



TESTIMONY OF

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ON

“Assessing the Adequacy of DHS Efforts to Prevent Child Deaths in Custody”

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Chairwoman Rice, Ranking Member Higgins, and Members of the Subcommittee, I appear before you today to discuss the actions that the Department of Homeland Security (DHS) and U.S. Customs and Border Protection (CBP) have taken to ensure all people in our custody—especially children—receive the care they need for the short time they are in our custody before entering the U.S. immigration system.

### **CBP's Law Enforcement Mission**

CBP is a federal law enforcement agency, yet it has a unique role. CBP bears the responsibility of serving as the frontline defense along the Nation's borders. CBP is responsible for protecting the public from dangerous people and materials, while simultaneously facilitating legitimate international travel and trade.

The men and women of U.S. Border Patrol (USBP), Office of Field Operations (OFO), and Air and Marine Operations (AMO) go to work each day not knowing who the next person they encounter will be: an armed criminal, a narcotics smuggler, an individual with ties to terrorism, an adult seeking a better life, or—as has increasingly been the case over the past year—an innocent child. In our unique law enforcement role, CBP must be ready to respond to any situation at any time.

Every day, our law enforcement personnel arrest individuals for a wide variety of criminal and immigration law violations. When we arrest an individual, he or she is booked into our systems; the appropriate biometrics are collected and record checks are run; then agents and officers begin to process the individual through the appropriate pathways in the U.S. criminal justice and immigration systems, depending on the individual circumstances.

As is the case for nearly every police station across the country, CBP's facilities along the border and at ports of entry (POEs) are designed to serve as short-term holding areas for those in our custody to undergo this initial processing. At the earliest opportunity, we notify and arrange a transfer of custody to the appropriate federal agency.

### **The Humanitarian Crisis of Fiscal Year (FY) 2019**

During FY 2019, CBP apprehended or found inadmissible more than 1.14 million individuals. Eighty-five percent of those encounters – more than 977,500 – occurred on the Southwest border, an average of nearly two apprehensions or findings of inadmissibility every minute of every day for the entire year.

Because the majority of illegal entries occur between the ports of entry, USBP apprehensions account for the majority of the people illegally crossing the 2,000-mile border with Mexico. During FY 2019, USBP Southwest border apprehensions exceeded 851,000 – the highest level since FY 2007. Nearly 65 percent of USBP apprehensions were families and children – more than 473,000 individuals – the highest number of family units in any year on record and an

increase of 342 percent over the previous record. Unaccompanied alien children (UAC) apprehensions also increased by 52 percent compared to the previous year. In total, USBP processed more than 321,000 alien children on the Southwest border during FY 2019.

At the peak of the crisis in May 2019, USBP apprehended nearly 133,000 people in a single month. Between January and May, both single adult and UAC apprehensions doubled while family unit apprehensions more than tripled. On a single day in May 2019, USBP apprehended more than 5,500 people on the Southwest border, including more than 1,000 who illegally entered the United States as a single group. This influx led to CBP facilities operating at unprecedented and unsustainable occupancy levels.

CBP's ability to transfer people out of its custody depends on the capacity of our partners at U.S. Immigration and Customs Enforcement (ICE) and the U.S. Department of Health and Human Services (HHS). These and other agencies are able to determine when they accept custody of individuals from CBP; as such, they have a level of flexibility that CBP does not. CBP must process individuals as they are apprehended and maintain custody until our partners can accept custody of them.

In areas of high rates of illegal entry, many Border Patrol stations were unable to efficiently process individuals due to exceedingly high volume. To address this shortfall, CBP temporarily detailed more than 730 CBP officers and more than 320 USBP agents from around the country to augment its operations in these locations. In addition, DHS surged more than 700 personnel from other components to serve in general support and medical support functions, including U.S. Coast Guard, Federal Protective Service, and the Federal Air Marshals Service. These volunteers assisted with functions such as personal property management, meal service, welfare checks, and transportation support.

CBP continued its long-standing practice of prioritizing the processing of UACs, followed by families, then single adults. In addition, CBP partnered with ICE to transport family units by plane or bus to other parts of the border to expedite processing. However, as processing times decreased, ICE and HHS began struggling to keep pace with USBP apprehensions, and the backlog of family units and UACs in USBP custody continued to swell.

Beginning in March 2019, Border Patrol stations released family units directly into the United States to reduce overcrowding. Rather than being transferred to ICE's limited bed space at family residential facilities, more than 145,000 individuals in family units were released on their own recognizance for a later appearance in immigration court. Non-governmental organizations that provided post-release support in border communities soon began experiencing their own overcrowding issues. In contrast to family units, UACs could not be released into communities. Under the Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA), CBP generally must transfer custody of UACs to HHS within 72 hours.

Border Patrol stations were not designed to hold large volumes of apprehended aliens or for their long-term custody after processing is complete. Beginning in February 2019, to accommodate the growing number of people in custody, USBP diverted operating funds to rapidly construct six soft-sided facilities in the Rio Grande Valley, El Paso, and Yuma Sectors. The temporary structures are weatherproof, climate-controlled, and provide areas for eating, sleeping, recreation, and personal hygiene. They include shower trailers, chemical toilets and sinks, laundry trailers, sleeping mats, personal property storage boxes, lockers, power, kitchen equipment, food/snacks/water, clothing and hygiene kits, and space for medical assessment and treatment. Additionally, since the beginning of the crisis, USBP invested over \$230 million in humanitarian support, to include consumables such as meals, snacks, baby formula, shampoo, diapers, and other hygiene items; enhanced medical support; and increased transportation services.

### **Emergency Humanitarian Supplemental Appropriation**

On May 1, 2019, the Administration submitted a request to Congress for emergency supplemental funding for CBP, ICE, and HHS to address the crisis. The *Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act, 2019* was signed into law on July 1, 2019, providing \$4.6 billion in supplemental funding.

This bill provided CBP with \$1.1 billion for humanitarian support, border operations, and mission support. To enhance humanitarian support efforts, CBP purchased food, water, sanitary items, blankets, medical support, and other consumables with these funds; in addition, 462 additional shower stalls, 79 additional portable toilets, six additional laundry trailers, 51 commercial washer-dryer sets, 90 refrigerators and freezers, and 200 climate control systems were procured. CBP also purchased additional transportation assets including buses, vans, and Emergency Medical Technician (EMT) vehicles.

Border operations funding was utilized for overtime and temporary duty assignments for USBP agents and CBP officers as well as costs associated with the DHS volunteer surge force. These supplemental funds enabled the replenishment of operational funds previously expended on soft-sided facilities and humanitarian investments. Without the supplemental appropriation, the funding for our humanitarian efforts would have been exhausted before the end of the fiscal year. Funds were also provided for modernized data systems to better integrate immigration processing and reporting by the DHS, HHS, and the Department of Justice.

Our partners at HHS received \$2.9 billion in the supplemental appropriation, which funded additional HHS shelters and beds, allowing for more expeditious processing and transport of UACs from CBP custody to facilities designed for the long-term care of children. As a result, the number of UACs in USBP custody at any one time dropped from the peak of nearly 2,700 in early June 2019 to around 300 in July 2019.

ICE bed capacity shortfalls limited CBP's ability to transfer single adults to facilities designed for long-term custody. As a result, USBP experienced a higher volume of single adults in custody for longer periods of time. From May through July 2019, USBP continually averaged more than 6,550 single adults in custody at any given time. While DHS requested \$108 million for beds at ICE detention facilities, this provision was not funded.

### **Enhanced Medical Care**

The recent humanitarian and security crisis along the Southwest border created a significant challenge for CBP. The agency was charged with addressing medical support requirements for the increased number of people in custody, including children and family units. CBP recognized the operational and medical importance of prioritizing the expansion of medical support along the Southwest border and remains committed to ensuring that people in CBP custody receive appropriate medical support. CBP has taken steps to significantly enhance our medical support program, consistent with our core law enforcement mission.

Following the surge in UAC encounters during 2014, CBP established a contract for on-site medical support in the busiest sector, Rio Grande Valley. In the summer of 2018 – prior to the tragic deaths of two Guatemalan children in December 2018 – CBP expanded the medical support contract to additional priority locations in the Laredo, El Paso, and Yuma sectors. CBP continued to enhance and expand medical support throughout 2019, dramatically increasing the number of contracted medical professionals from approximately 20 in January 2019 to more than 700 today. Currently, each day, there are approximately 300 contracted medical professionals engaged at more than 40 facilities along the Southwest border, providing 24/7 on-site medical support. Support is now available at all nine Southwest border USBP sectors and all four Southwest border OFO field offices.

CBP recognizes the unique challenges of providing medical support to children in custody, and has extensively consulted with internal and external pediatric subject matter experts, including multiple HHS pediatricians and other senior U.S. Government pediatric care experts. CBP has also collaborated with court-appointed pediatric consultants to inform CBP's approach to care for children in custody, and contracted regional pediatric advisors to provide advice, training, review, coordination, and quality management of CBP pediatric care efforts.

CBP's medical services contract employs medical teams, consisting of Advanced Practice Providers and medical technicians, to provide round-the-clock medical support at priority locations. These medical providers are licensed and credentialed to provide assessment and care for our population in custody, to include children and pregnant women.

This model, a family practitioner model that pairs advanced practice providers such as Physician Assistants or Nurse Practitioners with medical support personnel at CBP facilities, has a layer of supervisory physician-level oversight both regionally and nationally for medical direction and records review. This model has been observed and validated by medical experts including top

pediatricians within HHS, who have indicated it provides the appropriate care and scope of practice for CBP facilities. It also directs development of appropriate medical quality-management efforts, in consultation with the CBP Chief Medical Officer, Office of Chief Human Capital Officer, and the DHS Chief Medical Officer, as well as accountability through the Management Inspection Division and the Juvenile Coordinator.

As noted in the above, CBP utilizes a layered approach to medical support for people in custody. CBP relies heavily on local health systems and local standards of care, referring and transporting people with complex, urgent, or emergent health issues to local hospitals or medical facilities. CBP often operates in remote and austere areas where there are limited medical facilities. In these areas, USBP agents and CBP officers are often the first responders to a person in need of medical attention. More than 1,200 USBP agents and 275 CBP officers have voluntarily taken on the additional responsibilities and training required to maintain EMT or paramedic certifications as a collateral duty. In FY 2019 alone, USBP agents rescued more than 4,900 migrants in distress along the border after they were placed in dangerous situations by smugglers. In addition, USBP referred more than 26,000 people to hospitals or medical facilities.

Additionally, CBP relies upon our partners at ICE and HHS who have more robust medical capabilities in alignment with their respective missions. Medical services, such as vaccinations and convalescence centers, are better provided in shelter care environments such as those provided by HHS and long-term detention environments provided by ICE.

CBP is proud of the great strides we have made in providing critical and life-saving medical support to those in need while remaining cognizant that we are a frontline law enforcement element within a broader network of immigration agencies.

#### *Enhanced Medical Support Directive*

In January 2019, CBP issued an Interim Enhanced Medical Directive, which established initial priority approaches to enhancing CBP medical care for people in custody. On December 30, 2019, CBP issued an Enhanced Medical Support Directive as part of an overarching medical support construct involving a dynamic process of constant review and improvement. This directive was developed using operational and medical lessons learned, and with significant stakeholder and medical expert input.

The Enhanced Medical Support Directive outlines the responsibilities and procedures for both USBP and OFO in how they will deploy enhanced medical support efforts to mitigate health risks to those in custody. This effort aligns USBP and OFO medical support efforts, but is subject to resource availability and operational requirements. The Directive provides top-level guidance and is intentionally flexible, to facilitate modifications in alignment with changing conditions. Furthermore, it establishes foundational levels of medical support, although in many cases, CBP already exceeds these levels. It enhances processes established last year and

provides clear direction for USBP and OFO for establishing an ongoing contract mechanism to support enhanced medical support along the Southwest border.

The Enhanced Medical Directive ensures that CBP will sustain enhanced medical support capabilities with an emphasis on children less than 18 years old. These include a health interview upon initial arrival at a CBP facility. The interviews will be conducted by contracted medical personnel or by CBP agents/officers using a standardized health form. Subject to resource availability, USBP and OFO will ensure a more detailed medical assessment is conducted on all tender-age (12 and under) children, any person with a positive response to mandatory referral questions on the health interview form, or any other person with a known or reported medical concern. The medical assessments will be conducted by CBP contracted health providers where available, or, when appropriate, the individual will be referred to the local health care system/providers. CBP EMT-certified agents and officers will conduct medical assessments only in exigent circumstances and when operationally available.

### *Infectious Disease*

CBP works closely with state, local, and federal public health officials regarding public health and infectious disease issues. CBP continues to engage in extensive dialogue and consultation with numerous stakeholders who have provided subject matter expert consultation, including DHS, U.S. Coast Guard medical leadership, HHS, and the Centers for Disease Control and Prevention.

CBP contracted medical personnel are trained to provide early identification, treatment, isolation, infection control, and public health support for infectious diseases in CBP facilities. For example, CBP's onsite contracted medical teams provide early identification and diagnosis via rapid flu testing; they can also provide antiviral treatment and prophylaxis onsite. Furthermore, they have the ability to enact enhanced prevention and control measures, and referrals to hospitals and emergency rooms if necessary.

CBP's medical capabilities are part of a larger system of care for migrants in Government custody. CBP ensures that individuals in our custody receive the appropriate medical care during the short time they are in our custody; however, longer-term facilities at ICE and HHS have the resources and facilities to provide necessary comprehensive medical care, including vaccinations.

### **The Crisis Is Far from Over**

As a result of multiple whole-of-government initiatives to expedite immigration hearings, repatriate individuals ordered for removal, and effectively end the release of migrants directly from the border, Southwest border apprehensions have dropped by 75 percent since May 2019. Word of mouth, including the use of social media and other internet-based applications, which had been used to encourage, organize, plan, and initiate mass immigration from Central America,

is now informing prospective migrants that they can no longer rely on being released once they get here.

The reduced migration flows have begun to alleviate the stress on our system that the crisis created. Many of the improvements made to address the crisis relied on the influx of emergency supplemental funds that do not last forever. Similarly, these new initiatives rely heavily on partnerships with Mexico and Central American nations. Neither address the fundamental flaws in our immigration system. For more than a year now, CBP has pleaded with Congress to address the layers of existing law and judicial decisions that adversely impact our ability to effectively manage our immigration system. There are three key gaps in our legal framework that Congress has yet to address.

First, the 1997 *Flores* Settlement Agreement requires the Government to transfer alien minors to non-secure, licensed programs “as expeditiously as possible” and, if detention is not required, release alien minors from detention without unnecessary delay. Soon after the 2014 surge in UACs along the Southwest border, the U.S. District Court for the Central District of California reinterpreted the *Flores* Settlement Agreement as applying not only to minors who arrive in the United States unaccompanied, but also to those children who arrive with their parents or legal guardians. In other words, the U.S. District Court for the Central District of California applied the *Flores* Settlement Agreement to all children in our custody. The court also determined that ICE’s family detention facilities are not licensed and are secure facilities. As a result of this case and others like it, DHS’s ability to detain family units for the duration of their immigration proceedings is limited, in that DHS rarely detains accompanied children and their parents or legal guardians for longer than 20 days.

Second, the TVPRA requires that the U.S. Government extend certain protections to UACs. Specifically, the TVPRA requires that, once a child is determined to be a UAC, the child must be transferred to HHS custody within 72 hours, absent exceptional circumstances, unless the child is a national or habitual resident of a contiguous country and is determined to be eligible to withdraw his or her application for admission voluntarily (i.e., not a trafficking victim, does not have a fear of return, and is able to make an independent decision to withdraw). UACs from countries other than Canada and Mexico are not permitted to withdraw their application for admission and thus, cannot be quickly returned to their country of origin. During FY 2019, 79 percent of the UACs apprehended by USBP on the Southwest border originated in Guatemala, Honduras, and El Salvador.

Third, CBP has seen a significant increase in the number and percentage of people who seek admission without proper documentation or unlawfully enter the United States then assert an intent to apply for asylum or claim a fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. This dramatic increase is due in part to the systemic deficiencies created by the ineffective legal standards – again, further straining border security resources, immigration enforcement and courts, and other federal resources.



## **Conclusion**

DHS and CBP remain committed to ensuring that individuals in CBP custody receive appropriate care, including medical support, but these efforts do not address the ongoing challenges we face. Once again, we urge Congress to take a comprehensive look at the immigration laws and the implications from those court decisions that shaped immigration laws. Real change requires real reform.

Thank you for the opportunity to testify before you today. I look forward to your questions.