OFFICE OF INSPECTOR GENERAL

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Before the Committee on Homeland Security

U.S. House of Representatives

"Children in CBP Custody: Examining Deaths, Medical Care Procedures, and Improper Spending"

Homeland Security

July 15, 2020
12:00 PM

Chairman Thompson and Ranking Member Rogers, thank you for the opportunity to testify today about the Department of Homeland Security (DHS) Office of Inspector General's (OIG)'s work related to children in U.S. Customs and Border Protection (CBP) custody. My testimony today will include a discussion of our investigations of the tragic deaths of two migrant children while in CBP custody, our unannounced inspections of CBP facilities, and related ongoing work.

OIG is organized into three operational elements: the Office of Investigations, comprised of special agents who investigate criminal and administrative misconduct on the part of DHS personnel, contractors, and grantees; the Office of Special Reviews and Evaluations, comprised of inspectors, analysts and attorneys who inspect, evaluate, and review DHS programs and operations; and the Office of Audits, comprised of auditors and analysts who conduct financial, grant, and performance audits.

My testimony today includes work by all three of our organizational units; specifically, our special agents who investigated the circumstances of two children who died in CBP custody in December 2018; our inspectors who conduct unannounced inspections of CBP holding facilities; and our auditors who have ongoing work relevant to the Committee's interests here today.

My testimony today includes a discussion of the conditions on the Southwest Border in late 2018 and throughout 2019. Prior to my confirmation by the Senate in July 2019, I committed to your counterparts on the Senate Homeland Security Committee that I would visit the Southwest Border and observe these conditions personally if confirmed. After my confirmation, I also personally committed to this Committee to do the same. I was able to do so in October 2019, when I visited DHS facilities and operations in both the El Paso and Tucson Sectors.

Investigations of the Death of Children While in CBP Custody

On December 8, 2018, a seven-year old girl from Guatemala died while in CBP custody. Subsequently, on December 25, 2018, an eight-year old boy passed away while in CBP custody. DHS OIG Special Agents from our El Paso Field Office conducted two separate investigations to determine the circumstances of the in-custody deaths of both children, including any form of misconduct by CBP personnel, and if misconduct was found, to determine if it was criminal or administrative.[1]

[1] These investigations were not intended to be systemic reviews that would evaluate CBP's policies or procedures for caring for migrants in custody or from which over-arching conclusions about CBP's role could be drawn. While these investigations were not program

Both of our investigations determined that all CBP employees who were involved did everything possible to ensure both children received medical treatment. Our investigations did not find misconduct or malfeasance on the part of any CBP personnel.

Although the deaths of these two children occurred within 18 days of each other and less than 100 miles apart, each circumstance was unique and our office conducted separate investigations of each death. I will provide the Committee a summary of each investigation, beginning with the death of the seven-year old girl.

Investigation Concerning the Death of a Seven-Year Old Girl

The seven-year old girl and her father entered the United States on December 6, 2018 and were apprehended by Border Patrol agents with a large group of undocumented aliens at Forward Operating Base (FOB) Bounds, near the Antelope Wells, New Mexico, Port of Entry. During intake processing, Border Patrol agents conducted brief medical assessments of all detainees in the group and memorialized the assessments on the required form (I-779). DHS OIG reviewed the form for the girl and found that it was signed by her father and reported that both the child and her father were in good health. Border Patrol made arrangements to transport the detained migrants by bus from FOB Bounds to the Border Patrol Station in Lordsburg, New Mexico, 93 miles away, for further processing and for short-term detention. Because the group was large, the bus would need to make two round trips to transport them. Prior to transport, the group of undocumented aliens, to include the girl and her father, were asked again by Border Patrol agents if anyone was sick, pregnant, or was an unaccompanied child. DHS OIG was told that if anyone met these conditions, it was CBP's practice that they would be assigned to the first bus going to the Lordsburg station for processing. According to the interviews we conducted, no one came forward with these conditions.

Our investigation determined that because the Border Patrol was not aware of the child's illness, she and her father were assigned to the second bus transporting the undocumented aliens to the Lordsburg station. While boarding the bus, the child's father reported to one of the drivers that she was sick and vomiting. The driver notified his supervisor, who called ahead to the Lordsburg station, notifying them that there was a sick child on the bus.

According to our interviews, during transport to the Lordsburg station, the girl's father did not report to CBP that she was vomiting. However, according to interviews of the other bus passengers, the father did approach

evaluations of CBP procedures, we do have an ongoing audit regarding CBP's procedures for detained migrants experiencing serious medical conditions.

several other riders to ask for medicine for his daughter. When the bus arrived at the Lordsburg station, the child and her father were the first ones off the bus and were immediately met by the CBP paramedic on duty.

The girl's father reported to the paramedic that she was not breathing. After the paramedic performed a quick assessment, he determined that the child was breathing, but was having difficulty, and asked someone to call 911. Two additional CBP EMTs joined to assist with assessing and providing care to the child. Her father reported to the EMTs that she had not eaten and had been throwing up for the last two to four days. The paramedics took her temperature and discovered she had a fever of 105.7 degrees Fahrenheit. They administered oxygen with a mask and applied ice packs and wet towels in an attempt to cool her down. They were unable to provide children's Tylenol to the child because she could not swallow. Similarly, the paramedics were unable to intubate her because a manipulation of her mouth would have caused her to vomit.

County Emergency Medical Services (EMS) arrived approximately 10 minutes after the 911 call. The EMS staff performed life support measures, including oxygen and intravenous fluids, and recommended that the child be transported to the hospital by ground transport, which would have taken approximately 2 hours. Due to her worsening condition, the Lordsburg station paramedic recommended she be transported by air, to get her to the hospital faster. The air support was cleared to fly and arrived at the Lordsburg station approximately 40 minutes after it was requested. The child was transported to El Paso Children's Hospital—a level I trauma center.

The child arrived at the Hospital in El Paso, TX on December 7, 2018 and passed away on December 8, 2018. The medical examiner's report concluded that she died from organ dysfunction caused by sepsis, a rapidly progressive infection, and systemic bacterial spread.

DHS OIG received notice of the child's death on December 14, 2018 from CBP OPR and immediately initiated an investigation. The OIG conducted the first interviews on December 15, 2018.

We dedicated 7 agents and 2 support staff to investigate her death. Our investigation included interviews with approximately 23 individuals who had direct contact with the child and her father, or may have witnessed her condition. These individuals included Border Patrol agents and apprehended detainees who had contact with the child and her father. We reviewed all audio and video evidence that was available; including eight DVDs of video footage and recorded radio communications. We also reviewed the detailed medical examiner's report documenting the causes of death. Our investigation did not reveal any evidence of CBP employee malfeasance or misconduct.

Investigation Concerning the Death of an Eight-Year Old Boy

An eight-year old boy and his father were apprehended in El Paso, Texas on December 18, 2018. They were processed at the Paso Del Norte Station and then transferred to the El Paso Station due to detention space limitations. They remained at the El Paso Station until December 23, 2018, when they were transferred to Alamogordo, New Mexico to complete processing and then transferred to Highway 70 Alamogordo Checkpoint to await family placement.

On December 24, 2018, while at the Highway 70 Alamogordo Checkpoint, a Border Patrol agent observed the child in need of medical attention. The boy and his father were transported to the Gerald Champion Regional Medical Center for treatment. According to our interviews, while at the hospital, a medical professional administered acetaminophen to the child and informed his father that he had an upper respiratory infection. The corresponding hospital discharge paperwork also stated the child was diagnosed with an upper respiratory infection but prescribed ibuprofen. Medical records reviewed by OIG from the emergency room visit stated the diagnosis was a suspected acute upper respiratory infection and noted "low suspicion for any serious medical infection."

Hospital records reviewed by OIG indicated that the child was tested for Strep, Influenza A, and Influenza B during his first visit to the hospital. According to the records, the test for Influenza B was positive and the tests for Strep and Influenza A were negative. Hospital personnel did not tell Border Patrol or the child's father that he was diagnosed with Influenza B. The hospital discharge paperwork also did not include a diagnosis of Influenza B.

According to our interviews, the hospital called in a prescription to a nearby pharmacy for acetaminophen and amoxicillin. The hospital discharge paperwork; however, references only a prescription for ibuprofen. On their return trip from the hospital, the Border Patrol agent stopped at the pharmacy to fill the prescriptions; however, he was told that one prescription was not ready and the other would not be covered under insurance. The agent, the child, and the child's father left the pharmacy with no prescriptions.

That evening, a second Border Patrol agent went back to the pharmacy to pick up both prescriptions, and paid for one of them with his personal funds. When he returned, the child was given both medications. Approximately an hour after receiving the medications, the child's father reported that the child was feeling better and had eaten. However, later that night, the child's father requested to return to the hospital because his son was feeling ill again. A Border Patrol agent drove the child and his father to the Gerald Champion Regional Medical Center again.

Upon arriving at the hospital, the Border Patrol agent found the child's father holding him and crying. The Agent observed blood on the father's hand. The child received immediate attention from the hospital staff, but was pronounced dead a short time later.

The state medical examiner's autopsy report found the cause of the child's death was "complications of influenza B infection with Staphylococcus aureus superinfection and sepsis."

DHS OIG received notice of the child's death from CBP's Office of Professional Responsibility (OPR), on December 25, 2018, and initiated an investigation into the circumstances surrounding the death that same day. Because this was the second death investigation of a child in CBP custody in a short time frame, and because a large number of OIG agents were already assigned to the investigation of the death of the seven-year old girl, the OIG decided to leverage assistance from CBP OPR with conducting specific parts of the investigation, for example interviews.

Our investigation included interviews with 11 individuals who had direct or indirect contact with the child and his father. These individuals included Border Patrol agents, apprehended detainees who had contact with the child and his father, and the Public Information Officer at the Gerald Champion Regional Medical Center. We reviewed video footage of the child and his father's initial apprehension, footage from their holding cell at Alamogordo, and footage from the Gerald Champion Regional Medical Center. We also reviewed the detailed medical examiner's report documenting the causes of death. Our investigation did not reveal any evidence of CBP employee malfeasance or misconduct.

Upon the conclusion of both investigations, we posted summaries of the investigations on our public website. While we are prohibited by privacy laws from posting full OIG reports of investigation, in an effort to be transparent about OIG's work, we determined in these instances that public summaries were appropriate. We provided both reports to the Committee after receiving a written request from the Chairman. We have also provided two briefings to Committee staff regarding the investigations, and exchanged written correspondence with the Committee regarding several outstanding questions.

DHS Office of Inspector General's Unannounced Inspections of CBP Facilities

DHS OIG initiated an unannounced inspections program several years ago in response to concerns raised by Congress about conditions for aliens in CBP and U.S. Immigration and Customs Enforcement (ICE) custody.[2]

CBP is responsible for providing short-term detention for aliens arriving in the United States without valid travel documents in compliance with the National Standards on Transport, Escort, Detention and Search (TEDS).[3] TEDS standards govern CBP's interactions with detained individuals, providing guidance on things like duration of detention, access to medical care, access to food and water, and hygiene.

TEDS standards generally limit detention in CBP facilities to 72 hours, with the expectation that CBP will transfer unaccompanied alien children (UAC) to the Department of Health and Human Services (HHS) Office of Refugee Resettlement, and families and single adults to ICE long-term detention facilities. As such, CBP's holding facilities are intended for short-term custody, which is evident in how they are structured and equipped. Although the infrastructure can vary across different facilities, most CBP facilities hold detainees in locked cinderblock cells that have a metal combined toilet and sink. Facilities generally do not have beds, though some have plastic-covered foam mattresses, and only some facilities have showers. Further, most facilities are not equipped to wash laundry or cook meals; facilities generally do not have cloth blankets and rely on Mylar blankets for bedding, and staff use microwaves or warming ovens to heat frozen food or prepare other food items, such as instant soup or oatmeal.

OIG's unannounced inspections of CBP holding facilities evaluate compliance with TEDS and determine whether CBP provides reasonable care to detainees, from apprehension to holding. During our unannounced visits to ports of entry and Border Patrol facilities, we focus on elements of the TEDS standards that can be observed and evaluated by OIG inspectors without specialized law enforcement or medical training. These inspections are limited-

[2] Since 2014, DHS OIG has issued the following reports regarding unannounced inspections of CBP detention facilities: *Capping Report: CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge* (OIG-20-38), *Management Alert – DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley* (OIG-19-51), *Management Alert – DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center* (OIG-19-46), *Results of Unannounced Inspections of Conditions for Unaccompanied Alien Children in CBP Custody* (OIG-18-87), *Oversight of Unaccompanied Children 3* (Oct. 2, 2014), *Oversight of Unaccompanied Children 2* (Aug. 28, 2014), *Oversight of Unaccompanied Children 1* (July 30, 2014).

[3] U.S. Customs and Border Protection, National Standards on Transport, Escort, Detention, and Search, October 2015.

scope compliance inspections and we report solely on observations of compliance or non-compliance with TEDS on the day and time of the inspectors' visit. As part of our inspections, we also review records and logs and interview a limited number of CBP personnel and, when possible, detainees.

In fiscal year (FY) 2019, Congress mandated that OIG continue its program of unannounced inspections of immigration detention facilities, and directed OIG to "pay particular attention to the the health needs of detainees."[4] In response, between April and June 2019, we conducted 21 unannounced inspections of Border Patrol facilities and CBP ports of entry in Arizona, New Mexico, and Texas. Again, the objectives of our unannounced visits were to determine whether CBP complied with observable TEDS standards, and whether CBP provided reasonable care from apprehension to holding, including its ability to identify and respond appropriately to medical emergencies. During these inspections, we did not evaluate compliance with all provisions of TEDS standards, but rather prioritized those that protect children and other at-risk detainees, as well as those related to access to medical care.

We began our FY 2019 unannounced visits of CBP facilities in April 2019. In the summer of 2019, we issued two Management Alerts and made one recommendation about issues we observed requiring DHS' immediate attention. We issued these interim reports because the conditions we observed posed a serious and imminent threat to the health and safety of both DHS personnel and detainees. These issues included dangerous overcrowding and prolonged detention of children and adults in both the El Paso and Rio Grande Valley sectors.[5]

Building on the body of work we published last summer, we recently issued a capping report summarizing and incorporating our observations during 2019 unannounced inspections.[6] The capping report included the following findings:

- Border Patrol stations were overcrowded,
- Border Patrol stations held detainees longer than 72 hours,
- Overcrowding and prolonged detention affected Border Patrol's compliance with other standards for detainee care,
- Provision of medical care at short-term facilities has limits, and

[4] Joint Explanatory Statement, *Consolidated Appropriations Act, 2019* (P.L. 116-6).
[5] *Management Alert – DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley* (OIG-19-51), *Management Alert – DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center* (OIG-19-46).
[6] *Capping Report: CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge* (OIG-20-38).

- CBP Ports of Entry generally met TEDS standards.

Unable to Control the Number of Apprehensions, and with Limited Transfer Options, Border Patrol Stations Were Overcrowded

During FY 2019, CBP experienced a surge in families and UACs crossing the Southwest Border, with these two groups representing the majority of all Border Patrol apprehensions. These significant increases contributed to Border Patrol apprehending more than twice the undocumented aliens during FY 2019 than in any of the previous four full fiscal years.

With the surge in apprehensions in FY 2019, we observed overcrowding in 10 of the 14 Border Patrol facilities we visited; in some instances the overcrowding was so severe that detainees were in standing-room only conditions for days or weeks. As described in our Management Alerts for example, when our team arrived at the El Paso Del Norte Processing Center, they found that the facility — which has a maximum capacity of 125 detainees — had more than 750 detainees onsite.

Despite the crowding, our interviews with detainees and observations of the facilities indicated that Border Patrol ensured detainees had ready access to potable water and toilets. We also observed all Border Patrol stations had food, snacks, juice, and infant formula available for children. All Border Patrol stations we visited also had basic hygiene supplies (e.g., toilet paper, diapers, and baby wipes). However, not all facilities had consistently provided children access to hot meals as required. Additionally, not all facilities we visited had showers or provided showers consistently to detainees approaching 72 hours in detention. Border Patrol had arranged temporary shower trailers for some, but not all, facilities. Some facilities without showers on site provided "dry showers" (i.e., a wet wipe and dry wipe) to detainees.

In response to the FY 2019 surge in Southwest Border apprehensions, Border Patrol established temporary holding areas to provide additional shelter for the high volume of detainees. These included both makeshift arrangements such as parking lots or sally ports with access to portable toilets and water, and large soft-sided white tents as standalone facilities. These tents had air conditioning, portable toilets, washstands, showers, and laundry facilities. At the time of our site visit, these tents were reserved for families, who were being provided sleeping mattresses and hot meals.

Based on our observations, we recommended in one of our Management Alerts that DHS take immediate steps to alleviate the overcrowding at the El

Paso Del Norte Bridge Processing Center.[7] CBP concurred with our recommendation and described its efforts to construct additional soft-sided structures to accommodate more detainees, as well as to open a Centralized Processing Center within 18 months. That recommendation remains resolved and open, meaning that OIG considers CBP's proposed corrective actions responsive to the recommendations.

With Limited Transfer Options, Border Patrol Held Detainees for Prolonged Periods

With limited transfer options, in 12 of the 14 Border Patrol stations we visited, we identified detainees held longer than the 72 hours generally permitted, some of whom had been held for longer than a month. At the time of our visits, across the 14 facilities, at least 3,750 detainees out of approximately 9,400 (nearly 40 percent) had been held longer than 72 hours.[8] With HHS and ICE operating at or above their bed space capacity for UACs and single adults during the surge, Border Patrol officials said they struggled with prolonged detention for these populations.

After observing the challenges CBP faced during the surge with meeting the 72-hour target for release or transfer from CBP custody, we initiated a separate review to identify the key factors contributing to prolonged CBP detention during the surge and propose ways for DHS to enhance its ability to respond better to these challenges in the future. That review is ongoing and the results will be published in an upcoming OIG report.

Overcrowding and Prolonged Detention Also Affected Border Patrol's Compliance with Other Standards for Detainee Care

The overcrowding and prolonged detention described above affected Border Patrol's compliance with other TEDS standards.

For example, UACs must be offered use of a telephone to call a relative, sponsor, or consulate. We interviewed UACs at several busy and overcrowded facilities and were told that, in some facilities, they had not been offered telephone access; logs in Border Patrol's data system confirmed this. Incomplete records in other facilities indicated Border Patrol was either not tracking UAC access to telephones or was not offering the telephone calls. In

[7] *Management Alert – DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center* (OIG-19-46).

[8] We derived these numbers from apprehension and custody data maintained in Border Patrol's case management database, which stores real-time data on detainees currently in Border Patrol's custody. However, due in part to system outages at the time of our visit and detainee transfers between facilities, the precise numbers may be slightly higher or lower than the numbers reflected in the data.

contrast, at another Border Patrol facility, we observed UACs making phone calls.

Additionally, according to TEDS standards, CBP will safeguard detainees' personal property unless it is deemed contraband. However, we observed Border Patrol agents in the El Paso sector discarding detainee property, at times indiscriminately. For instance, while property-handling practices varied by station and there did not appear to be a sector-wide policy on discarding property, we observed agents at the El Paso Del Norte Processing Center collecting detainees' valuables (e.g., money and phones), but discarding virtually all other detainee personal property — including backpacks, suitcases, handbags, and children's toys — in the nearby dumpster. We made similar observations in other locations in the El Paso sector. In contrast, in other sectors such as the Tucson sector, we observed that all detainee personal property was tagged and stored.

In response to these observations, we made two recommendations to CBP. First, we recommended that CBP establish procedures for evaluating compliance with requirements to provide and document phone calls for unaccompanied alien children in custody. Second, we recommended that CBP implement consistent guidance on how it handles detainee personal property.

CBP concurred with both of our recommendations and both of them are resolved and open. CBP is taking steps to implement each recommendation by December 31, 2020.

In addition to our observations regarding access to phone calls for UACs and the safeguarding of detainee personal property, we also observed that—with the exception of facilities dedicated to housing UACs and families—Border Patrol facilities did not consistently meet TEDS standards requiring some special protections for children in detention, including additional requirements for food, clothing, and conditions of detention. Based on our observations, not all children had access to a shower after 48 hours, or a change of clothing, as recommended under the standards. Two facilities in the Rio Grande Valley had not provided children access to hot meals until the week we arrived; management at these facilities told us there were too many detainees on site to microwave hot meals, and it had taken time to secure a food contract. Additionally, preventing the spread of contagious illnesses resulted in some UACs and families needing treatment being held in closed cells, rather than the least restrictive setting recommended in TEDS.

However, overall, in the facilities we visited, we observed CBP staff members making an effort to care for the detained children. For example, we observed CBP personnel trying to provide the least restrictive setting available for children when possible (e.g., by leaving holding room doors open or cells

unlocked). We also observed in most facilities CBP staff had purchased toys or snacks that appealed to children.

We did not make a recommendation with respect to these specific issues relating to these special protections for children because we believe that overcrowding and prolonged detention affected Border Patrol's compliance with standards for children. In normal circumstances, CBP has sufficient microwaves or warming ovens to heat frozen food and can transfer unaccompanied children to Health and Human Services custody before the need for showers or a change of clothing arise. Transfer of families to ICE custody, or to CBP facilities that offer more amenities, is also easier when facilities are not overcrowded. We are conducting a separate review to evaluate the root causes of prolonged detention.

Provision of Medical Care at Short-Term Facilities Has Limits

Under TEDS standards, CBP agents and officers are also tasked with observing and reporting physical and mental injuries and illnesses for appropriate medical care. In addition, detainees should have access to emergency medical care and necessary medications. Although TEDS standards do not require CBP to have trained on-site medical staff in its holding facilities, in fiscal year 2014, Border Patrol established the Centralized Processing Center in the Rio Grande Valley and staffed it with contracted medical teams led by a nurse practitioner or physician's assistant. The Centralized Processing Center was the first CBP facility with an on-site medical team. Between 2014 and the end of 2018, CBP expanded the Centralized Processing Center's medical contract to provide medical staff and services at five additional Border Patrol stations. The contract included the services of an on-site medical team led by a nurse practitioner or physician's assistant, as well as an on-call physician, to provide basic care, refill prescriptions, and determine which detainees required care at a hospital or clinic. All other CBP facilities relied on CBP agents and officers to identify medical issues.

At the time of our inspections, medical coverage varied by facility, but the facilities we visited generally met the TEDS standards for access to medical care even in the crowded conditions.[9] Specifically, upon a detainee's entry into a CBP hold room, detainees were asked about, and visually inspected for, any sign of injury, illness, or physical or mental health concerns, and asked

[9] At the time these inspections were completed, we did not have medical expertise to evaluate the quality of medical care. With the expanded funding received from Congress in Fiscal Year 2020, I ordered a contract for medical services to supplement our expertise across audits, inspections, and investigations and I am pleased to report that contract will be awarded in the next few weeks.

questions about any prescription medications. In addition, although TEDS does not require CBP to maintain on-site medical staff, due to initiatives by CBP and the DHS Office of the Chief Medical Officer, 10 CBP facilities had on-site medical personnel handling medical assessments and triage. In the remaining facilities, CBP officers and agents, some of whom were emergency medical technicians (EMT), performed assessments in accordance with TEDS standards.

Most Border Patrol facilities we visited took steps to try to evaluate and respond to the medical needs of the sizeable detainee population resulting from the increase in apprehensions. This included conducting medical screenings of all detainees before entrance into a facility, stocking common over-the-counter medications, and arranging dedicated appointment hours at local clinics. At several facilities we visited with on-site medical personnel, a medical team consisting of two-to-four staff questioned detainees about their health and conducted a physical assessment of each detainee before processing detainees for intake into the facility. In facilities without medical staff, CBP officers and Border Patrol agents medically assessed detainees by asking them about their health concerns, injuries, and medications.

At the facilities with medical staff, the medical personnel could treat detainees who had minor injuries or illnesses using over-the-counter medication, which the facilities stocked. Also, the medical personnel could identify detainees who needed additional medical care, and could prescribe medications. If a detainee needed additional treatment, the medical personnel would contact CBP, or call the local emergency room, for transport to a local medical facility.

Even though the Border Patrol stations we visited generally met the TEDS standard for access to medical care, crowded conditions presented health challenges for on-site medical staff in some facilities, including containing the spread of contagious illnesses. On-site medical staff we interviewed said they were overwhelmed and the crowded conditions at the facilities were not conducive to treating contagious illnesses. For instance, Border Patrol's short-term detention infrastructure generally did not provide sufficient space for quarantining or specialized ventilation systems. Border Patrol agents also expressed concern that having many detainees with contagious illnesses in their facilities represented a health risk to detainees and CBP personnel alike. In addition, Public Health Service officials working in Border Patrol stations said that with the large number of detainees arriving and departing each day, neither medical personnel nor CBP staff could observe and monitor the health status of all detainees. Crowding at the facilities further lessened the opportunity to identify detainees who may require immediate medical care.

To prevent the spread of contagious illnesses, CBP took measures such as conducting medical assessments outside of the facilities and providing protective masks to detainees. At times, efforts to contain contagious illnesses indirectly contributed to overcrowding in other areas of facilities, as Border Patrol had to set aside multiple holding cells or repurpose other space to separate detainees with lice, scabies, measles, and flu from each other and from healthy detainees.

Given these observations, as well as the circumstances of the deaths of the two children in CBP custody, and our ongoing dialogue with the Committee regarding these issues, we have initiated an audit of detention facility policies and procedures for handling medical intervention. Our planned audit objective is to determine whether CBP (1) has policies and procedures to address identifying serious medical conditions of detained migrants; and (2) is implementing those policies and procedures to ensure the detained migrants with serious medical conditions are identified and their health needs are properly addressed. We look forward to sharing the results of that audit with the Committee when it is complete.

Ports of Entry Generally Met TEDS Standards

In contrast to Border Patrol, which could not control the number of undocumented aliens apprehended, CBP Office of Field Operations (OFO) ports of entry limited the number they processed by implementing "Queue Management"[10] and other practices.[11] "Queue Management" allowed the ports of entry to control the volume of detainees entering the facilities, and OFO did not accept more detainees than could be transferred to ICE custody. As a result, relatively few detainees were held longer than 72 hours; of the ports of entry we visited, only Nogales and Hidalgo ports of entry held detainees longer than 72 hours.

Ports of entry generally met other TEDS standards as well. Our observations and interviews with detainees confirmed ports of entry were generally able to more easily monitor UACs and provide both adults and children hot meals and a variety of foods. Although holding cells at the ports of

[10] See June 5, 2018 Memorandum from Secretary Nielsen, "Prioritization-Based Queue Management," stating OFO may create separate lines for migrants with appropriate travel documents and those without such documents. When employing "Queue Management," CBP officers are stationed at the international boundary with Mexico and advise undocumented aliens to add their names to a waiting list and stay in Mexico until CBP has space and staffing to process them.

[11] Other initiatives to control intake include the Migrant Protection Protocol, through which certain undocumented aliens arriving from Mexico are issued a Notice to Appear before an immigration judge, placed in removal proceedings, and then transferred to Mexico to await further proceedings.

entry we visited were comparable to those in Border Patrol stations (e.g., locked cinderblock cells and metal combined toilets and sinks), some ports of entry had converted other areas into space to hold UACs and families, giving the ports more options for holding children in the least restrictive setting possible.

Ports of entry also faced fewer challenges in meeting TEDS standards for medical care. Because ports of entry were not overcrowded, it was less difficult to separate detainees with contagious illnesses. Although most ports of entry we visited did not have medical staff or EMTs on site, all were near communities with clinics and hospitals, and therefore, had easier access to local medical care. In addition, fewer detainees required transport for medical care. At the time of our site visits, some ports of entry sent all children and family units to a clinic or hospital for medical screening after initial processing.

Ongoing OIG Oversight

Using data-driven, risk-based decision making, our office will continue to conduct independent and objective audits, inspections, and investigations and make recommendations to improve the Department's programs and operations. Consistent with our obligations under the *Inspector General Act of 1978*, we will keep Congress fully and currently informed of our findings and recommendations.

We plan to publish several reports this year and next year reviewing CBP and ICE, including:

- CBP's Holding of Detainees Beyond 72 Hours: This evaluation's objective is to determine the causes leading to CBP's inability to comply with the general requirement to hold detainees in its custody for no more than 72 hours.

- CBP's Processing of Asylum Seekers: We are reviewing CBP's handling of asylum seekers at ports of entry. The objective was to determine if CBP OFO was turning away those who present themselves for asylum at the ports of entry.

- CBP's Use of FY 2019 Appropriated Funds for Humanitarian Assistance: Our objective is to determine whether CBP has adequately planned for deployment, and is deploying, FY 2019 appropriated funds quickly and effectively to address the humanitarian needs on the southern border.

- CBP's Procedures for Detained Migrants Experiencing Serious Medical Conditions: Our objective is to determine whether CBP's policies and procedures safeguard detained migrants experiencing serious medical conditions while in custody.

- Southern Border Detainee Transportation and Support: The objective is to determine how the migrant surge affected CBP staffing and its ability to secure the Southern Border.

- Implementation of DHS' Streamlined Asylum Review Pilot Programs: The objective is to determine how DHS, especially CBP and USCIS, have implemented the Prompt Asylum Claim/Screening Review and Humanitarian Asylum Review Process (HARP) pilot programs.

- Audit of CBP Border Security Technology and Infrastructure: We will assess the effectiveness of CBP's current tools and technologies to support Border Patrol's mission operations for preventing the entry of illegal aliens or inadmissible individuals who may pose threats to national security.

- CBP Leadership's Knowledge of and Actions to Address Offensive Content Posted on Facebook by CBP Employees: The objective is to determine whether complaints were made to CBP leadership regarding the "I'm 10-15" or similar private Facebook group(s) prior to recent media reporting; which senior-level officials knew about the "I'm 10-15" or similar private Facebook group(s) prior to the July 2019 media reporting, when they became aware, and what they knew about the content; and what actions, if any, were taken to evaluate and address potential employee misconduct in the group.

- U.S. Customs and Border Protection's Use of Canine Teams: The objective is to determine to what extent CBP's canine training approach and execution support the Canine Program mission.

- U.S. Customs and Border Protection's Use of Force Near the San Ysidro, California Port of Entry on November 25, 2018 and January 1, 2019: Our objective is to review the circumstances surrounding the incidents and determine whether CBP complied with its use of force of policy.

- Review of Removal of Separated Alien Families: Our work will determine whether ICE removed any parents without first offering them the opportunity to bring their separated children with them.

- ICE's Use of Segregation in Detention Facilities: To determine whether ICE's use of administrative and disciplinary segregation across all authorized detention facilities complies with Departmental detention standards.

- DHS DNA Collection: Our objective is to determine whether DHS law enforcement agencies collect DNA samples from arrested or detained persons as required by the Fingerprint DNA Act of 2005 and subsequent Department of Justice regulations.

- DHS Management and Oversight of Immigration Hearings in Temporary Courts along the Southwest Border: Our objective is to determine the extent to which DHS provides accurate hearing notices and facilitates immigration hearings at temporary courts in accordance with laws and regulations.

- U.S. Immigration and Customs Enforcement Efforts to Combat Human Trafficking: Our objective is to determine the extent to which ICE identifies and tracks human trafficking crimes to save victims.

- Review of July 2018 family reunifications issues at Port Isabel Detention Center: Our objective is to determine whether children were held in vans for up to 39 hours, why that occurred, and whether ICE has taken steps to prevent it from happening again.

- Unannounced Inspections of CBP Holding Facilities & ICE Adult Detention Facilities: Our objective is to continue conducting unannounced inspections of DHS and contract facilities to monitor DHS compliance with health, safety, and civil rights standards outlined in CBP's National Standards on Transport, Escort, Detention, and Search; and ICE's Performance-Based National Detention Standards.

- CBP's Searches of Electronic Devices at Ports of Entry: Our objective is to determine to what extent CBP conducted searches of electronic devices at U.S. ports of entry in accordance with its standard operating procedures.

- ICE's Efforts to Prevent and Mitigate the Spread of COVID-19 in its Facilities: Our objective is to determine whether ICE Enforcement and Removal Operations effectively managed the pandemic at its detention facilities and adequately safeguarded the health and safety of both detainees in their custody and their staff.

- Early Experiences with COVID-19 at CBP Facilities: Our objective is to determine how CBP (Office of Field Operations and Border Patrol) is managing the COVID-19 pandemic at their facilities, with respect to both detainees in their custody and to their staff.

- ICE Should Document its Process for Adjudicating Disciplinary Matters Involving Senior Executive Service Employees: Our objective was to evaluate U.S. Immigration and Customs Enforcement (ICE) policies and procedures regarding Senior Executive Service (SES) employee discipline after complaints were raised that a former ICE SES official received favorable treatment during disciplinary proceedings.

- Assessing the Effectiveness of DHS's Joint Task Forces: Our objective is to determine whether DHS has effectively managed and coordinated its Joint Task Forces (JTF) resources to accomplish the JTFs' intended mission.

- CBP's Covert Testing Efforts: Our objective is to determine whether CBP's covert tests identify vulnerabilities at ports of entry and borders and whether CBP uses the test results to address identified vulnerabilities and shares lessons learned throughout the component.

Thank you for the opportunity to discuss the important work of the OIG. This concludes my testimony, and I am happy to answer any questions you may have.