her pain during an immigration interview that she was taken to a doctor outside of the facility. She feared that she was not able to provide enough nourishment to her baby because of the insufficient food at the facility.

E. [redacted] (A# [redacted]). A 2-month pregnant woman with a history of eclampsia was hospitalized during her incarceration at Karnes.

[redacted], a 2-month pregnant woman who suffers from eclampsia, was detained for 19 days in January and February 2021, although she had a Lawful Permanent Resident sponsor ready and willing to receive her family. [redacted] experienced bleeding and was hospitalized in the community during the course of her detention, but no information was provided to her during her detention regarding the results of testing she underwent during her hospitalization. Some documents were provided to [redacted] upon her release from detention, which may include medical records, but because they are not in her language and no one explained them to her in her language, she is still not sure of the results of that testing. [redacted]’s eclampsia is concerning because she expressed a history of eclampsia with previous pregnancy. In her previous pregnancy, she suffered from seizures that would cause injuries to her jaw and mouth as well as limit her ability to eat. Her condition worsened while detained and she was detained within the medical unit at Karnes.

F. [redacted], (A# [redacted]). A 2-month pregnant mother was so ill that her five year old son sought medical care on her behalf.

[redacted], a 2-month pregnant mother detained for 16 days in January and February 2021, who stated that she felt, “terrible being pregnant at the detention center.” See Exh. 8 Declaration of [redacted] She felt dizziness, uneasiness, nausea. Her dizziness was so severe she reported that she had to lay down during phone calls with her lawyers. [redacted] expressed distress at being separated from her husband within the immigration prison. [redacted]’s 5-year-old sought medical attention for her one time when [redacted] was vomiting
severely. Her 5-year-old son brought her water, and when a guard finally arrived, his son reports that she walked around the room and left without providing any assistance to his mother. She also reported that the prenatal care she received at Karnes was limited to a vitamin, although she didn’t receive any explanation about the vitamin in her language. Medical staff at Karnes made her open her mouth when they provided the pill to her to make sure she swallowed it. She expressed concern that the conditions of detention are inappropriate for anyone, but that she should have received special care but that ICE and GEO did not provide it.

G. A 3-month pregnant woman could not eat, or sleep well at Karnes in part because the lights remained on through the night.

A 3-month pregnant mother detained in January and February 2021, remained in detention for 12 days. See Exh. 9 Declaration of reported that the only prenatal care she received at Karnes consisted of vitamins. She expressed that she felt uncomfortable while detained, that she needed medical attention for her baby’s abnormal and painful position in her abdomen, and that she had difficulty eating at Karnes. She reported troubling sleeping conditions at Karnes, because the lights were on at all times and she could not control the conditions. She reported that medical staff at Karnes spoke to her in Spanish, rather than her native Haitian Creole. She reported that officials at Karnes did not provide access to information regarding legal assistance, leaving families to share information among each other when they had rare access to one another. She reports that she witnessed ICE deport an 8-month pregnant woman.

III. As Evidenced Above, ICE Fails to Provide Legally Required Medical Care and Custody Review for Black Mothers and Young Children at Karnes

A. DHS fails to make appropriate custody determinations and ensure the provision of appropriate medical care to pregnant women and babies in its custody, as required by law.

The imprisonment of immigrants in DHS custody is always discretionary. As it relates to families, there is ample authority to support prompt release from DHS custody after families initially encounter immigration authorities. Absent a legally sufficient finding to support detention under the Flores Settlement Agreement (FSA), 8 C.F.R. § 1236.3, and Ms. L. v. U.S. Immigration & Customs Enforcement, ICE is required to quickly release the families that it has chosen to detain in its custody. While families remain in custody, ICE is obligated to provide adequate medical care in keeping with constitutional standards, the FSA, and its own Family Residential Standards (FRS).

The FRS mandates a baseline of medical care for all detained families that includes: initial screenings, pregnancy tests, comprehensive routine and preventative care, emergency care, specialty care, timely responses to complaints, and hospitalization as needed, all conducted in the appropriate language. See FRS 4.3, Health Care, Expected Practices (2020). Furthermore, the FRS also prescribes special health care standards for women and pregnant individuals in ICE custody. See FRS 4.4 Health Care (Females) (2020). Specifically, for example, medical staff are required to provide access to:
Pregnancy services, including pregnancy testing, routine or specialized prenatal care, postpartum follow-up, lactation services, and abortion services.

- Counseling and assistance for pregnant women in keeping with their express desires in planning for their pregnancy, whether they desire abortion, adoptive services, or to keep the child; and

- Routine, age-appropriate, gynecological health care services, including offering women’s specific preventative care.

FRS 4.4 Health Care (Females) at Expected Practices. All pregnant individuals should be given medical supervision, such as access to prenatal and specialized care, nutrition counseling, exercise counseling, pregnancy complication counseling, prenatal vitamins, delivery and labor counseling, postpartum care, lactation counseling, family planning counseling, and abortion access. Id. Those identified as having a high-risk pregnancy or complication should be referred to a physician specializing in high-risk pregnancies. Id. The FRS requires that the ICE Field Office Director must be notified within 72 hours of a determination that an individual is pregnant. FRS 4.3 at Notice of Residents with Serious Illnesses and Other Specified Conditions.

Under the FSA, ICE is required to provide “safe and sanitary” conditions for children, which must be, “consistent with [ICE]’s concern for the particular vulnerability of minors.” FSA, ¶ 12A. Minimum standards under the FSA also require appropriate routine and emergency medical care. FSA, Exhibit 1 (Minimum Standards for Licensed Programs). United States District Judge Dolly Gee, reviewing detention conditions in April 2020, stated that Flores plaintiffs had, “raised significant concerns by a preponderance of the evidence about each [Family Residential Center’s] ability to provide safe and sanitary conditions.” Flores v. Barr, No. CV 85-4544-DMG (AGRx), Dkt. No. 833 at 3 (C.D. Cal. Apr. 24, 2020). Throughout 2020, Judge Gee consistently found ICE not in compliance with the FSA’s mandate to provide safe and sanitary conditions and meet minimum standards.

In addition to the general health care standards applicable to all individuals in ICE custody, the FRS mandates specialized procedures for children 10 years of age or younger. Each minor child 10 years of age and under is required to be enrolled in a “Well Baby” or “Well Child” clinic. FRS 4.3 at Special Provisions for Health Care of Children. At prescribed regular developmental milestones, beginning with an initial intake visit, members of the medical staff should evaluate young children for appropriate developmental progress. Specifically, these evaluations should take place at: 2-4 weeks of age; 2 months old; 4 months old; 6 months old; 9 months old; 12 months old; 15 months old; 18 months old; 2 years old; 2.5 years old; and annually from 3-10 years of age. Id.

ICE must comply with the U.S. Constitution when the agency uses its discretion to detain people. Individuals detained by ICE are entitled to the same Fifth and Fourteenth Amendment due process protections as any other pretrial detainee. See Zadvydas v. Davis, 533 U.S. 678, 690 (2001); E. D. v. Sharkey, 928 F.3d 299, 306–07 (3d Cir. 2019). The government also has an affirmative duty toward those it detains, to provide conditions of reasonable health and safety. DeShaney v. Winnebago County Dept. of

21 These medical exams should include, but are not limited to, an evaluation of the following: developmental tasks, including physical, behavioral, and mental; diet and nutrition adequate and appropriate for the age and development status of the individual child; immunizations; vital signs examinations; and a physical examination, including evaluating dental health. FRS 4.3 at Special Provisions for Health Care of Children. Results should be documented and discussed with the child’s parent or guardian. Id.
The Eighth Amendment to the U.S. Constitution prohibits cruel and unusual punishment including unsafe conditions of detention. While in order to demonstrate a violation of the Eighth Amendment, a detained individual must prove detention officials were deliberately indifferent to a substantial risk of harm, the Supreme Court has clarified that "a remedy for unsafe conditions need not await a tragic event." Farmer v. Brenner, 511 U.S. 825 (1970); Helling v. McKinner, 509 U.S. 25, 33 (1993). The federal government cannot “ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month of year.” Id. Thus, even though the harm may not “occur immediately and even though the possible infection might not affect all those exposed,” the constitution still require[s] a remedy for those exposed to a risk of infectious disease. Id. (citing Hutto v. Finney, 437 U.S. 678, 682 (1978)). RAICES has notified ICE of complaints of substandard medical care numerous times in recent years. Therefore, the ongoing medical indifference at the Karnes family immigration prison may constitute an Eighth Amendment violation.

As discussed above, pregnant women and young children are particularly vulnerable to the risks associated with the COVID-19 virus. Endangering particularly vulnerable populations by prolonging their unnecessary detention by ICE may constitute a violation of these individual’s Constitutional protections, and the conditions described above demonstrate a failure to meet the minimum standards of care contemplated in the Flores Settlement Agreement and Family Residential Standards. Indeed, several courts across the country have ordered the release of individuals detained by ICE and at a high risk for COVID-19 complications.

H. ICE Is in Violation of the Preliminary Injunction Orders in Fraihat v. ICE.

On April 20, 2020, U.S. District Judge Jesus Bernal in California issued a nationwide preliminary injunction in Fraihat v. ICE ordering ICE to (1) immediately identify and track individuals in its custody with certain defined factors that make them especially vulnerable to COVID-19 and (2) make timely custody redeterminations for all class members, including for people whose custody has already been reviewed. Fraihat v. ICE, Case No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Apr. 20, 2020), ECF No. 133. In that order, Judge Bernal certified two subclasses of individuals with specific risk factors and disabilities in ICE custody to whom the order applies. Id at 38. Subclass one consists of, “All people who are detained in ICE custody who have one or more of the Risk Factors placing them at heightened risk of severe illness and death upon contracting the COVID-19 virus.” Id at 21. The court specifies several “Risk Factors,” including pregnancy. Id. According to the court order, these determinations should be made regardless of

22 RAICES sent approximately 96 emails to ICE in 2020 to communicate the medical concerns of detained children and adults.
23 See, e.g. Basank v. Decker, 499 F.Supp.3d 205 (S.D.N.Y. March 26, 2020) (finding the risk of possible, fatal infection for immigration detainees with preexisting conditions constitutes irreparable harm and ordering the immediate release of those named detainees.); Calderon v. Wolf, 445 F.Supp.3d 408 (N.D. Cal. April 9, 2020) (finding the public interest considerations weighed in favor of ordering the release of an ICE detainee with underlying health conditions putting him at heightened risk for severe illness from COVID-19.)
whether a detained individual has submitted a bond or parole request, petitioned a court for habeas corpus or other relief, and regardless of whether any such requests have been denied. Id at 38. Based on ICE’s failure to provide evidence of custody review pursuant to Fraihat and the continued lengthy stays of pregnant women at Karnes, there is little to show ICE has been conducting these custody redeterminations. Indeed, RAICES has submitted at least 46 requests for custody determination pursuant to Fraihat to ICE at Karnes, 12 specifically for pregnant women, and all of these requests went ignored.24 Since February 2020, RAICES estimates pregnant women have been detained by DHS for 22 days on average. This violates the Fraihat mandate to release medically vulnerable individuals from detention, absent exceptional findings outweighing the risks of death and serious illness.

I. The Continued Detention of Black Pregnant Women and Young Children is a Departure from Routine ICE Policy and Practice.

The examples highlighted in this complaint demonstrate situations that should have resulted in more serious medical attention and a speedier release of families from detention. In rare instances in which ICE did respond to requests for release, ICE generally cited immigration case status as the reason for continued detention. Yet, ICE maintains discretion to release anyone in its custody, and previously exercised such discretion to promptly release pregnant women and families with infants under one year of age. Prior to 2018, ICE routinely released women from custody at Karnes subsequent to a positive pregnancy test. Infants under one year of age were infrequently detained at Karnes, and RAICES could notify ICE leadership of an infant in custody after which ICE would often promptly release the family. Notably, ICE’s departure from these policies coincided with a change in population at Karnes to include the detention of primarily Black families.

Furthermore, ICE’s lack of medical care for pregnant women and failure to meaningfully communicate regarding custody review and medical attention fall short of requirements in ICE’s written policy, which includes express guidelines for custody review and medical care for pregnant women.25 Specifically, ICE policy requires that pregnant women receive a “14-day full medical assessment” and “timely referral for appropriate prenatal and medical care.” Id. ICE policy contemplates a robust and multi-level custody review for any pregnant person in detention, including notification to the Field Office Director and Headquarters level of ICE Health Service Corps (IHSC). Id. Communication between local ICE and IHSC Headquarters is to include “ongoing” coordination “to ensure that the pregnant detainee is appropriately housed, to track the term of the pregnancy, and to ensure the pregnant detainee is receiving necessary and appropriate medical care while in custody.” Id. Additionally, ICE policy indicates that IHSC is to maintain a system to monitor, track and communicate with field level officers “concerning the medical condition of the pregnant detainee and/or the fetus.” Id. Furthermore, ICE must review custody determinations of pregnant women who may be subject to mandatory detention weekly, and in consultation with the Office of the Principal Legal Advisor, and policy indicates that alternatives to detention should be considered in lieu of detention. Id.

The experiences of families outlined above and RAICES’ communication with ICE indicate a complete lack of evidence that ICE is in compliance with its own policy mandates. No pregnant woman

24 Exhibits 3 and 8 to this complaint provide examples of RAICES communications with ICE, citing Fraihat.
who RAICES represented reported that she received a “full medical assessment” after 14 days in custody nor a “timely referral for appropriate prenatal and medical care.” At best, pregnant women received a prenatal vitamin, and in one case hospitalization when medical conditions deteriorated to emergency levels. Furthermore ICE has provided no evidence of multi-level custody review or pregnancy monitoring as required by the agency. Instead, ICE routinely ignores requests for prenatal care from pregnant women and their legal representatives. Finally, in no case did ICE exercise its discretion - as it did prior to 2018 - to release pregnant women and infants on alternatives to detention regardless of immigration case status. ICE’s actions constitute blatant neglect of its own written policy and a departure from previous practice that has caused harm to numerous Black pregnant women and their families.

IV. Request for Investigation

Complainants seek immediate investigation into the above described pattern and practice of deliberate indifference and discriminatory practices related to the prenatal, maternal, gynecological, and pediatric medical needs of detained Black women and young children at the Karnes County Family Residential Center. These discriminatory practices and the continued lengthy detention of pregnant Black mothers and young children are particularly egregious in light of the enhanced dangers of the COVID-19 pandemic for these populations. Failure to provide adequate and non-discriminatory medical care violates Complainants’ constitutional protections, ICE’s own Family Residential Standards and policy guidelines, Fraihat v. ICE orders, Flores settlement agreement protections, and is a departure from ICE’s historic policy and practice. In particular, Complainants ask CRCL to:

- Review the medical records of Black women and children to investigate allegations of inadequate medical care, to investigate DHS's compliance with ICE’s Family Residential Standards, ICE policy guidelines, and Complainants’ constitutional rights, and to investigate whether racially discriminatory practices have occurred and are continuing to occur at Karnes.

- Determine if GEO Group is equipped to provide adequate and non-discriminatory medical care to detained individuals at Karnes. If GEO Group is not equipped to do so, ICE must terminate GEO Group’s contract to operate the Karnes Family Residential Center.

- Respond to Complainant’s claims in a timely, written response, detailing what ICE and staff at Karnes have done and will do to prevent further discriminatory and inadequate medical treatment and violations of Complainant’s rights and planned next steps.

- Investigate whether ICE and GEO staff or other medical contractors retaliate or threaten to do so in response to medical complaints, and ensure proper training of ICE and all contractors to mitigate such threats.

- Investigate whether the ICE Field Office and ICE Health Service Corps Headquarters are in compliance with ICE policy memoranda regarding communication and review of care for pregnant detained women.
● Determine whether proper language interpretation practices are in use at Karnes, particularly from medical service providers, and implement practices to ensure all medical staff communicate to detained persons in their native language using qualified medical interpreters.

● Analyze whether the continued detention of infants under 1 year, toddlers 1-3 years old, and young children (5 years and younger) is a violation of the *Flores* settlement agreement and existing ICE policy and make appropriate recommendations regarding future and ongoing custody determinations.

● Analyze whether the continued detention of pregnant women during the ongoing COVID-19 pandemic is a violation of the recent orders in *Fraihat v. ICE* and make appropriate recommendations regarding future and ongoing custody determinations.

● Evaluate ICE’s written custody determinations to determine whether ICE officers conduct custody review of pregnant women and children as required by *Fraihat, Flores*, and ICE policy memoranda.

● Review statistics regarding the length of detention of pregnant women and infants under 1 year, toddlers 1-3 years old, and young children (5 years and younger) and evaluate how statistics have changed.

● Bring ICE into compliance with constitutional mandates for all individuals detained at Karnes by developing, supervising, and enforcing a written policy to prevent inadequate and discriminatory medical care.

### III. Conclusion

DHS should not detain individuals the agency is not equipped to provide with consistent, adequate and non-discriminatory medical care. The Karnes family immigration prison has a lengthy history of providing detained individuals with inadequate and substandard medical care, as evidenced in multiple reports, studies and other CRCL complaint letters sent to your office.26 These violations and their dangers are only further exacerbated by the ongoing COVID-19 pandemic. Black pregnant mothers and young children are at particularly high risk for serious illness from the COVID-19 virus.

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26 *See, e.g.* Letter dated April 5, 2020 “RE: Request for Investigation into the prolonged detention of accompanied immigrant children in violation of the Flores settlement agreement and Judge Gee’s March 28, 2020 order.”; CRCL Complaint (July 30, 2015), available at [https://www.aila.org/advo-media/press-releases/2015/deplorable-medical-treatment-at-fam-detention-ctrs/public-ve rsion-of-complaint-to-crcl](https://www.aila.org/advo-media/press-releases/2015/deplorable-medical-treatment-at-fam-detention-ctrs/public-version-of-complaint-to-crcl). This complaint documented specific failings in the provision of medical care at the three FDCs, including: (1) instances of medical professionals at the FDCs providing “insufficient information about medical care to mothers and disregard [for] their concerns, the information they provide and their complaints”; (2) descriptions of “[m]edical staff frequently direct[ing] mothers and children to ‘drink more water’ regardless of the illnesses or injuries presented”; (3) reports that families were made to wait between three to fourteen hours for medical care; and (4) examples of inadequate follow-up treatment. *Id.* at 1–2.
Immigration detention is discretionary. All pregnant mothers and young children should be expeditiously processed through DHS custody and released to their sponsors so they can seek appropriate medical care outside of detention. While detained by DHS, at Karnes or otherwise, medically vulnerable populations should receive at least the minimum adequate medical care legally due them. In administering medical care to detained families, ICE and any private contractors should be cognizant of the dire consequences of racially discriminatory medical care practices and make proactive steps to prevent and remedy disparities.

If your office has any questions, please contact us at: 210-226-7722 or raiceskarnes@raicestexas.org.

Respectfully submitted,

Andrea Meza  
Director, Family Detention Services  
RAICES  
andrea.meza@raicestexas.org

Laila Ayub  
Special Projects Attorney, Family Detention Services  
RAICES  
laila.ayub@raicestexas.org

Briana D. Perez  
Staff Attorney, Family Detention Services  
RAICES  
briana.perez@raicestexas.org

Sylvie Bello  
Founder & CEO  
Cameroon American Council  
cameroon.american.council@gmail.com

Breanne J. Palmer, Esq.  
Policy & Community Advocacy Counsel  
UndocuBlack Network  
breanne@undocublack.org

Nicole Phillips  
Legal Director, Haitian Bridge Alliance  
nmp.law@gmail.com
Exhibit 1, Declaration of Dr. Latasha Nelson ................................................................. p. 1
Exhibit 2, Declaration of ................................................................. p. 4
Exhibit 3, Email Correspondence with ICE re: .............................................................. p. 7
Exhibit 4, Declaration of ................................................................. p. 12
Exhibit 5, Declaration of ................................................................. p. 15
Exhibit 6, Email Correspondence with ICE re: .............................................................. p. 23
Exhibit 7, Declaration of ................................................................. p. 27
Exhibit 8, Declaration of ................................................................. p. 29
Exhibit 9,Declaration of ................................................................. p. 32
Exhibit 10, FOIA Request for Medical Records ............................................................ p. 35
DECLARATION OF LATASHA NELSON, MD

I, LaTasha Nelson, MD, hereby declare as follows:

1. I am over 18 years of age and competent to make this declaration. If called to testify as a witness in this matter, I could and would testify truthfully to each of the matters set forth below.

2. My name is LaTasha Nelson. I hold specialty board-certification in Obstetrics and Gynecology, and sub-specialty board certification in Maternal Fetal Medicine. I am an Associate Professor, Department of Obstetrics and Gynecology, at Northwestern Feinberg School of Medicine.

3. I received my undergraduate degree from Alabama State University and my medical degree from the University of Tennessee. I completed my residency in obstetrics and gynecology at Tulane University, and my Fellowship at Northwestern University, McGaw Medical Center. I am currently on staff at Northwestern Memorial Hospital in Chicago, Illinois, and Northwestern Lake Forest Hospital in Lake Forest, Illinois.

4. I was asked to review available medical records and written statements of individuals and families detained at Karnes County Detention Center. I reviewed statements of eight individuals and the medical records of one woman.

5. There is a concerning pattern of indifferent treatment that emerges from the declarations of these individuals, as well as multiple accounts of poor living conditions and substandard medical care.

6. Complaints voiced by detained women or their partners through declarations given to RAICES included an uncomfortably cold detention environment; inadequate nutrition, including giving spoiled milk to toddlers; indifference toward complaints of pain; inadequate monitoring or examination despite complaints warranting medical evaluation; failure to give or obtain informed consent; threats of psychological treatment; unnecessary stress being placed on expectant mothers; and lack of access to medical records.

7. Any condition that negatively impacts an expecting mother also impacts her developing baby. It is troubling that several women detained at the Karnes County Family Residential Center reported that their complaints of pain, sickness, difficulty sleeping, and difficulty eating or vomiting, were ignored. This is not how compassionate, appropriate medical care is provided by competent physicians.

8. While it may not be possible to regulate a facility’s temperature in a manner that keeps all occupants comfortable, it is concerning that several women or their partners stated in their declarations that the Karnes County Family Residential Center was uncomfortably cold. In one instance, a woman’s partner stated that the cold environment was contributing to his wife’s deterioration and worsening...
rheumatic disease. Based on the number of complaints of cold temperatures, it
appears that the facility is not providing adequate thermal comfort to the detainees.

9. Nutrition is important during pregnancy. Good nutrition helps women
handle the extra demands on their body as pregnancy progresses and is critical to the
growth of a developing fetus. Proper nutrition is equally important for women who
are breastfeeding and young children. Women and families in detention are unable
to choose their food sources or provide for their own nutrition. They are dependent on
the facility to provide proper nutrition. This means that the facility must account and
adjust for the nutritional demands of pregnant women in its care. There are no
circumstances in the United States where it is acceptable to provide pregnant women
or young children spoiled food or milk.

10. Several individuals stated that they suffered from pain that was
uncontrolled by medication or that their complaints of pain were ignored. There are
multiple peer-reviewed publications that recognize racial bias in treatment of pain.
ACOG, The American College of Obstetricians and Gynecologists, acknowledged
racial disparities and inequity in healthcare in a Joint Statement on Racism just last
year.\(^1\) The immigrants detained at this facility are presumably persons of color. They
deserve compassionate, unbiased care. More importantly, pain is often a symptom of
an underlying medical problem. One woman reported severe pain that was not
controlled with medication, and continued bleeding several days after her
miscarriage. These are concerning symptoms that require examination to rule out
life-threatening complications.

11. Detained persons deserve to have their health concerns timely and
thoroughly addressed. This is especially true for pregnant women who can suffer any
number of complications as a result of their pregnancy. Likewise, young children with
medical needs deserve prompt and attentive care.

12. Proper treatment includes providing patients with informed consent,
and doing so in a manner that they understand. This means that they are entitled to
know and understand the risks, benefits, and alternatives of any course of treatment.

13. It is never acceptable for a medical provider to threaten or suggest
psychiatric evaluation to a patient for any reason that is not medically indicated.
Such a practice may discourage patients from seeking care they need. This is
especially true for pregnant women who are already an increased risk of depression
or other disorders.

14. I am informed that the individual whose declarations I reviewed, and
potentially many others, requested copies of their medical records with no or
incomplete records provided in response. It is important that patients have complete
access to their medical records. Having complete medical records helps ensure

\(^1\) Obstetrics & Gynecology: Collective Action Addressing Racism, joint statement by ACOG
and 19 other organizations, August 2020.
continuity of care. In one case, a detained woman was not given a complete set of her medical records despite being told by a physician in May that she could have gynecologic cancer and that she needed to undergo surgery as soon as possible. The records I reviewed contained very little documentation regarding her gynecologic care. Based on interviews with RAICES staff, this woman was still seeking treatment as of July. She was also still waiting on copies of prior imaging studies for her new physicians to review. This may represent a significant delay in treatment.

15. In my expert medical opinion, there are serious concerns about the living conditions and quality of care provided to women and children detained by ICE at the Karnes County Family Residential Center. The accounts of these individuals suggests that valid medical complaints are being ignored or met with indifference by the staff and clinicians affiliated with the facility.

I declare under penalty of perjury that the forgoing is true and correct.

By: [Signature]
LaTasha Nelson, MD

Date: 2/22/21
Declaration of [Redacted]

Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. I entered the United States on 08/12/2020. I have been detained at Karnes since 08/14/2020, with my wife [Redacted], and our baby.

2. I suffered beating before I fled my country, which has left me with back pain. It hurts very much when I sit and it has been very difficult for me to stretch out here.

3. Usually, I would walk around, jog, or work a lot and be active, so I did not feel the pain so much. Whenever I sit down for hours, it becomes very difficult to stand up again. My pain becomes severe.

4. Here, I am stuck in my room all day due to the quarantine, which makes it hard to walk around or be active. I usually have to just sit down or go to bed. I sit down for too long here which makes it very difficult to stand up and causes me a lot of pain. The other day, I tried to get up but because of the pain in my back I fell down.

5. They have been giving me pain medication but it still feels the same.

6. Since being detained, I have been struggling to eat and losing sleep each night. I am crying all night every night from my worries. I have difficulty sleeping and eating because I worry about my wife. Currently we are both in quarantine separately and can only speak to each other by phone at nighttime.

7. My wife is two months pregnant. She is detained with our 15 month old child. She also suffers from rheumatism, a condition that causes problems with her bones, her joints, and even her breathing.

8. Cold temperatures like those here at Karnes exacerbate my wife’s rheumatism. Right now, her hand hurts and it is becoming severe. She cannot lift it at all. This makes things very difficult for her because she is alone with our 15 month old baby and cannot hold her.

9. Sometimes her condition causes her to have difficulty breathing, she has been unconscious for 3 days at one point because she struggled breathing. People perceive her as healthy but in reality she has this disease. They have given her some medication but it is not giving her any relief at all.

10. Her condition worsens when she worries and thinks about it a lot about it, and it is always hard for her to recover when her rheumatism becomes that severe. She has been worrying
a lot while detained, so I am concerned that all of these factors will make her condition much worse.

11. Furthermore, things are difficult for my wife because she speaks a dialect, she speaks very little English and very little of any other language. There is never an interpreter available who can interpret her dialect. I am the only one who can communicate with her, so the fact that we are apart makes things very difficult. My wife is the only person that I have, she is everything to me and I do not want anything to happen to her.

12. My daughter is only on breast milk here. Normally, she would also eat some blended rice, but we do not have access to the appropriate foods here. I am usually the one who feeds my daughter, and she is used to me doing so. She will not take food from anyone else other than my wife breastfeeding her. Because of the quarantine, I cannot be with her.

13. My wife is not getting nutritious food, and on top of that she is breastfeeding so she loses a lot of her fluids. From looking at her, I can tell that she has lost a lot of weight and looks visibly sick.

14. Yesterday, my daughter saw me from behind a window. I was not allowed to go see her because of the quarantine. She cried so much but I could not go see her. I had to just turn away to avoid making her cry.

15. ICE has not told me anything about me or my family being released from detention. ICE has never told me why they are detaining me, my wife, or my child. When I first arrived here, they did ask me about my child. But I do not really know what they were asking, I did not understand them very well. They spoke to me in English and I am not fluent in English and could not hear them very well.

16. When I was at the border, the CBP officers only asked me where I was coming from and why, I told them I was fleeing for my life. They asked me what mosque I was attending. That was all that they asked.
I, Laila Ayub, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am an attorney with the Refugee and Immigrant Center for Education and Legal Services (RAICES), where I have worked since September 23, 2019. I am an attorney licensed to practice in the District of Columbia.

2. On August 19, 2020, I spoke with by telephone through a certified interpreter 182485 who is certified to interpret in the English and languages. During the telephone call I read the entirety of the “Declaration of” in English, and Interpreter 182485 translated the entirety of the declaration into . I swear under the penalty of perjury that confirmed that the information contained in the declaration is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Laila Ayub

Executed 08/19/2020 in San Antonio, Texas.
Request for Release Due to Serious Medical Concerns and Pursuant to Fraihat
4 messages

Laila Ayub@raicestexas.org> Fri, Aug 21, 2020 at 6:16 PM
To: KCD_Correspondence @ice.dhs.gov>
Cc: RAICES - Karnes @raicestexas.org>, Andrea Meza@raicestexas.org>, Javier Hidalgo @raicestexas.org>, Tony Ortega@raicestexas.org>

Good Afternoon Officers,

We represent Ms. , his wife, , and their 16-month old child, . Ms. is two months pregnant and has rheumatism, an autoimmune disease. Her medical condition requires exceptional care that cannot be provided unless this family is released from detention to live with their sponsor, . This family has been detained in DHS custody for over 23 days.

Ms. is a pregnant woman. This puts her at risk for complications related to COVID-19, which is present at Karnes. Furthermore, she has rheumatism. This is an autoimmune disease that causes her bone pain, joint pain, and breathing problems. It affects her whole body. Stress and cold, which have been her conditions at Karnes, exacerbate her poor health.

We know this to be the case given that Ms. was found unresponsive last night for an unknown period of time while with her baby, . During this time of Ms.’s unresponsiveness, she was alone with as family units are detained separately at Karnes. Such conditions are not safe for and are therefore not compliant with ICE’s obligations under the Flores Settlement Agreement.

Ms. has not eaten well at Karnes and she is breastfeeding. Ms. loses fluids from breastfeeding her baby and feels very weak, and has lost weight since being detained. Mr. also suffers from back pain that has been exacerbated by the conditions of quarantine and the inability to participate in physical activity.

Given her medical conditions, namely her pregnancy and rheumatism, Ms. is a class member in Fraihat v. ICE. (Fraihat v. ICE, Case No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Apr. 20, 2020), ECF No. 133.) On April 20, 2020, Judge Bernal issued a nationwide preliminary injunction in Fraihat ordering ICE to (1) immediately identify and track individuals in its custody with certain defined factors that makes them especially vulnerable to COVID-19 and (2) make timely custody redeterminations for all class members, including for people whose custody has already been reviewed.

In that order, Judge Bernal certified two subclasses of individuals in ICE custody to whom the order applies. Ms. is a member of subclass one, which consists of, "All people who are detained in ICE custody who have one or more of the Risk Factors placing them at heightened risk of severe illness and death upon contracting the COVID-19 virus." She is also a member of subclass two. Ms.’s risk factors, pregnancy and rheumatism, are specifically listed in Judge Bernal’s order, so there is no question that she is a Class Member.

Ms. must be released along with her whole family so that they can access the health care they need. The Flores Settlement Agreement mandates that children in immigration custody must be held in facilities that are, "safe and sanitary....and consistent with the [DHS’s] concern for the particular vulnerability of minors." (Flores Settlement Agreement para. 12.A.) Furthermore, minors must be placed, "in the least restrictive setting appropriate to the minor’s age and special needs." (Flores Settlement Agreement para. 11). Given the confinement of quarantine and the limited services offered at the medical center at Karnes, it cannot be said that the detention center is a safe and sanitary custodial placement for . She, with her family, should be released. The Regulations at 8 CFR 1236.3 state that the first preference is to release a child to their parent and that ICE shall evaluate simultaneous release. Indeed, and her parents should have been released sooner given Judge Gee’s orders mandating release of children detained for more than 20 days by July 27, 2020.

The foregoing factors mandate that ICE release this family as a unit, unless there is a specific and individualized determination that detention is necessary to avoid a flight risk or to protect a Flores class member, or that a parent is unfit or otherwise a danger to their child. See Ms. L. v. U.S. Immigration & Customs Enforcement, 310 F. Supp. 3d 1133 (S.D. Cal. Jun. 26, 2018). Here, there is no indication that the family would be a flight risk or that release would put or the community in danger.
Please let us know if ICE requires any assistance in arranging this family’s release to their sponsor, [Name]. If ICE fails to release this family, please provide evidence of a custody determination compliant with the *Flores Settlement Agreement* and 8 C.F.R. 1236.3 that not only delineates a specific, individualized reason besides immigration case status for [Name]’s continued detention but also provides evidence that simultaneous release of [Name] with her parents was specifically evaluated.

Thank you.

Sincerely,
Laila Ayub

---

**Laila Ayub**

Special Projects Attorney

*Family Detention Services*

Refugee and Immigrant Center for Education and Legal Services (RAICES)

San Antonio, Texas

Office Phone: [Phone]

Direct Phone: [Phone]

@raicestexas.org

www.raicestexas.org

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**PRIVILEGED AND CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATION, ATTORNEY WORK PRODUCT AND ATTORNEY MENTAL IMPRESSIONS.**

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**3 attachments**

- SIGNED_1641K.pdf
- SIGNED_1644K.pdf
- SIGNED_1644K.pdf

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Laila Ayub [raicestexas.org] Fri, Aug 28, 2020 at 4:29 PM

To: KCD_Correspondence [email]
Good afternoon Officers,

We wrote with regards to the release status of our clients, [redacted] his wife, [redacted] and their 16-month old child, [redacted] one week ago, on August 21, 2020. We have yet to receive a response to that email.

Again, please let us know if ICE requires any assistance in arranging this family’s release to their sponsor, [redacted]. If ICE fails to release this family, please provide evidence of a custody determination compliant with the Flores Settlement Agreement and 8 C.F.R. 1238.3 that not only delineates a specific, individualized reason besides immigration case status for [redacted]’s continued detention but also provides evidence that simultaneous release of [redacted] with her parents was specifically evaluated.

Thank you,
Laila Ayub
[Quoted text hidden]

De Leon, Maria V <[redacted]@ice.dhs.gov> Fri, Aug 28, 2020 at 4:47 PM
To: Laila Ayub <[redacted]@raicestexas.org>, KCD_Correspondence <[redacted]@ice.dhs.gov>
Cc: RAICES - Karnes <[redacted]@raicestexas.org>, Andrea Meza <[redacted]@raicestexas.org>, Javier Hidalgo <[redacted]@raicestexas.org>, Tony Ortega <[redacted]@raicestexas.org>

This FAMU is still pending a decision from CIS. I understand there have been some delays because of interpreter availability. We expect a decision early next week.

Maria Villagomez De Leon
Supervisory Detention and Deportation Officer
ICE/ ERO/ Karnes County Residential Center
409 FM 1144
Karnes City, TX 78118
[Quoted text hidden]
[Quoted text hidden]
[Quoted text hidden]
Good afternoon, Officer De Leon,

Please clarify Kames ERO's policy with regard to custody of Fraihat class members. Is it Kames ERO's policy to not...
make custody determinations of *Fraihat* class members prior to receiving a decision from CIS irrespective of timeliness?

Very truly yours,

Javier O. Hidalgo, Esq.

[Javaer O. Hidalgo, Esq.

Supervising Attorney

Family Detention Services

Refugee and Immigrant Center

for Education and Legal Services (RAICES)

San Antonio, Texas

Tel: [Redacted]

Fax: [Redacted]

[www.raicestexas.org](http://www.raicestexas.org)
DECLARATION OF ***********

Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. My name is *********** A***********, and I am currently detained under ICE custody at the Karnes City Family Detention Facility in Karnes City, Texas, with my husband, *********** A#*********** and 16 month old child, ***********. We were born and used to live in ***********, and we fled to the United States because of persecution.

2. We came to the United States seeking asylum. We entered the United States on July 26, 2020, and were taken into custody by Customs and Border Protection (CBP) officers. I was three months pregnant. I had a miscarriage a few days after entering the United States, which caused me bleeding and pain. I also have headaches and pain in my left knee from an injury I suffered when I was attacked in ***********.

THE MISCARRIAGE

3. On or about July 26, 2020 I was taken to the “hielera” (ice box) by the CBP. I was very scared of what was going on and scared of the CBP officials. Every time they came in through the doors, they would slam them. Every time they slammed the door, it made me feel nervous and frightened.

4. This caused me to feel a lot of stress. I felt heavy, my head felt heavy because of all of this stress. A few days after I started having headaches, I began to start bleeding. On July 30, 2020 approximately, I had a miscarriage.

5. I told them that I was pregnant when I first arrived at the hielera. The doctor checked me and told me everything was fine. When I started bleeding about four days later, I was in so much pain that the other people in the room went and told someone to find a doctor. The officers took me to a hospital and did some tests and scans, and the doctor came and told me that I was having a miscarriage and that there was nothing that they could do about it other than give me pain medication. When I returned to the hielera, I was still experiencing pain and bleeding. There was a man in a uniform who used to come around and check on everybody and told us that he was a doctor. That doctor told me that my bleeding was normal because of the miscarriage. I was in so much pain that I just kept walking and moving around to manage it. The doctor gave me medicine to ease my pain, and told me there was nothing else that they could do for me.

6. A couple days later, they took me to the hospital again. They did not do anything other than give me pain killers.
I HAVE NOT RECEIVED PROPER TESTING AND MEDICAL TREATMENT FOR
THE MISCARRIAGE AND THE ASSOCIATED AILMENTS

7. About a day after that, me and my family were transferred to the Karnes County Family Detention Facility. Whenever I am in pain, I tell the medical staff here and they give me pills for the pain. The pills work for a while, but when the effect wears out, the pain comes back.

8. I have told the medical staff at Karnes that I feel something moving in my belly and I requested they perform further tests and scans because my bleeding and pain continues.

9. About two days after arriving at Karnes, I had a big blood clot come out of me, and the bleeding is constant. Every time I go to the restroom, I need to change my sanitary napkin.

10. I am still bleeding on and off throughout the day. I have not yet been seen by a doctor. I went to the medical center here and they told me that they do not have the machine to examine me. They said they would book an appointment for me but I have not heard from them again about that. That was about a week ago. So far, no further tests have been ordered for me to determine any underlying cause of my bleeding and find an appropriate treatment to tackle the symptoms.

11. I am still in pain and desperately need proper medical testing and treatment. I cannot sleep at night because of the pain and I have a one-year-old baby to take care of, which is a really tough situation. Sometimes I am in pain but she wants me to carry her. She wants me to carry her all the time. I do not have my husband’s help, I am only able to speak to him sometimes on the iPad.

12. I still have a lot of stress and fear about what happened to me.
Declaration of Laila Ayub

I, Laila Ayub, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am an Attorney with the Refugee and Immigrant Center for Education and Legal Services (RAICES), where I have worked since September 23, 2019. I am an attorney licensed to practice in the District of Columbia.

2. On August 4, 2020, I spoke with [redacted] by telephone in English. During the telephone call I read the entirety of the “Declaration of [redacted]” in English. I swear under the penalty of perjury that [redacted] confirmed that the information contained in the declaration is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Laila Ayub

Executed August 12, 2020 in San Antonio, Texas.
DECLARATION OF [REDACTED], A [REDACTED]

I, [REDACTED], declare under penalty of perjury that the following is true and correct to the best of my knowledge and recollection.

1. My name is [REDACTED], A [REDACTED]. I was born [REDACHTED] in [REDACHTED]. I am detained with my husband, [REDACTED], A [REDACTED], born in [REDACHTED], and our 13-month-old daughter, [REDACTED], born on [REDACHTED] in [REDACHTED]. We have been imprisoned in Karnes family detention center (“Karnes”) since July 10, 2020.

2. We came to the U.S. to seek asylum. We fled [REDACHTED] because a group of criminals in the [REDACHTED] government are trying to kill my family. I never imagined that my family and I would be detained upon arriving here.

MY 13-MONTH-OLD DAUGHTER HAS A SEVERE RESPIRATORY CONDITION

3. My daughter [REDACTED] was born with the umbilical cord wrapped around her neck. The doctors said she had grave asphyxia within the womb. The doctors stated that if she had not been born when she was, she would have died in the womb. They said if she had spent even another minute inside, she would have died. I have the documents with me explaining her full condition and diagnosis.

4. After I delivered her, the doctors took her to a different hospital because she required specialized treatment. I did not get to see her for two days because they took her to that special hospital. When I got to that hospital to see my daughter, the doctors told me that the prospects for my daughter were very low.

5. They removed all of my baby’s hair and put her on a machine. My baby spent 8 days on oxygen and intensive care. Even when the baby came home, she had to go to the doctor for regular follow up appointments. I had to take her every month, but most of the time I would take her even earlier than her next appointment. She would regularly meet with a neurologist, a nephrologist, and a pediatrician.

6. In February 2020, my daughter was supposed to take the baby back to the hospital but my family had made the choice at that point to flee [REDACHTED]. As a result, my daughter has been without the medical exams that she requires. When they took her to the daughter to get medical exams in Mexico, they said that they are only accepting patients whose conditions are at an emergency level, so they would not take their daughter for medical exams.
I NOTIFIED THE OFFICERS AT KARNES OF MY DAUGHTER’S CONDITION AND NEED TO SEE A SPECIALIST, BUT THEY DID NOT HEED MY CONCERN

7. My daughter has been sick throughout our detention. When my family and I first arrived at Karnes in early July, my husband and I disclosed all our daughter’s medical issues to the prison officers who did intake with us. We explained that she needed to see a specialist, that she would regularly see a neurologist, nephrologist, and pediatrician prior to being detained. I showed them her medical records and explained that my daughter needed tests as the paperwork showed. The officers could not read them at the time as the records are in Spanish due to our time in [redacted], but they took copies of them and promised that a Spanish speaking doctor would review them and would meet with us the next day to see what our daughter needed.

8. The next day, nothing happened. As new intakes into the detention center, my daughter and I were held in medical isolation at first due to the ongoing coronavirus pandemic, so guards would regularly check on us as is standard practice for families in medical isolation. Because I was with my daughter the whole time, to my knowledge the doctor never came to follow up with us as I was told they would. And if they did, I as the baby’s mother was not communicated to about it at all. If a doctor had come, they should have spoken to me. Because I was never spoken to, I do not believe a doctor ever actually followed up with us that next day.

9. We were not given any more information about what was going on with my daughter’s health. Because we are in prison, I did not speak up about the lack of follow up in my first weeks in the detention center. I did not know that I had the right to follow up about receiving the medical care that my daughter needs.

MY BABY CANNOT STOMACH THE FOOD HERE IN KARNES AND SHE IS NOT GIVEN A SPECIAL DIET DESPITE HER AGE

10. Before being detained, I would blend food together for the baby that was more natural and easier for her to eat. I would also usually give the baby natural juice. Here in Karnes, we do not have access to either of those things. At first, the officers would give me the same food for me, an adult woman, as they would give me for our 13-month-old daughter.

11. Because my husband and I are in prison, we were reluctant to ask for different food as we are not the ones paying for our food. We did not know that we have a right to food that we can stomach until we spoke to the attorneys at RAICES.
12. After learning of our rights, I tried to speak to one of the officers about how my daughter could not stomach the adult food at Karnes, but they could not understand me because I speak Haitian Creole. They sent me to the medical center at Karnes.

13. At the medical center, I explained that my baby is very young and needed baby food. Since then, I have been receiving Gerber baby food for [redacted]. She still does not eat it though. I do not remember exactly when we began receiving the Gerber food during our detention, as the days blend together.

14. Now, my daughter just cries. She still does not eat the food.

MY DAUGHTER BEGAN VOMITTING AND THE KARNES OFFICERS INSISTED THAT SHE WAS FINE

15. On Wednesday, July 29th, 2020, my daughter began dry heaving and shaking. She then vomited. The vomit was a light beige color. I went to the medical center in Karnes and asked for help. The detention center medical staff gave her an IV with saline. They told me that there was no doctor at Karnes at the time, but that there would be the next day. They told me that she was fine and sent us back to our room.

MY DAUGHTER VOMITTED AGAIN AND THE OFFICERS AT KARNES AGAIN INSISTED THAT SHE WAS FINE

16. On Thursday, July 30th, 2020, the medical staff brought an IV with saline in it to my daughter and my room around 7:00 or 8:00 in the morning. Around mid-day, my husband, daughter, and I were eating in the lunchroom, and my daughter threw up again. The vomit was a beige color again.

17. My husband [redacted] was called by our attorneys at the time, so my daughter and I went to the medical center alone. The medical staff told me to let the vomit fall on clothes so that I could bring the vomit back and they could check it next time my daughter threw up. I told the nurse I did not understand how the child was breathing, that her breathing was off. The medical staff again insisted that the child was okay.

SHORTLY AFTER THE OFFICERS AT KARNES TOLD ME MY DAUGHTER WAS FINE, SHE FAINTED
18. I took my daughter back to our room, and I tried to get her to eat about three spoons of Gerber even though she still would not accept the food. I then tried to breastfeed her, as I was desperate for her to get some food in her amidst all the vomiting.

19. While I was breastfeeding her, she fainted in my arms. I immediately brought her to the medical center. The staff called for an ambulance. I remember crying, waiting to find out what was happening to my daughter.

I DID NOT HAVE ACCESS TO AN INTERPRETER THROUGHOUT MY DAUGHTER’S HOSPITALIZATION, SO I COULD NOT ADVOCATE FOR HER AS A MOTHER SHOULD

20. While I was waiting for the ambulance, I asked the medical staff if I could go get my daughter’s medical records from my room. The staff did not understand me, as they did not have an interpreter and I speak Haitian Creole.

21. After a few minutes, my husband joined us. The staff had not told him what was going on. Instead, one of the other detained fathers let him know that they had seen me rushing with the baby in the medical center, so he came running to see what was going on.

22. Once was with me, with his help we asked the officers in my husband’s limited Spanish if we could go get our daughter’s medical records while we waited for the ambulance. The staff said no, it’s not important. They assured us that they would explain everything.

23. While the ambulance was on the way, my daughter started to move her hands. I do not know how long she was unconscious for. I was very startled by the whole situation.

24. The officers told us in Spanish that if I did not calm down, they might not allow me into the hospital with my daughter. I did not understand them telling me this, but my husband is able to understand some Spanish, so he translated this into Haitian Creole for me.

25. Finally, the ambulance arrived. The Karnes medical officers then told us that my husband could not come with to the hospital. They again did not use an interpreter to explain this in our language of Haitian Creole, so my husband was put in the position of having to explain to me what they were saying. This separation was extremely upsetting for my husband, as he also wanted to be there as a father and husband.
26. My daughter threw up again as we were entering the ambulance. The ambulance driver did not speak to me at all in a language I can understand. They just gave me a piece of paper to wipe the vomit off the baby. I did not have access to an interpreter, and I do not speak English, so I was not able to ask the ambulance staff what was going on.

27. Around ten minutes later, we arrived at the hospital. The doctors did some tests on my daughter and gave me a bottle for her. I do not know for sure what tests they performed on her because there was no interpretation in my language.

28. It was difficult and scary being with my baby in the hospital during the coronavirus pandemic. She is too young to understand why a mask is important, and anytime my husband and I try to put one on her she takes it off. In the hospital, she still would not wear one. I am scared she could have been exposed to the coronavirus.

29. At the hospital, two prison guards from Karnes joined my daughter and me. They were wearing blue and beige-colored uniforms, like the prison guards in Karnes. The doctors primarily spoke to these two officers. They spoke to me, too, but I did not understand because there was no interpretation and they spoke in English.

30. A few hours later, the prison guards brought me and my daughter back to Karnes. I was never able to speak to the doctors at the hospital with an interpreter about my baby’s health. They made me sign some paperwork at the hospital and then gave an envelope with paperwork to the prison guards, all without an interpreter. Then, my daughter and I were transported back to Karnes in a private car with the Karnes prison guards.

**MY DAUGHTER STILL HAS NOT RECEIVED THE CARE SHE NEEDS**

31. When we arrived back at Karnes, my daughter and I were placed in medical isolation at Karnes. We stayed in medical isolation from Thursday through Saturday, July 30th through August 1st.

32. Once we were back in Karnes, the staff tested my daughter and I for coronavirus on Thursday. On Friday, July 31st, the medical staff gave me a form to sign that was all in English. They did not explain what it said.

33. Later on Friday, the nurse came around to check my daughter’s temperature. I tried to ask the nurse what was going on with my daughter’s health, but she did not understand me due to the lack of interpreter. She called an interpreter and told me that the baby was okay, but she had a fever. Even though I was finally able to speak to someone on the
medical staff with an interpreter, she did not tell me anymore than that about what was happening to my baby’s health.

34. While we had the interpreter on the phone, I told the nurse that I wanted to see a specialist. She told me that the pediatrician would be in on Tuesday, August 4th and she gave me an appointment. She did not give me a specific time for the appointment; I was just told that when the pediatrician got here, they would call me. I told her that my daughter needed to see a neurologist, as she always has. The nurse told me to “just wait to see the pediatrician, and then we can discuss seeing a neurologist at that time.”

35. For Thursday evening and Friday during the day, I was not able to speak to my husband and he remained in the dark about whether or not our daughter was okay because we were still detained separately. Finally, on Friday night the officers brought me a tablet, but it was on 10% charge. I was finally able to let my husband know everything that had happened since we were separated, but the tablet died shortly after we connected so we were not able to speak for very long. My husband told me that he had asked to speak to me earlier in the day, but the officers ignored his request and just responded to him in English with “I’m sorry.” My husband also told me that he had asked about the results of my daughter and my coronavirus tests, and that they had come back as negative.

36. On Saturday, August 1st, my daughter and I were moved to a cell in the general population area of the detention center. Then, about half an hour later the guards moved us to another cell. I am not sure why they moved us more than once and the officers did not explain what was going on.

37. Later on Saturday, I saw my husband sitting alone in the yard of the detention center. I asked the guard if I could visit with him, and I was finally able to let him see in person that our daughter was okay. Our baby ran to him. She was very happy to see him after the separation.

38. My daughter and I run a risk of having been exposed to the coronavirus due to being transferred to the hospital, but we were only kept in medical isolation for three days after getting back from the hospital. I know that we have since been tested for the virus, but it is possible to get a false negative. We are now detained with the general population at Karnes, and we can associate with other detained families and detention center staff.

39. The medical staff tested my daughter and me for coronavirus again last night, August 2nd. I have not been informed of the results yet.
40. To this date, I still have not received a full explanation of what happened or of how my daughter’s health is in my own language. We need to have a specialist for our daughter, and up until today we have not been able to get one here in Karnes.

41. Ever since I arrived to Karnes, I have been asking for my daughter to be able to see a specialist. I do not feel I can rely on the medical staff for help because we still have not gotten to see a specialist despite their promises. I do not know if I can rely on the medical care in Karnes after everything that has happened. What happens in the meeting with the doctor on Tuesday will inform how I feel. If they do not help us again, I will know for sure that I cannot trust the medical care here.

42. I am very concerned about the lack of medical care here in Karnes. Please free my family and me so that we may get the medical care our baby needs outside of detention.
CERTIFICATE OF INTERPRETATION

I, Julia Valero, certify that I speak English and read the foregoing in the English language to Julie, a certified telephonic interpreter in the English and Haitian Creole languages. The interpreter read the foregoing in the Haitian Creole language to [REDACTED] before the declarant signed it.

/s/ Julia Valero                                             08/03/2020
Signature                                                Date

2511 Texas 1604 Loop, #201
San Antonio, TX 78258
Interpreter Address

855-571-8342
Interpreter Telephone
Request for Release Due to Medical Conditions A# XXX-XXX-

Good Afternoon Officers,

We represent Mr. [REDACTED], his wife [REDACTED], and their daughter, [REDACTED], who is a lawful permanent resident of the United States. This family has been detained in DHS custody for over 23 days.

[REDACTED] is 13 months old and she was born with neonatal asphyxia. This is a respiratory condition putting [REDACTED] at a heightened risk of serious complications given the presence of COVID-19 at the detention center.

[REDACTED]'s condition means that when she was born, she was deprived of oxygen because the umbilical cord had been wrapped around her neck. The doctors told Ms. [REDACTED] that had [REDACTED] been born even minutes later, she would not have survived. Days after her birth, neurological specialists who had treated [REDACTED] told Ms. [REDACTED] and Mr. [REDACTED] that [REDACTED]'s prospects for survival were low. The National Institutes of Health states that, "in the short term, neonatal asphyxia is reported to have a mortality in excess of 30%, with the majority of deaths occurring within the first few days after birth. Those infants who survive are often left with mild to severe neurological deficits, and they also end up dying from aspiration or systemic infections. Long-term survivors have been found to have disabling cerebral palsy, inadequate mental development or low psychomotor scores, seizures, blindness, and severe hearing impairment. The management of these infants, in the long run, is complex and prohibitively expensive."

Since being at Kames, Ms. [REDACTED] has gone to the medical center and attempted multiple times to get her daughter to see a doctor like she normally would. The staff at the medical center told Ms. [REDACTED] when she first arrived that her daughter would see a doctor but that has yet to happen. She went to the medical center as recently as this morning and only received medical treatment specific to the vomiting her daughter was experiencing at the time, but nothing else. [REDACTED] has yet to see a specialist here and it is not clear to Ms. [REDACTED] whether any of the staff that have attended to her daughter have been doctors.

Ms. [REDACTED] knows that her daughter needs to see a neurologist. Before their detention, the family would take [REDACTED] to the doctor, both a primary physician and a neurologist, oftentimes more than once a month, because of her severe respiratory issues. Specifically, [REDACTED]'s lungs need to be examined regularly to monitor her development and breathing. The family received specific instructions from a doctor in Chile that these exams need to be conducted on [REDACTED].

Given her medical conditions, namely her respiratory problems due to neonatal asphyxia, [REDACTED] is a class member in Frihat v. ICE. (Frihat v. ICE, Case No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Apr. 20, 2020), ECF No. 133.) On April 20, 2020, Judge Bernal issued a nationwide preliminary injunction in Frihat ordering ICE to (1) immediately identify and track individuals in its custody with certain defined factors that makes them especially vulnerable to COVID-19 and (2) make timely custody redeterminations for all class members, including for people whose custody has already been reviewed.

In that order, Judge Bernal certified two subclasses of individuals in ICE custody to whom the order applies. [REDACTED] is a member of subclass one, which consists of, "All people who are detained in ICE custody who have one or more the Risk Factors placing them at heightened risk of severe illness and death upon contracting the COVID-19 virus." [REDACTED]’s risk factors include having a chronic health condition and a respiratory condition. [REDACTED] also is a member of subclass two, which is made up of, "All people who are detained in ICE custody whose disabilities place them at heightened risk of severe illness and death upon contacting the COVID-19 virus." Neonatal asphyxia is linked to many conditions classified as disabilities under federal law.
The *Flores Settlement Agreement* mandates that children in immigration custody must be held in facilities that are, “safe and sanitary….and consistent with the [DHS's] concern for the particular vulnerability of minors.” (Flores Settlement Agreement para. 12.A). Furthermore, minors must be placed, “in the least restrictive setting appropriate to the minor’s age and special needs.” (Flores Settlement Agreement para. 11). Given the limited services offered at the medical center at Karnes, it cannot be said that the detention center is a safe and sanitary custodial placement for Taimara. She, with her family, should be released. See 8 CFR 1236.3 (b) (1) stating that the first preference is to release a child to their parent. Indeed, they should have been sooner given Judge Gee's orders mandating release of children detained for more than 20 days by July 27, 2020.

The foregoing factors mandate that ICE release this family as a unit, unless there is a specific and individualized determination that detention is necessary to avoid a flight risk or to protect a Flores class member, or that a parent is unfit or otherwise a danger to their child. See Ms. L. v. U.S. Immigration & Customs Enforcement, 310 F. Supp. 3d 1133 (S.D. Cal. Jun. 26, 2018). Here, there is no indication that the family would be a flight risk or that release would put [redacted] or the community in danger.

Please let us know when this family will be released to their sponsor, [redacted], a lawful permanent resident of the United States, so that [redacted] can receive the medical attention that she needs.

Thank you.

Sincerely,

Laila Ayub

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Laila Ayub

Pronouns: she/her

Staff Attorney

Family Detention Services

Refugee and Immigrant Center for Education and Legal Services (RAICES)

[redacted]

San Antonio, Texas

Office Phone: [redacted]

Direct Phone: [redacted]

[redacted]@raicestexas.org

www.raicestexas.org

PRIVILEGED AND CONFIDENTIAL ATTORNEY-CLIENT COMMUNICATION, ATTORNEY WORK PRODUCT AND ATTORNEY MENTAL IMPRESSIONS.

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I understand that Ms. [Redacted] and her daughter [Redacted] were taken to the hospital today. Mr. [Redacted] was not informed of the reason for this hospital visit. Could you please inform our client of the health status of his wife and child and communicate the same to us as the family’s attorney of record?

Thank you,
Andrea

[Quote text hidden]
I should also specify that we request that Mr. XXX and his wife Ms. XXX be permitted to communicate today and regularly during the course of the hospitalization about XXX's health so that they can make joint decisions about her care and treatment.

Thank you,
Andrea
Declaration of [Redacted] A#

I, [Redacted], declare under penalty of perjury that the following is true and correct to the best of my knowledge and recollection.

My name is [Redacted], A# [Redacted]. I was born on [Redacted] in [Redacted]. I am [Redacted] years old and currently detained in ICE custody at the Karnes County Residential Center with my partner and our two children.

I am on the sixth month of pregnancy of my second child. Since I been in detention, I started feeling very bad, I am suffering of back pain, pain in my pelvic region. I have vertigo. Every time I eat, I get diarrhea. I hardly eat since I been in detention. I have been in medical several times, but I was given just a vitamin and was told I need to eat a lot, but I cannot tolerate food. I do not know what kind of vitamin they are giving me. Once, one of the doctors here in Karnes told me he cannot do anything to help me because I had nothing, that if I am crazy and have mental issues, he will kept me in insolation, that he will he give me meds and I would not been able to see my children again. He said he will kept me where the crazy people are, and if I keep complaining, I will be deported to Haiti sooner. I am too scare to go back to [Redacted], so I started crying, the doctor then said it was fine, he won’t do that anymore.

The problem with the nurses is that they don't really take other people's feelings or circumstances, they do not have any consideration. You could be in pain, crying, and they don't care. When I spoke out about how I was not treated well by the nurses, one of the medical staff told me: “You can tell me about it, but don't tell anyone else outside this facility about the treatment or how you are being treated.” This person was the head of the nurses here in Karnes, she introduced herself as the director of the nurses.

When I was scheduled for an interview on 02/22/2020, I was not able to continue with the interview because I was in a lot of pain. The Asylum Officer continued the interview with my husband and asked for me to be taken to an outside doctor. They did, and I was given two pain pills. I do not know what kind of pills, but it helped for about 24 hours, then when I tried to eat next day, the pain came back. I think that if the Asylum officer did not ask for me to be seen for an outside doctor, Karnes medical staff would never do it.

I am very concerned about my baby’s health. I do not think I am able to nourish my baby properly. I do not feel strong enough and do not think I will have the strength to give birth because I am not eating well here, and I am very weak. I am asking to please be released with my family so I can peacefully give birth to my baby in a healthy environment.
I, ____________________________, swear under penalties of perjury that the above declaration is true and accurate to the best of my abilities. This declaration was read back to me in __________________, a language in which I am fluent.

______________________________
Signature

03/17/2020
Date

CERTIFICATE OF INTERPRETATION

I, ____________________________, certify that I speak English and I read the foregoing in the __________________________ language to __________________________, a certified telephonic interpreter in the __________________________ and __________________________ languages. The interpreter read the foregoing in the __________________________ language to __________________________ before the declarant signed it.

______________________________
Signature

03/17/2020
Date

______________________________
Interpreter Address

______________________________
Interpreter Telephone
Pursuant to 28 U.S.C. § 1746 and subject to penalty of perjury, I declare that the following is true and correct:

1. My name is [Redacted], I am [Redacted] years old. I was born in [Redacted] and I fled to the United States with my husband, [Redacted], A# [Redacted], and our 5-year-old child, [Redacted] [Redacted], seeking asylum. We entered the United States on January 26, 2021. We were subsequently detained by Customs and Border Protection (“CBP”) for 3 days, before we were transferred to ICE custody at the Karnes County Family Residential Center (“Karnes”) in Karnes City, Texas, where we were detained for 13 days.

2. I am two months pregnant, and I was detained during my pregnancy.

3. I felt terrible being pregnant at the detention center. I could not eat the food at Karnes, it made me nauseous. I felt dizzy. I just did not feel at ease. Anything that I smelled there made me feel nauseous and I could not eat it. Although I am free now, when I think about the food that they used to serve there, it still makes me feel like I am going to vomit. Even thinking about the food, it makes me feel ill now.

4. It was especially bad the last week that I spent at the detention center. I could not stand up at all. Once I stood up, I immediately felt like I had to sit back down. I had no issues like this during my previous pregnancy. I even had to lay down during my meetings with my lawyers.

5. I was very stressed at the detention center because my husband and I were separated. When I did not feel well, I did not want to go out of my cell and leave my son alone because I was the only one taking care of him and protecting him while in Karnes due to being separated from my husband. When he was sleeping I did not want to wake him, because it is already so hard to sleep in the detention center. So, when I was feeling ill, I would just lay down instead.

6. Last week, I was vomiting a lot one day. My 5-year-old son wanted to help me, so he went to the door of our cell and called for a guard, he yelled “señora, señor” to at least one nearby officer. However, nobody came to help. My son instead gave me water and I threw that over my head and went to lay down. It was not until moments later that a woman in beige pants with her face completely covered walked into our room without knocking, went straight to my bathroom, and walked back out. My son told her, “My mom is throwing up,” and she did not help.

7. I did not receive any medical care or treatment related to my pregnancy until I spoke to the attorneys at RAICES about my pregnancy, and after that I received one pill each evening. When the prison staff gave me the pill, they just asked me if I had water to take a pill. They said it was a vitamin in Spanish, which is not my language. They did not explain what it was. They did not ask for my consent to take the pill or give me the option to refuse it. They had me open my mouth to make sure that I had swallowed it. Other than that, I did not receive any prenatal care, other medical care, or information.
8. I would like the government to stop detaining pregnant women. And I wish the conditions of detention for pregnant women were better. Detention is bad enough for any person, and for pregnant women it is especially bad. I felt treated like any other person although I was pregnant and I needed special care. I felt like the officers treated me as if they did not have time to take care of me, with the food, with the medical care, when I felt sick— with all of it.

9. I would not wish what I experienced in detention upon anyone.
Declaration of Julia Valero

I, Julia Valero, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am a legal assistant with the Refugee and Immigrant Center for Education and Legal Services (RAICES), where I have worked since June, 2018.

2. On February 16, 2021, I spoke with [redacted] by telephone through a certified interpreter Ursula who is certified to interpret in the English and [redacted] languages. During the telephone call I read the entirety of the “Declaration of [redacted]” in English, and Ursula translated the entirety of the declaration into [redacted]. I swear under the penalty of perjury that [redacted] confirmed that the information contained in the declaration is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

/s/ Julia Valero

Executed February 16, 2021 in San Antonio, Texas.
Declaration of [redacted] (A# [redacted])

I. [redacted] hereby swear under penalty of perjury that the following declaration is true and correct to the best of my abilities and recollection:

1. My name is [redacted] and I was born on [redacted] in [redacted]. I am currently detained at the Karnes County Residential Center ("Karnes") with my husband, [redacted] Saint (A# [redacted]) born [redacted] my four-year-old son, [redacted] Leury (A# [redacted]) who was born on [redacted] and my three-year-old daughter, [redacted] Analmia (A# [redacted]) who was born on [redacted].

2. My family and I entered the United States on or around January 31, 2021 through Del Rio, Texas. Almost immediately after crossing the border, we were detained by Customs and Border Protection ("CBP"). The border facility was very difficult. My family and I were then transported to Karnes on Wednesday, February 03, 2021.

   ICE did not provide me information about how to access a lawyer.

3. The way it is when people get here now, to detention, is that they do not let them contact RAICES, the lawyers. They just deport them. We, the detained families, help each other—another detained family shared the RAICES number with my family. From what I have seen, I have not found the RAICES number or contact information posted anywhere in Karnes. My family and I did not receive any information about the process, how it works, or anything.

   It is hard being detained while pregnant.

4. Being in Karnes is hard. I am about three months pregnant. The only prenatal care I have received is a vitamin in the evenings.

5. I do not feel comfortable here. I feel the baby is in a low position in my belly and I need to go to the doctor about it. Having been pregnant before, I can feel that this is not a normal position for the baby to be in. Sometimes it hurts.

6. I have trouble with the food in Karnes. I do not eat much. I have been vomiting and I have been spitting a lot. I have gas that bothers me as well.

7. I do not sleep well here. The lights are on all the time. I am troubled. I am not home.

8. When I go to the medical center, they just take my blood pressure and tell me I’m fine. They don’t ask me what’s going on or give me time to explain. They speak to me in Spanish, which is not my language. I have not tried to ask for an interpreter because the officers always ask if we can just speak in Spanish.

9. The only time the medical staff here has spoken to me through a [redacted] interpreter was when my husband, my children, and I received vaccinations. The [redacted] interpreter told us that they were vaccinating us against COVID-19, the flu, and mumps.
10. The detention staff gave us some paperwork regarding the vaccinations. I could read a little bit of it because one page is in [redacted], and it discussed vaccines and had our names on it. On February 10, 2021, my husband attempted to fax the medical records to our attorneys. The detention staff would not allow him to send the medical records to our attorneys. My husband and I did not find out that the medical records had been discluded from the fax until we compared the papers we had asked the guards to send with the paper RAICES received, and they did not match up.

11. I knew of another mom here in Karnes who was around eight months pregnant and ICE deported her. To me, that shows that they do not care about anyone.
Declaration of Julia Valero

I, Julia Valero, hereby declare under penalty of perjury as prescribed in 28 U.S.C. § 1746:

1. I am a Legal Assistant with the Refugee and Immigrant Center for Education and Legal Services (RAICES), where I have worked since June 2018.

2. On February 10, 2021, I spoke with [redacted name] by telephone. During the telephone call I read the entirety of the “Declaration of [redacted name]” to interpreter Davina in English who then translated into [redacted language], a language that [redacted name] is fluent in.

3. I swear under the penalty of perjury that [redacted name] confirmed that the information contained in the declaration is true and correct.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Date: February 10, 2021 /S/ JULIA VALERO
January 19, 2021

Via Federal Express to:
U.S. Immigration and Customs Enforcement
Freedom of Information Act Office
500 12th Street, S.W., Stop 5009
Washington, D.C. 20536-5009

And email to:
ICE-FOIA@dhs.gov

Dear Freedom of Information Officer:

This letter constitutes a request pursuant to the Freedom of Information Act, 5 U.S.C. § 552 (FOIA) submitted on behalf of the ALLGOOD Foundation and The Refugee and Immigrant Center for Education and Legal Services (RAICES). The Requesters also request a fee waiver, pursuant to 5 U.S.C. § 552(a)(4)(A)(iii) and 6 C.F.R. § 5.11(k), and expedited processing, pursuant to 6 C.F.R. § 5.5(d) and 5 U.S.C. § 552(a)(6)(E). The justifications for the fee waiver and expedited processing are set out in detail following the request.

THE REQUESTERS

The ALLGOOD Foundation is a nonprofit organization committed to gender equality and the empowerment of women through advocacy, education, humanitarian assistance and legal support.

RAICES is a nonprofit agency that promotes justice by providing free and low-cost legal services to underserved immigrant children, families, and refugees. With legal services, social programs, bond assistance, and an advocacy team focused on changing the narrative around immigration in this country, RAICES is operating on the national frontlines of the fight for immigration rights.
REQUEST FOR INFORMATION

Requesters seek any and all records\(^1\) that were prepared, received, transmitted, collected or maintained by the U.S. Immigration and Customs Enforcement that describe, refer or relate to policies, guidelines, or procedures regarding the identification, detention and treatment of pregnant persons in ICE detention.\(^2\) We request the specified records below from January 1, 2016 to the present (unless otherwise noted). We are not requesting individual detainee records that contain protected health information. Additionally, please construe this as an ongoing FOIA request, so that any records that come within the possession of the agency prior to your final response to this FOIA request should also be considered within the request’s scope. Where available, we request that records responsive to this request be produced in the original electronic format with all metadata and load files. We ask that any records produced in PDF, TIFF, or other image formats be produced in full, uncompressed form; please do not compress images or downsample the resolution, as this interferes with their legibility. To facilitate a speedy response, we ask that records responsive to this request be produced on a rolling basis.

For purposes of this request, the documents referenced herein are defined as follows:


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\(^1\) The term “records” as used herein includes, but is not limited to: communications, correspondence, directives, documents, data, videotapes, audiotapes, e-mails, faxes, files, guidance, guidelines, standards, evaluations, instructions, analyses, memoranda, agreements, notes, orders, policies, procedures, protocols, reports, rules, manuals, technical specifications, training materials, and studies, including records kept in written form, or electronic format on computers and/or other electronic storage devices, electronic communications or videotapes, as well as any reproductions thereof that differ in any way from any other reproduction, such as copies containing marginal notations.

\(^2\) This includes detention by ICE in any of the following settings: Service Processing Centers, Contract Detention Facilities, Family Residential Facilities, Intergovernmental Service Agreement (IGSA) Facilities, Dedicated Intergovernmental Service Agreement (DIGSA) Facilities, Intergovernmental Agreement (IGA) Facilities, and any other facilities where individuals may be held in ICE custody for 72 hours or more.

“NCCHC Position Statement” means the National Commission on Correctional Health Care: Position Statement on Women’s Health Care in Correctional Settings. A copy of the 2020 NCCHC Position Statement is attached as Exhibit C.

Specific records requested:

1. Any and all records stored in the “system for tracking and monitoring all pregnant detainees in ICE custody” as noted in Sections 4.3(4) and 4.4(2) of the 2017 Pregnancy Directive including, but not limited to, any and all data that can be exported in electronic form in spreadsheet format (e.g., *.XLSX or *.CSV formats).

2. Any and all records stored in the “system” for tracking of pregnant detainees as noted in Section 6 of the 2016 Pregnancy Directive including but not limited to, any and all data that can be exported in electronic form in spreadsheet format (e.g., *.XLSX or *.CSV formats).

3. Any and all records relating to or embodying any amendments, modifications, additions, deletions, or other changes to the 2016 Pregnancy Directive.

4. Any and all records related to IHSC “oversight and review of facility capabilities” as contemplated in Section 4.3(3) of the 2017 Pregnancy Directive.

5. Any and all records related to the 2016 or 2017 Pregnancy Directives that were sent from or received by any of the following ICE units or personnel:
   a. Enforcement and Removal Operations;
   b. Homeland Security Investigations;
   c. Any ICE Field Office Director(s);
   d. Any Special Agent(s) in Charge;
   e. ICE Field Medical Coordinator;
f. ICE Health Service Corps;

g. Office of Detention Oversight;

h. Office of Detention Policy and Planning;

i. Office of the Director/Acting Director;

j. Office of the Deputy Director/Acting Deputy Director;

k. Office of the Principal Legal Advisor;

l. Chief of Staff;

m. Office of Public Affairs; and

n. Office of Congressional Relations.

6. Any and all records including but not limited to PowerPoint presentations and handouts, displayed or distributed to ICE and IHSC staff as well as any contractors in connection with any training related to the 2016 or 2017 Pregnancy Directives.

7. Any and all records including communications such as grievances and requests received by ICE from persons in ICE detention relating to pregnancy including medical and custody concerns related to pregnancy.

8. Any and all records generated in response to media inquiries, for public affairs purposes, or for media purposes that are related to the 2016 or 2017 Pregnancy Directives (including but not limited to talking points, quotes or statements provided to the press, and memoranda).

9. Any and all records discussing, preparing, proposing, editing, or approving records responsive to Request 8.

10. IHSC Policy No. 04-02 “Women’s Medical Care”, and any and all other IHSC policies regarding the provision of medical care to women in ICE custody. This includes all versions of such policy that were in effect during the request period, as well as any updates, amendments and attachments thereto.
11. ICE Policy No. 11020.1: “Use of GPS Monitoring Devices on Persons who are Pregnant or Diagnosed with a Severe Medical Condition (Sept. 14, 2009) as well as any updates, amendments and attachments thereto.

12. From January 1, 2016 to the date this request is fulfilled, any databases, spreadsheets, lists, and other data compilations reflecting the following:

   a. The total number of individuals ICE has identified as pregnant while in ICE detention, broken down by month and detention facility;

   b. The total number of incidents of miscarriages and live births in ICE detention broken down by detention facility;

   c. For each person identified as pregnant in ICE detention, the following data:

      i. The total time period they remained in ICE detention, including the initial date of detention, date of release and any transfers between detention facilities;

      ii. For each person released from ICE detention, information indicating whether the person was released on a grant of parole, bond, recognizance, an order of supervision, or placed into an ICE alternative to detention program;

      iii. For each person who departed from the United States directly from ICE detention, information indicating whether the person departed on an order of voluntary departure, an expedited order of removal, reinstatement of prior removal order, final administrative removal order, or an order of removal entered by an Immigration Judge;

      iv. Information indicating whether and the number of times each person was transferred to an external medical facility such as a hospital, emergency room or other medical care facility for medical care or treatment associated with the pregnancy and the date of such transfer.
13. Any and all policies or procedures applicable to the Karnes County Family Residential Center in Karnes City, Texas. This includes any policies or procedures maintained by or at the facility. Specifically, but not exclusively, please provide all policies or procedures relating to:

a. The keeping of protected health information\(^3\) of ICE detainees.
b. The retention of protected health information of ICE detainees.
c. The destruction of protected health information of ICE detainees.
d. The disclosure of protected health information of ICE detainees.
e. Staffing of health care providers at the facility.
f. Medical or nursing examination of ICE detainees.
g. Change in health condition of ICE detainees.
h. Communication between facility staff and any health care provider, relating to the health of ICE detainees.
i. Referral to contractors, subcontractors, or outside health providers relating to health of ICE detainees.
j. Any requirement of Section 4.4 (Health Care – Females) of the Family Residential Standards (2020) or applicable prior versions.

14. Any and all policies or procedures applicable to the South Texas Family Residential Center in Dilley, Texas. This includes any policies or procedures maintained by or at the facility. Specifically, but not exclusively, please provide all policies or procedures relating to:

a. The keeping of protected health information of ICE detainees.
b. The retention of protected health information of ICE detainees.
c. The destruction of protected health information of ICE detainees.

\(^3\)“Protected health information” is defined in 45 C.F.R. § 160.103.
d. The disclosure of protected health information of ICE detainees.

e. Staffing of health care providers at the facility.

f. Medical or nursing examination of ICE detainees.

g. Change in health condition of ICE detainees.

h. Communication between facility staff and any health care provider, relating to the health of ICE detainees.

i. Referral to contractors, subcontractors, or outside health providers relating to health of ICE detainees.

j. Any requirement of Section 4.4 (Health Care – Females) of the Family Residential Standards (2020) or applicable prior versions.

15. Any and all policies or procedures applicable to The Geo Group, Inc., at both the corporate and facility levels, relating in any manner to the services provided to ICE vis-à-vis the detention of immigrants.

16. Any and all policies or procedures applicable to CoreCivic, at both the corporate and facility levels, relating in any manner to the services provided to ICE vis-à-vis the detention of immigrants.

17. Any and all documents, policies, procedures, guidelines, directives, memoranda or similar documents relating to the creation, editing, retention, destruction, preservation, or disclosure of protected health information of ICE detainees, including any specifically applicable to the Karnes County Family Residential Center or the South Texas Family Residential Center.

18. Any and all documents relating to the detention or care of pregnant or potentially-pregnant ICE detainees.

19. Any and all documents relating to the postpartum care of ICE detainees.

20. Any and all documents relating to obstetrical or gynecologic care of women in ICE detention.

21. Any and all documents relating to the keeping of electronic protected health information of ICE detainees, specifically including the owner’s manuals,
operating manuals, training manuals, or any other document describing the functionality and operation of any electronic health record (EHR) or electronic medical record (EMR) system used at the Karnes County Family Residential Center or the South Texas Family Residential Center.

22. Any and all business associate agreements between ICE and The GeoGroup, Inc., CoreCivic, the Karnes County Family Residential Center, or the South Texas Family Residential Center effective on or since January 1, 2016.

23. Any and all subcontractor agreements between ICE and The GeoGroup, Inc., CoreCivic, the Karnes County Family Residential Center, or the South Texas Family Residential Center effective on or since January 1, 2016.

24. Any and all trading partner agreements between ICE and The GeoGroup, Inc., CoreCivic, the Karnes County Family Residential Center, or the South Texas Family Residential Center effective on or since January 1, 2016.

25. Any and all business associate agreements, effective on or since January 1, 2016, between The GeoGroup, Inc., CoreCivic, the Karnes County Family Residential Center, or the South Texas Family Residential Center and any contractor or subcontractor providing obstetrical or gynecologic services to these entities.

26. All other documents relating to obstetrical or gynecologic services provided or available to ICE detainees detained at a facility operated by The GeoGroup, Inc. or CoreCivic, including the Karnes County Family Residential Center and the South Texas Family Residential Center.

27. Any and all documents referencing the NCCHC Position Statements relating to the health care of women published in 2014 or 2020.

28. Any and all blank record request documents, including copies of all written forms and form instructions, created, used, accepted, or required at a facility operated by The GeoGroup, Inc. or CoreCivic, including the Karnes County Family Residential Center and the South Texas Family Residential Center regarding the disclosure of detainee protected health information.

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4 “Business associate” is defined in 45 C.F.R. § 160.103.
5 “Subcontractor” is defined in 45 C.F.R. § 160.103.
6 “Trading partner agreement” is defined in 45 C.F.R. § 160.103.
29. Any and all documents distributed to female detainees by The GeoGroup, Inc. or CoreCivic, including the Karnes County Family Residential Center and the South Texas Family Residential Center in complying with Section 4.4 (B)(1) of the Family Residential Standards providing “information on services related to women’s health care.”

30. Any and all blank screening documents used by The GeoGroup, Inc. or CoreCivic, including the Karnes County Family Residential Center and the South Texas Family Residential Center, in complying with Section 4.4 (B)(2) to identify:

   a. Possible pregnancy.

   b. Prior sexual victimization.

   c. Perpetrated sexual abuse.

   d. Sexual assault occurring within 7 days of assessment.

   e. Domestic abuse or violence.

31. Any and all documents demonstrating the training and qualifications of health care providers who are employed or contracted by The GeoGroup, Inc. or CoreCivic, including the Karnes County Family Residential Center and the South Texas Family Residential Center, to provide initial health assessments for women and girl detainees.

FEE WAIVER

Requesters ask for a total waiver of document search, review, and duplication fees on the grounds that disclosure of the requested records is in the public interest and because disclosure “is likely to contribute significantly to the public understanding of the activities or operations of the government and is not primarily in the commercial interest of the requester.” 5 U.S.C. § 552(a)(4)(A)(iii); 6 C.F.R. § 5.11(k).⁷

1. The Request is likely to contribute significantly to public understanding of the operations or activities of the government and is not primarily in the commercial interest of the Requesters.

⁷ In the alternative, Requesters ask for a limitation on fees pursuant to 6 C.F.R. § 5.11(d).
The detention and treatment of pregnant women in federal immigration custody is of great concern to the public. In December 2017, Immigration and Customs Enforcement made a decision to substantially revise a directive regarding the detention of pregnant women. The previous directive, issued in August 2016, only allowed the detention of pregnant women in narrow circumstances and required ICE to track custody determinations as well as medical care provided to all women in its custody. By contrast, the 2017 Pregnancy Directive eliminates the presumption of release and removes various reporting requirements.

This is a major change that has rightly generated significant public scrutiny.\(^8\) In response to this policy change, 276 organizations across the country joined in a letter calling on ICE to reverse its decision and reinstate a presumption of release for pregnant persons.\(^9\) Major medical organizations including the American Academy of Pediatrics, American Academy of Family Physicians and American College of Obstetricians and Gynecologists also called on ICE to reverse its decision stating, “Pregnant women and adolescents should have access to high levels of care, care that is not available in these facilities. The conditions in DHS facilities are not appropriate for pregnant women or children.”\(^10\)

Pregnant women are a highly vulnerable group in the detention system. They face considerable stress including the inability to access necessary medical care and support, separation from family and the uncertainty of immigration proceedings. Prior to this policy change, several organizations jointly submitted a complaint to the

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Department of Homeland Security Office of Inspector General and Office for Civil Rights and Civil Liberties in September 2017, asking them to investigate ICE's treatment of pregnant women in its custody.\textsuperscript{11} The complaint highlights the cases of ten women who report being ignored and denied adequate medical care even in emergencies such as pain, bleeding and, in some instances, miscarriage. The Requesters are aware of similar complaints made by women currently or recently in ICE custody. Many of the women detained by the Department of Homeland Security are survivors of abuse seeking protection in the United States. These reports raise immediate concerns about the health and safety of pregnant women in custody as well as the decisions made by the federal government to detain them.

The Requesters are not filing this Request to further a commercial interest. The requesting organizations are nonprofit organizations, each with the ability to widely disseminate the requested information through a variety of sources including reports and press briefings.

Specifically, the requesting organizations have a practice of disseminating information obtained through FOIA or other means to further the public's understanding of immigration laws and policy. For example, in 2020, the ALLGOOD Foundation used documents obtained from ICE, together with documents that were obtained by partner organizations, to support publication of findings relating to gynecologic abuse of immigrant women in ICE detention and the potential complicity of the detention facility.\textsuperscript{12} This resulted in significant public and congressional attention, including republication of the summary in whole or part by countless national and international news organizations.\textsuperscript{13} As outlined below, RAICES has similarly published information that has received significant attention.

Thus, a fee waiver would fulfill Congress's legislative intent in amending the FOIA. See Judicial Watch, Inc. v. Rossotti, 326 F.3d 1309, 1312 (D.C. Cir. 2003) (“Congress amended FOIA to ensure that it be liberally construed in favor of waivers for noncommercial requesters” (internal quotation marks omitted)). Citizens for Responsibility and Ethics in Washington v. U.S. Dept. of Educ., 593 F. Supp. 2d 261, 268 (D.D.C. 2009) (“[FOIA’s] purpose . . . is to remove the roadblocks and technicalities which have been used by . . . agencies to deny waivers”) (internal quotation marks and citation omitted)).

2. Requester RAICES is a representative of the news media and the records are not sought for commercial use.

Requesters also request a waiver of search fees on the grounds that RAICES qualifies as a “representative of the news media” and the records are not sought for commercial use. 5 U.S.C. § 552(a)(4)(A)(ii)(II). Specifically, RAICES meets the statutory and regulatory definitions of a “representative of the news media” because it is an “entity that gathers information of potential interest to a segment of the public, uses its editorial skills to turn the raw materials into a distinct work, and distributes that work to an audience.” 5 U.S.C. § 552(a)(4)(A)(ii)(III). See also Nat’l Sec. Archive v. DOD, 880 F.2d 1381, 1387 (D.C. Cir. 1989) (finding that an organization that gathers information, exercises editorial discretion in selecting and organizing documents, “devises indices and finding aids,” and “distributes the resulting work to the public” is a “representative of the news media” for purposes of the FOIA); Serv. Women’s Action Network v. DOD, 888 F. Supp. 2d 282 (D. Conn. 2012)(finding the requester entitled to a fee waiver as a news media representative).

RAICES publishes reports about government conduct and immigrant rights issues based on its analysis of information derived from various sources, including information obtained from the government through FOIA requests. Disseminating that information to the press and public are critical and substantial components of the RAICES’s work. This material is broadly circulated to the public in a variety of formats and widely available to everyone for no cost. These reports, analysis, multimedia features, including videos and articles, as well as case related news and archives addressing immigrants’ rights issues are disseminated through the organization’s website. See https://raicestexas.org.

In addition, RAICES publishes a widely read blog where original editorial content reporting on and analyzing issues impacting immigrant rights is posted weekly. See https://raicestexas.org/latest/. In the past year alone, RAICES’ website

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14 See also 5 C.F.R. § 2604.103; 28 C.F.R. § 16.10(b)(6); 5 C.F.R. § 294.103(c); and 41 C.F.R. § 105-60.305-1 (i).
received greater than 1.8 million page views from 440,000+ unique visitors. The organization has 147,000 followers on Instagram and 193,000 followers on Twitter (with greater than 74 million impressions), and it uses these platforms to disseminate its content. Therefore, when it conducts these public education and dissemination activities, RAICES is a representative of the news media.

Underscoring this point, courts have found that other organizations whose mission, function, publishing, and public education activities are similar in kind to RAICES “representatives of the news media” as well. See, e.g., Cause of Action v. IRS, 125 F. Supp. 3d 145 (D.C. Cir. 2015); Elec. Privacy Info. Ctr., 241 F. Supp. 2d 5, 10-15 (D.D.C. 2003) (finding non-profit public interest group that disseminated an electronic newsletter and published books was a “representative of the news media” for purposes of the FOIA); Nat’l Sec. Archive v. U.S. Dep’t of Defense, 880 F.2d 1381, 1387 (D.C. Cir. 1989); Judicial Watch, Inc. v. DOJ, 133 F. Supp. 2d 52, 53-54 (D.D.C. 2000) (finding Judicial Watch, self-described as a “public interest law firm,” a news media requester).15

As representatives of the news media, Requesters plan to analyze, publish, and disseminate to the public the information gathered through this Request at no cost. On account of these factors, fees associated with responding to FOIA requests should be waived for RAICES as a “representative of the news media.”

EXPEDITED PROCESSING

We request Track 1 expedited treatment for this FOIA request, which qualifies for expedited treatment pursuant to 6 C.F.R. § 5.5(e) and 5 U.S.C. § 552(a)(6)(E). There exists a clear “urgency to inform the public concerning actual or alleged Federal Government activity,” and is the Requesters are “primarily engaged in dissemination of information.” 5 U.S.C. § 552(a)(6)(E)(v)(II); see also 6 C.F.R. § 5.5(e)(1)(ii) (expedited processing is warranted where there is “[a]n urgency to inform the public about an actual or alleged federal government activity.”).

As set forth in the numerous cites supra in the fee waiver section, the treatment of pregnant persons in ICE custody is a matter of widespread media and public interest, and the requested records will inform the public concern of this activity by ICE. 5 U.S.C. § 552(a)(6)(E)(i)(I). The urgency to inform the public goes

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15 Courts have found these organizations to be “representatives of the news media” even though they engage in litigation and lobbying activities beyond their dissemination of information and public education activities. See, e.g., Elec. Privacy Info. Ctr., 241 F. Supp. 2d 5; Nat’l Sec. Archive, 880 F.2d at 1387; see also Leadership Conference on Civil Rights, 404 F. Supp. 2d at 260; Judicial Watch, Inc., 133 F. Supp. 2d at 53-54.
beyond the general public interest in government transparency—it responds to ongoing serious concerns from Congress and the public, and will answer specific questions that have very recently been raised regarding ICE’s decision to significantly change a policy about the detention of pregnant persons.

The Requesters are primarily engaged in the dissemination of information. As described supra, our organizations produce newsletters, news briefings, right-to-know handbooks, and other materials that are distributed to the public. As mentioned supra, the requesting organizations will likely distribute the information obtained through this FOIA request through these as well as other means available to us.

Furthermore, there is a “compelling need” for expedited processing. 5 U.S.C. § 52(a)(6)(E)(i)(I). Denial of expedited disclosure of records revealing information about detention and treatment of pregnant women under the ICE pregnancy directive could “reasonably be expected to pose an imminent threat to the life or physical safety of an individual.” 5 U.S.C. § 552(a)(6)(E)(v)(I); 6 C.F.R. § 5.5(d)(1)(i).

As noted supra, at the time ICE was revising the 2016 Pregnancy Directive, several organizations documented many cases in which pregnant women were not receiving adequate medical care and suffered extreme physical and mental harm. Some women experienced miscarriages while in DHS custody. Furthermore, recent statements by medical experts discussed above underscore that there is serious risk to pregnant women who are detained. Delay in the disclosure of information about the treatment of pregnant persons in ICE custody could prevent abuses from coming to light and being corrected, thereby increasing the chances of avoidable injuries or even deaths in the future.

Pursuant to 6 C.F.R. § 5.5(d)(3), the undersigned certifies that the information provided above as the basis for requesting expedited processing is true to the best of their knowledge and belief.

Thank you for your consideration of this request. If this Request is denied in whole or in part, we ask that you justify all deletions by reference to specific exemptions of the FOIA. We expect the release of all segregable portions of otherwise exempt material. We reserve the right to appeal a decision to withhold any information or deny a waiver of fees. We expect your reply to this Request within twenty (20) business days, as required under 5 U.S.C. § 552(a)(6)(A)(I).
Please provide all responsive records to:

Adam Snyder  
The ALLGOOD Foundation  
60 W. Randolph St, Ste. 400  
Chicago, Illinois 60601

Questions may be directed to Adam Snyder at [redacted]. If you prefer, the Requesters will provide a secure ShareFile link to upload all records.

Thank you for your attention to this request.

Sincerely,

Adam Snyder

cc: RAICES  
Ms. Andrea Meza  
Director of Family and Detention Services  
Ms. Laila Ayub  
Special Projects Attorney
MEMORANDUM FOR: Field Office Directors
Deputy Field Office Directors
Assistant Field Office Directors
ICE Health Service Corps

FROM: Thomas Homan
Executive Associate Director

SUBJECT: Identification and Monitoring of Pregnant Detainees

1. Purpose/Background.

1.1 U.S. Immigration and Customs Enforcement (ICE) Enforcement and Removal Operations (ERO) must consider and address the particular needs and vulnerabilities of pregnant women detained in its custody. As directed in Secretary Johnson’s memorandum, entitled Policies for the Apprehension, Detention and Removal of Undocumented Immigrants (Nov. 20, 2014), absent extraordinary circumstances or the requirement of mandatory detention, pregnant women will generally not be detained by ICE. While detained in ICE custody, pregnant women will be re-evaluated regularly to determine if continued detention is warranted, receive appropriate prenatal care, and be appropriately monitored by ICE for general health and well-being.

1.2 This memorandum sets forth procedures to ensure that pregnant individuals detained in ICE custody are identified, monitored, and housed in the most appropriate facility to manage their care. The memorandum outlines the relevant responsibilities of offices within ERO to identify and track pregnant detainees, ensure that they are receiving appropriate prenatal care, and re-evaluate their continued detention on an ongoing basis.

1.3 This memorandum codifies existing ICE policy and procedures that address the identification and monitoring of pregnant women detained in ICE custody, and complements ICE’s national detention standards and ICE Health Service Corps (IHSC) policies, including those referenced below.¹

¹ Unless stated otherwise, any reference to “ICE’s national detention standards” within this memorandum refers to the 2000 National Detention Standards, the 2008 Performance-Based National Detention Standards, and the 2011 Performance-Based National Detention Standards.
Identification and Monitoring of Pregnant Detainees
Page 2

2. Policy.

2.1 ERO is committed to identifying and providing appropriate care for pregnant women detained in ICE custody. ICE’s national detention standards require facilities housing immigration detainees to provide the following to all newly admitted detainees: (1) an initial medical screening immediately upon their arrival, including appropriate pregnancy screening; (2) a 14-day full medical assessment; and (3) timely referral for appropriate prenatal and medical care.

2.2 Consistent with ICE’s national detention standards, detention facilities are required to notify ERO whenever a pregnant detainee is identified (i.e., detainees with “special needs”). The Field Office Director (FOD) shall take steps to ensure he or she is notified whenever a detainee is determined to be pregnant, and shall notify IHSC Headquarters (HQ) as further provided in Sections 5.1 through 5.3, below. FODs will coordinate with ERO Field Operations on an ongoing basis to determine whether continued detention of the pregnant detainee is warranted. The FOD shall also coordinate with IHSC on an ongoing basis to ensure that the pregnant detainee is appropriately housed, to track the term of the pregnancy, and to ensure the pregnant detainee is receiving necessary and appropriate medical care while in custody.

2.3 IHSC will maintain information regarding all pregnant detainees in ICE custody, based on information received from the FODs, IHSC Health Services Administrators (HSA), IHSC Field Medical Coordinators (FMC), and other designated IHSC personnel. IHSC will develop a system for maintaining this information, providing for ongoing monitoring, tracking, and communication with the field concerning the medical condition of the pregnant detainee and/or the fetus.

3. Superseded Policies and Guidance. The following ICE policy is hereby superseded:


4. Apprehension, Detention, and Release. If a pregnant detainee is not subject to mandatory detention, or is otherwise eligible for parole after a finding of credible fear, the FOD shall ensure she is not detained or, if already detained, is released from detention unless the FOD determines that “extraordinary circumstances” warrant detention.\(^2\) Any decision to detain a woman determined to be pregnant, who is not subject to mandatory detention, must be approved by the FOD, and the FOD must notify ERO Field Operations of the decision. If a pregnant detainee would be subject to mandatory detention, the FOD shall, when feasible, consult with Office of the Principal Legal Advisor (OPLA) management prior to making a custody determination. Pregnant women released subject to enrollment in an Alternatives to

Identification and Monitoring of Pregnant Detainees

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Detention program will not be required to wear a radio frequency or global positioning system monitor.

5. Identification and Notification Procedures.

5.1 IHSC facilities. In detention facilities staffed by IHSC, the HSA shall notify the FOD as soon as practicable of any detainee housed at the facility who is determined to be pregnant, but no later than 72 hours after such determination.

5.2 Non-IHSC facilities. In facilities not staffed by IHSC, the FOD, in coordination with the FMC or other designated IHSC personnel, shall take steps to ensure that he or she is notified as soon as practicable by facility custody personnel or medical staff of any detainee housed at the facility who is determined to be pregnant, but no later than 72 hours after such determination.

5.3 Upon receipt of notification from detention facility personnel, IHSC or other ERO personnel, or any other source, of a detainee determined to be pregnant, the FOD, in coordination with HSAs, FMCs and other designated IHSC personnel in the FOD’s area of responsibility, shall immediately notify IHSC HQ, in writing, of the detainee’s pregnancy.

6. Centralized Tracking of Pregnant Detainees. In coordination with ERO Field Operations and the ERO Custody Management, IHSC HQ shall collect and maintain relevant information received from the FODs, HSAs, FMCs, and other designated IHSC personnel regarding pregnant detainees, and shall develop a system for maintaining that information to allow for ongoing monitoring and tracking.

7. Monitoring Status of Pregnant Detainees

7.1 Upon receipt of information that a detainee is pregnant, IHSC shall review facility capabilities to determine if another detention or off-site treatment facility would provide an environment better suited to the needs of the detainee. IHSC shall immediately report its conclusion to the FOD and, where appropriate, suggest the detention facility for transfer and treatment. Where it is determined that the detainee is not appropriately housed, absent exceptional circumstances, the FOD shall transfer the detainee as soon as practicable. All transfer determinations shall be made in accordance with the requirements of ICE Policy No. 11022.1: Detainee Transfers (Jan. 4, 2012).

7.2 IHSC shall, in coordination with the FOD, continuously monitor the detainee’s condition and ensure the detainee is receiving appropriate care. The term of the pregnancy, as well as the general health of the pregnant detainee and the medical condition of the fetus must all be monitored while the detainee remains detained in ICE.

3 In facilities not staffed by IHSC, IHSC and the FMC will work with facility medical staff, but will not control or provide direct medical care.
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custody. HSAs, FMCs, and other designated IHSC personnel shall provide updates to
IHSC HQ at least weekly.

7.3 HSAs, FMCs, and other designated IHSC personnel must report any major changes in
the health of the pregnant detainee or the medical condition of the fetus to the FOD and
to IHSC HQ immediately.


8.1 At least weekly, ERO Field Operations shall, in consultation with IHSC HQ and OPLA
management, evaluate whether each pregnant detainee’s continued detention is
appropriate.

8.2 In cases ERO Field Operations deems appropriate, it shall consult with the relevant
FOD to consider whether a pregnant detainee’s continued detention warrants
reconsideration.

9. Authorities and References.

9.1 Immigration and Nationality Act §§ 212(d)(5), 235(b), 236, 241.

9.2 8 C.F.R. §§ 1.1(q), 212.5, 235.3, 236.2(b).

9.3 Memorandum from Jeh Charles Johnson, Secretary of Homeland Security, Policies for
the Apprehension, Detention and Removal of Undocumented Immigrants (Nov. 20,
2014).

9.4 National Detention Standards, including “Medical Care” Standard.

9.5 2008 Performance Based National Detention Standards, including Standard 4.3
“Medical Care.”

9.6 2011 Performance Based National Detention Standards, including:

1) Standard 4.3 “Medical Care.”

2) Standard 4.4 “Women’s Medical Care.”

9.7 IHSC Policy 04-02 “Women’s Medical Care.”

9.8 ICE Policy No. 11020.1: Use of GPS Monitoring Devices on Persons who are
Pregnant or Diagnosed with a Severe Medical Condition (Sept. 14, 2009).
10. No Private Right of Action. This document provides only internal ICE policy guidance, which may be modified, rescinded, or superseded at any time without notice. It is not intended to, does not, and may not be relied upon to create or diminish any rights, substantive or procedural, enforceable at law or equity by any party in any criminal, civil, or administrative matter. Likewise, no limitations are placed by this guidance on the otherwise lawful enforcement or litigative prerogatives of ICE.
ICE Directive 11032.3: Identification and Monitoring of Pregnant Detainees

Issue Date: December 14, 2017
Effective Date: December 14, 2017
Federal Enterprise Architecture Number: 306-112-002b

1. **Purpose/Background.** This Directive sets forth policy and procedures to ensure pregnant detainees in U.S. Immigration and Customs Enforcement (ICE) custody for immigration violations are identified, monitored, tracked, and housed in an appropriate facility to manage their care. This Directive codifies existing ICE policy and procedures and complements ICE’s national detention standards\(^1\) and ICE Health Service Corps (IHSC) policies.

2. **Policy.** ICE is committed to identifying and providing appropriate care for pregnant detainees in ICE custody. ICE’s detention standards generally require detention facilities to notify ICE after a pregnant detainee is identified.

   Enforcement and Removal Operations (ERO) officers and Homeland Security Investigations (HSI) agents will notify their Field Office Directors (FODs) and Special Agents in Charge (SACs), respectively, when they arrest and detain a pregnant individual in ICE custody. HSI SACs shall notify the ERO FOD when administratively arresting a pregnant individual who will be detained in ICE custody. ERO FODs shall notify the local Field Medical Coordinator (FMC) upon learning of a pregnant detainee.

3. **Definitions.** None.

4. **Responsibilities.**

4.1. **ERO Field Office Directors** are responsible for:

   1) Ensuring local IHSC and custody personnel, or medical staff in non-IHSC staffed facilities, have a process in place to notify the FOD, consistent with applicable detention standards, no later than 72 hours after a detainee is determined to be pregnant;

   2) Ensuring detention facilities are aware of their obligations regarding pregnant detainees under this Directive and applicable ICE detention standards;

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3) Ensuring pregnant detainees receive appropriate medical care including effectuating transfers\(^2\) to facilities that are able to provide appropriate medical treatment;

4) Monitoring, in coordination with IHSC, the condition of pregnant detainees; and

5) Ensuring that ERO officers are aware of policy related to the use of restraints for pregnant detainees.

4.2. **HSI Special Agents in Charge (SACs)** are responsible for:

1) Ensuring the HSI agents notify the SAC as soon as practical when a pregnant individual is arrested;

2) Notifying the FOD as soon as practical when a pregnant individual is arrested and is detained in ICE custody; and

3) Ensuring HSI agents are aware of policy related to the use of restraints for pregnant detainees.

4.3. **IHSC Personnel** are responsible for:

1) Notifying the FOD and IHSC HQ, as soon as practical, when a pregnant detainee is identified;

2) Monitoring, in coordination with the FOD, the condition of pregnant detainees, including the term of the pregnancy, general health of the pregnant detainee, and medical condition of the fetus, and communicating with the FOD about any specific risk factors or concerns;

3) Oversight and review of facility capabilities to determine if a pregnant detainee’s needs can be accommodated and recommending to the FOD when a pregnant detainee’s transfer to another facility is necessary for appropriate medical care; and

4) Developing and maintaining a system for tracking and monitoring all pregnant detainees in ICE custody.

4.4. **ERO Field Operations Personnel** are responsible for:

1) Consulting with FODs and IHSC on custody determinations or detention facility placement decisions for a pregnant detainee; and

2) Providing case, location, and status information as appropriate to assist IHSC with tracking and monitoring pregnant detainees.

\(^2\) All transfer determinations shall be made in accordance with the requirements of ICE Policy 11022.1: Detainee Transfers (Jan. 4, 2012), or as updated.
4.5. **ICE Officers and Agents** are responsible for notifying, as soon as practical, the SAC or FOD, through their chain of command, when a pregnant individual is arrested and detained in ICE custody.

5. **Procedures/Requirements.**

5.1. **Medical Needs of Detainees.** IHSC will assess detention facilities to determine their ability to meet the needs of pregnant detainees and monitor and track the medical condition of individual pregnant detainees while in ICE custody. When it is determined that a facility cannot provide appropriate medical care in a particular case, the pregnant detainee will be transferred to another detention facility or off-site treatment facility that can provide appropriate medical care.

6. **Recordkeeping.** IHSC will maintain medical records in accordance with records retention schedule DAA 567-2015-0002, which states in relevant part, that medical records for an adult will be retained for 10 years after an individual has been released from ICE custody, and then shall be destroyed. Medical records for minors must be retained until the minor’s 27th birthday. ERO will maintain the records of custody determinations in accordance with records schedule DAA-0563-2013-0001-006. These records are destroyed 75 years after the end of the calendar year in which the data is gathered.

7. **Authorities/References.**

7.1. Immigration and Nationality Act §§ 212(d)(5), 235(b), 236, & 241.

7.2. 8 C.F.R. §§ 1.1(q), 212.5, 235.3, & 236.2(b).

7.3. 2000 National Detention Standards, including “Medical Care” Standard.

7.4. 2008 Performance Based National Detention Standards, including Standard 4.3 “Medical Care,”

7.5. 2011 Performance Based National Detention Standards, including: Standard 2.15 “Use of Force and Restraints”; Standard 4.3 “Medical Care”; and Standard 4.4 “Women’s Medical Care.”

7.6. IHSC Policy 04-02 “Women’s Medical Care.”

7.7. ICE Policy No. 11020.1: Use of GPS Monitoring Devices on Persons who are Pregnant or Diagnosed with a Severe Medical Condition (Sept. 14, 2009), or as updated.

8. **Attachments.** None.

9. **No Private Right.** This document provides only internal ICE policy guidance, which may be modified, rescinded, or superseded at any time without notice. It is not intended
to, does not, and may not be relied upon to create any right or benefit, substantive or procedural, enforceable at law by any party in any administrative, civil, or criminal matter. Likewise, no limitations are placed by this guidance on the otherwise lawful enforcement or litigative prerogatives of ICE.

Thomas D. Homan
Deputy Director and Senior Official
Performing the Duties of the Director
U.S. Immigration and Customs Enforcement
POSITION STATEMENT

Women’s Health Care in Correctional Settings

Introduction

In 2017, women represented 15% of adults in jails and 7% of adults in prisons in the United States (Bronson & Carson, 2019; Zeng, 2019). While the number of incarcerated males has steadily declined, the number of incarcerated females continues to rise. Women have gender-specific health needs that correctional facilities must address. Rates of substance use disorder, prior trauma and abuse, mental illness, and sexually transmitted infections (STIs) are high among incarcerated women, and higher than those of incarcerated men, and these factors intersect with various adverse social determinants of health that characterize their preincarceration lives (Sufrin et al., 2015). Moreover, the majority of incarcerated women are younger than 45 (Bronson & Carson, 2019) and therefore have specific reproductive health needs. Research on the provision of gynecologic and other women’s health care services for incarcerated females is limited, but what does exist has identified neglect of their gender-specific health care needs (Sufrin et al., 2015). This position statement addresses some of the unique health care needs of women in correctional settings.

Background

Gynecological

Research has documented that incarcerated women tend to have higher rates of gynecological conditions, such as irregular menstrual bleeding and vaginal discharge, than nonincarcerated women, and may have had limited access to gynecologic care prior to incarceration. For instance, the chronic stress that characterizes the lives of many incarcerated women, including factors such as unstable housing, poverty, exposure to trauma and violence, addiction, and mental illness, may influence menstrual bleeding. In one study, up to 40% of incarcerated women had abnormal menstrual bleeding (Allsworth et al., 2007). Although the majority of incarcerated women are young and therefore menstruating, their access to menstrual hygiene products is inconsistent and often inadequate (Kravitz, 2019).

To optimize care, a thorough gynecologic history should be collected at intake; standard elements should include menstrual history, sexual activity, prior STIs, prior diagnoses of pelvic pain or fibroids, prior breast and cervical cancer screening, and contraception history. It should also inquire about current symptoms such as vaginal discharge, bleeding, and pelvic pain, and whether the woman has had unprotected sex with a man within the last 5 days (to assess the need for emergency contraception). The U.S. Preventive Services Task Force (USPSTF; 2017) has determined that evidence is insufficient to recommend routine pelvic examinations on asymptomatic, nonpregnant women. Therefore, pelvic exams must be done only when indicated, such as when a woman has symptoms of pain, abnormal bleeding, or discharge, or when cervical cancer screening is due. If a pelvic exam is indicated, health care providers should incorporate a trauma-informed approach (see, for instance, the Reproductive Health Access Project, 2015).

Trauma, Substance Use, and Mental Illness

Incarcerated women have high rates of mental illness and substance use disorders, which are often inadequately treated in the community. In prisons, 66% of females had a history of a mental health...
diagnosis compared to 35% of males (Bronson & Berzofsky, 2017). Similarly in jails, 68% of females had a history of a mental health diagnosis compared to 41% of males (Bronson & Berzofsky, 2017). In state prisons, 69% of females met criteria for drug dependence or abuse (using DSM-IV criteria; Bronson, Stroop, et al., 2017).

The prevalence of histories of sexual, physical, and emotional trauma, including intimate partner violence, among incarcerated women is also astoundingly high, as high as 90% in one study (Lynch et al., 2012). Trauma and victimization may relate to women’s involvement in the criminal justice system, and incarceration itself may retraumatize some of these individuals. Such histories can lead to lifelong mental health issues, such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance use disorders (with their attendant physical health problems), and behavioral problems. Screening for traumatic histories can help identify women who need treatment and other resources, and should be done for all women entering correctional facilities. Correctional health staff should be trained in trauma-informed care and be aware of appropriate referrals for those with a positive screen. Importantly, pelvic and breast exams can be retraumatizing for people with a history of sexual trauma and should be done only when clinically indicated.

**Breast and Cervical Cancer**

Rates of cervical and breast cancer are higher among incarcerated women, likely related to under-screening both before incarceration and while in custody (Brousseau et al., 2019; Pickett et al., 2018). Most cervical cancers are preventable with appropriate screening via Pap smears and HPV testing. The American College of Obstetricians and Gynecologists (ACOG; 2018) recommends screening all females ages 21 to 29 every 3 years, and those ages 30 to 65 every 3 to 5 years. Immunocompromised women and those with history of cervical dysplasia should have more frequent screening, per national guidelines. Importantly, abnormal Pap smear results must be followed up appropriately, which often means colposcopy. Correctional facilities should not routinely perform Pap smears upon intake, unless the woman is due for one based on previous screening, nor annual Pap smears for women serving long sentences. The Centers for Disease Control and Prevention (CDC; n.d.) recommends HPV vaccination through age 26 to reduce cervical cancer risk, and this can be implemented in correctional settings.

National guidelines for screening mammograms for women of average risk should be followed in correctional settings. ACOG (2017a), USPSTF (2016), and the American Cancer Society (ACS; 2019) all have evidence-based guidelines that differ based on the age of initiation of mammograms, screening intervals, and the role of shared decision making. Correctional facilities should decide on one set of guidelines to follow. Recommendations on screening clinical breast exams also vary, with USPSTF and ACS recommending against it and ACOG recommending annual exams beginning at age 40. As with avoiding unindicated pelvic exams due to lack of benefit and potential to retraumatize women, breast exams for asymptomatic women should not be part of routine intake/exam procedures. Women with known personal or familial risk for breast cancer who are serving long sentences should also undergo screening and diagnostic imaging according to national guidelines (Society of Gynecologic Oncology, 2017).

Follow-up of abnormal pap smear or mammogram results may present challenges in short-stay facilities as women may be released before results are returned. Tracking systems and contact with community health providers may facilitate postrelease cancer prevention and diagnosis.
Sexually Transmitted Infections (STI)
A common reported symptom among women in custody is vaginal discharge, which may be related to higher rates of STIs, nonsexually transmitted bacterial vaginosis, or physiologic discharge that women may not be aware can be normal. To distinguish among these diagnoses, women with symptoms should undergo appropriate testing. Women entering correctional facilities have high rates of STIs: A Rhode Island study found that 33% of women tested positive for an STI at admission, including 26% with trichomoniasis (Willers et al., 2008). Rates of gonorrhea as high as 3% (Javanbakht et al., 2014) and chlamydia as high as 14% (Willers et al., 2008) have been reported. The prevalence of HIV among incarcerated women was 1.3% in 2015 (Maruschak & Bronson, 2017).

Based on this high prevalence, the CDC recommends that all females age 35 or younger receive screening for gonorrhea and chlamydia at intake to a correctional facility (Workowski & Bolan, 2015). Vaginal NAAT testing has the highest accuracy and women can collect this as a self-swab. Urine testing, while less accurate, is easier to collect and may be appropriate when vaginal swabs cannot be feasibly collected. Given the trauma that pelvic exams can cause, pelvic exams for the sole purpose of GC/CT testing should be avoided. Women in custody should also be screened for HIV and other STDs in accordance with CDC guidelines (Workowski & Bolan, 2015).

Family Planning
Incarcerated women generally have had limited access to contraceptive services in the community and have high rates of prior unintended pregnancy (Clarke, Herbert, et al., 2006; LaRochelle et al., 2012). A study in Rhode Island showed that only 28% of sexually active women had consistently used birth control in the 3 months prior to incarceration; 85% of these women planned to be sexually active upon release, yet only 9% reported wanting to be pregnant (Clarke, Herbert, et al., 2006). In this same setting, nearly half of the pregnant inmates had become pregnant in between incarcerations (Clarke et al., 2010). Moreover, 60% of incarcerated women who could become pregnant upon release wanted to start a method of contraception while in jail (Larochelle et al., 2012). Despite this need for contraception among incarcerated women, in a national study of correctional health providers only 38% reported that contraceptive methods were available on-site and 55% said that women could not continue using their current method of contraception (Sufrin et al., 2009). In another study, nearly one-third of women entering jail had had unprotected sex within the last 5 days and could therefore be candidates for emergency contraception (Sufrin et al., 2010).

Research has documented the feasibility in a variety of correctional settings of offering the full range of reversible contraceptive methods, including pills, injectable contraception, intrauterine devices, and implants (Sufrin et al., 2017). However, given the potential for women to experience diminished autonomy and coercion in correctional settings, care should be taken when providing long-acting reversible contraceptive methods, which require a provider to insert and remove the device. Likewise, especially given documented recent abuses in prisons, and in accordance with ACOG guidelines, sterilization should generally not be performed on incarcerated people (ACOG, 2017b). Incarceration is also a time to help women who want to become pregnant after release. These women should receive preconception counseling that focuses on the risks of substance use, improving nutritional status such as folate supplementation, and optimizing physical and mental health (ACOG, 2012).
Aging and Chronic Disease
Many prisons may be failing to recognize and prepare for the special physical, preventive health, social, and psychological needs of older females (Revie & Young, 2004), such as menopausal hot flashes, which can be challenging for women to manage in the correctional environment. Incarceration also has been linked to greater prevalence of hypertension, hepatitis, and cancer in women when compared to men, which indicates a need for better health care resources for older females (Binswanger et al., 2009).

Nutrition and Diet
Correctional institutions should ensure that women across all life stages receive a healthy diet consistent with federal dietary and nutrient guidelines (U.S. Department of Agriculture [USDA], 2020). Obesity is more common among incarcerated women (37%-43%) compared to incarcerated men (20%-27%; Maruschak et al., 2015). While the USPSTF has concluded that evidence is insufficient to recommend routine calcium and vitamin D supplementation to prevent fractures in community-dwelling women, they do not make recommendations for women in institutional settings; diets for women in correctional settings should have adequate calcium and vitamin D, following recommendations from the USDA and the National Academies (n.d.).

Pregnancy, Postpartum, and Parenting
Some women enter correctional settings pregnant. Sexually active women remain at risk for pregnancy until they go through menopause or have a hysterectomy. Correctional facilities should screen all women for pregnancy with a history, and offer urine testing to all females under age 50 within 48 hours of arrival. There is a dearth of data on pregnancy frequency and outcomes for people in custody, but a 2019 study reported that a total of 4% of women admitted to 22 state and all federal prisons were pregnant, and that 753 women gave birth in custody (Sufrin, 2019). Additionally, most incarcerated women are mothers and the primary caregivers to young children, ranging from 56% in federal prisons to 70% in local jails (Glaze & Maruschak, 2010). Facilities should support efforts for women to provide breast milk for their infants and to maintain contact with their children, and should recognize the psychological difficulties that separation may cause to incarcerated mothers and their families.

Correctional facilities must provide pregnancy and postpartum care in accordance with community standards of care and national guidelines. More information about pregnancy and postpartum care and nutrition in corrections, the nonuse of restraints in pregnancy, and promoting breastfeeding is available from NCCHC through the following resources:
• Pregnancy and Postpartum Care (white paper)
• Restraint of Pregnant Inmates (position statement)
• Breastfeeding in Correctional Settings (position statement)

Standards
NCCHC recognizes that incarcerated women have gender-specific health care needs that correctional facilities must address. In the Standards for Health Services (the basis of NCCHC’s accreditation program for jails, prisons, and juvenile detention and confinement facilities), standards that impact women’s health care include the following:
• Receiving Screening (E-02) requires inquiry into current and past illnesses, health conditions, and special health requirements; this would encompass current gynecological problems and pregnancy status for women and female adolescents.
• Initial Health Assessment (E-04) recommends that clinical practice guidelines be followed for pelvic examinations and Pap smears.

• Medically Supervised Withdrawal and Treatment (F-04 for adults) and Intoxication and Withdrawal (G-07 for juveniles) acknowledge the special management of pregnant patients with opioid use disorders.

• Contraception (B-06 for adults) and Contraception and Family Planning Services (G-08 for juveniles) recommend providing nondirective contraception counseling and methods, access to emergency contraception, and, along with Medication Services (D-02 for adults), continuation of current contraceptive method while incarcerated.

• Counseling and Care of the Pregnant Inmate (F-05 for adults) and Counseling and Care of the Pregnant and Postpartum Juvenile (G-09) specify that comprehensive counseling and assistance are given to pregnant individuals in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child. It also addresses prenatal care and the nonuse of restraints during childbirth.

• Response to Sexual Abuse (F-06 for adults) recommends that emergency contraception is available.

Position Statement

NCCHC recognizes that the number of incarcerated females is large and growing annually, presenting unique issues for health services. Therefore, NCCHC recommends the following:

1. Correctional institutions must meet recognized community standards for women’s services as promoted by standards set by NCCHC.

2. Correctional health services, community clinicians, and advocacy groups can collaborate to provide leadership for the development of policies and procedures that optimize women’s gender-specific health care needs in corrections, and to do so in trauma-informed ways.

3. Correctional institutions should provide comprehensive services for women’s unique health issues:
   a. Follow age-appropriate screening guidelines established by national organizations for STD screening, breast and cervical cancer screening, and HPV vaccination.
   b. Implement intake procedures that include histories on menstrual cycle, prior pregnancies, gynecologic problems, STI risk factors, HPV vaccine history, current and prior contraception use, current breastfeeding, and history of sexual and physical abuse.
   c. Offer a pregnancy test within 48 hours of admission to all females who could be pregnant—i.e., those who are sexually active (until they go through menopause or have a hysterectomy).
   d. Screen all women at entry for sexual and physical trauma histories and refer for services as indicated; do not perform routine pelvic and breast exams on asymptomatic women as this is medically unnecessary and may be traumatizing.
e. Make trauma-informed, gender-appropriate counseling and treatment available for all women, especially those with mental health issues.

f. Make counseling and treatment available for women with alcohol and other substance use disorders.

g. Recommendations for contraception and pregnancy planning:
   i. Allow women to continue contraceptive methods they are already on pre-incarceration, especially if their incarceration is short term or if the method is for noncontraceptive reasons.
   ii. Offer contraception counseling and access to initiating reversible methods of contraception methods in a noncoercive manner, especially in preparation for release.
   iii. Screen for eligibility for emergency contraception at intake and make such contraception available in a timely fashion.
   iv. Defer sterilization until release.

h. Address the unique health care needs of older women, including symptom management and treatment of menopausal hot flashes.

i. Provide individuals with access to an appropriate, no-cost supply of menstrual hygiene products.

4. Correctional institutions should provide comprehensive sexual and reproductive health education to females that includes education about topics such as STIs, normal and abnormal vaginal discharge, and family planning.

Adopted by the National Commission on Correctional Health Care Board of Directors: September 25, 1994
Reaffirmed with revision: October 9, 2005; October 19, 2014; May 3, 2020

References


