

**ASSESSING THE ADEQUACY OF DHS EFFORTS
TO PREVENT CHILD DEATHS IN CUSTODY**

HEARING

BEFORE THE

**SUBCOMMITTEE ON
BORDER SECURITY, FACILITATION,
AND OPERATIONS**

OF THE

**COMMITTEE ON HOMELAND SECURITY
HOUSE OF REPRESENTATIVES**

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ASSESSING THE ADEQUACY OF DHS EFFORTS TO PREVENT CHILD DEATHS IN CUSTODY

Tuesday, January 14, 2020

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
SUBCOMMITTEE ON BORDER SECURITY,
FACILITATION, AND OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:06 a.m., in room 310, Cannon House Office Building, Hon. Kathleen M. Rice [Chairwoman of the subcommittee] presiding.

Present: Representatives Rice, Correa, Torres Small, Green, Clarke, Thompson, Underwood, Garcia, Higgins, Joyce, and Guest.

Also present: Representatives Jackson Lee and Garcia.

Miss RICE. Subcommittee on Border Security, Facilitation, and Operations will come to order. The subcommittee is meeting today to receive testimony on assessing the adequacy of DHS efforts to prevent child deaths in custody.

Without objection, the Chair is authorized to declare the subcommittee in recess at any point.

The Chair asks unanimous consent that Representative Underwood be permitted to sit and question the witnesses.

The Chair asks unanimous consent that Representative Garcia be permitted to sit and question the witnesses.

Without objection, so ordered.

Jakelin Caal Maquin, 7 years old. Felipe Gómez Alonzo, 8 years old. Darlyn Cristabel Cordova-Valle, 10 years old. Juan de León Gutiérrez, 16 years old. Wilmer Josué Ramírez Vásquez, 2 years old. Carlos Hernandez Vásquez, 16 years old. These 6 children died in the custody of the U.S. Government just in the past 18 months. These children were migrants from Central America who died of preventable conditions that went untreated. Three of these children spent the last hours of their lives in detention facilities on our Southern Border.

We must never forget their names, their suffering, or the terrible losses their families had to endure. So we are here this morning to examine the conditions that led to these avoidable tragedies. We have seen a dramatic increase in the numbers of families and children arriving on the Southern Border over the past several years. Most of these families and children arrived from Central America, fleeing vicious cartels, gang violence, and extreme poverty.

After surviving long dangerous journeys, these families should have been met with safe refuge, but instead they encountered this administration's myriad of inhumane border policies like family

separation, zero tolerance detention, and the Remain in Mexico policy. These policies and management decisions by the administration have contributed to mass overcrowding and wide-spread inhumane conditions at Customs and Border Protection facilities across our Southern Border.

Numerous reports by the DHS Office of Inspector General and court observer attorneys confirm these intolerable conditions. I have seen the problems with these facilities with my own eyes along with several of my Congressional colleagues on this panel today on both sides of the aisle. Yet when pressed about these conditions, DHS has consistently failed to maintain transparency by stymieing Congressional inquiries.

This raises concerns that they are hiding serious issues with management, in addition to the leadership vacancies at the top of the Department. One example of this is the Department's decision to conceal information on the death of Carlos Hernandez Vasquez. Carlos was a teenage boy from Guatemala, who died tragically in U.S. custody on the morning of May 20, 2019. CBP issued a press release later that day calling the death a tragedy and declaring that they consider the health, safety, and humane treatment of migrants to be of the highest priority.

However, despite information requests by this committee, it was not until a *ProPublica* report was released 7 months later that Congress and the public learned more about what happened to Carlos, that his death may have been caused by the failure to provide urgently needed medical care, and the failure to follow the most basic procedures to simply check on a sick child.

While I understand that this specific case is still under investigation, this lack of transparency by the Department is completely unacceptable. The Office of the Inspector General must be doing everything in its power to examine the factors that led to these tragedies. That is why I am extremely disappointed that the current DHS inspector general declined our invitation to testify this morning, especially given the recent news that his office closed its investigations into the first 2 child deaths in Border Patrol custody.

The publicly-available summaries of these investigations are extraordinarily narrow in scope. They focus only on whether DHS personnel committed malfeasance and not whether the Department's policies and resources could properly protect the children in its care.

For instance, even with these 2 completed reports, we still do not know why Felipe Gómez Alonzo and his father were in CBP custody for 6 days before Felipe passed away. I, along with several other Members of this committee, remain concerned that DHS still isn't doing enough to protect the children in its custody.

Reporting over this past weekend indicates that CBP continues to detain families with young children in need of medical attention well beyond the 72 hours allowed by the agency's own protocols. This is a disturbing pattern that needs to be remedied immediately, or we risk losing more children to preventable deaths in the future. We must act urgently to ensure that the policies and decisions that contributed to these tragic deaths are addressed.

I hope the witnesses here today are prepared to explain whether the Department's current approach incorporates the lessons

learned after these tragedies and how they intend to safeguard children in DHS custody going forward. As Members of Congress, we may disagree about immigration policy, but there should be no disagreement that the Federal Government must take responsibility for the human beings in its custody, particularly young children. We must never forget Jakelin, Felipe, Darlyn, Juan, Wilmer, and Carlos, and we must never let this happen to another child again.

I want to thank the witnesses for joining us, and I now recognize the Ranking Member for his opening statement.

[The statement of Chairwoman Rice follows:]

STATEMENT OF CHAIRWOMAN KATHLEEN M. RICE

JANUARY 14, 2020

Jakelin Caal Maquin. Seven years old. Felipe Gómez Alonzo. Eight years old. Darlyn Cristabel Cordova-Valle. Ten years old. Juan de León Gutiérrez. Sixteen years old. Wilmer Josué Ramírez Vásquez. Two years old. Carlos Hernandez Vásquez. Sixteen years old. These 6 children died in the custody of the United States Government in the past 18 months. These children were migrants from Central America, who died of preventable conditions that went untreated. Three of these children spent the last hours of their lives in detention facilities on our Southern Border. We must never forget their names, their suffering, or the terrible losses their families had to endure. So, we are here this morning to examine the conditions that led to these avoidable tragedies.

We've seen a dramatic increase in the numbers of families and children arriving on the Southern Border over the past several years. Most of these families and children arrived from Central America, fleeing vicious cartels, gang violence, and extreme poverty. And after surviving long, dangerous journeys, these families should have been met with safe refuge. But instead, they encountered this administration's myriad of inhumane border policies, like family separation, "zero tolerance" detention, and the Remain in Mexico policy. These policies and management decisions by the administration have contributed to mass overcrowding and wide-spread inhumane conditions at Customs and Border Protection facilities across our Southern Border.

Numerous reports by the DHS Office of Inspector General and court observer attorneys confirm these intolerable conditions. I have seen the problems with these facilities with my own eyes, along with several of my Congressional colleagues on this panel today. Yet when pressed about these conditions, DHS has consistently failed to maintain transparency by stymying Congressional inquiries. This raises concerns that they are hiding serious issues with management, in addition to the leadership vacancies at the top of the Department. One example of this is the Department's decision to conceal information on the death of Carlos Hernandez Vásquez. Carlos was a teenage boy from Guatemala, who died tragically in U.S. custody on the morning of May 20, 2019. CBP issued a press release later that day calling the death a tragedy, and declaring that they consider the health, safety, and humane treatment of migrants to be of the highest priority.

However, despite information requests by this committee, it was not until a *ProPublica* report was released 7 months later that Congress and the public learned the truth about what happened to Carlos. That his death may have been caused by the failure to provide urgently-needed medical care and the failure to follow the most basic procedures—to simply check on a sick child. While I understand that this specific case is still under investigation, this lack of transparency by the Department is completely unacceptable. The Office of the Inspector General must be doing everything in its power to examine the factors that led to these tragedies. And that's why I am extremely disappointed that the current DHS inspector general declined our invitation to testify this morning. Especially given the recent news that his office closed its investigations into the first 2 child deaths in Border Patrol custody. The publicly available summaries of these investigations are extraordinarily narrow in scope. They focus only on whether DHS personnel committed malfeasance and NOT whether the Department's policies and resources could properly protect the children in its care.

For instance, even with these 2 completed reports, we still do not know why Felipe Gómez Alonzo and his father were in CBP custody for 6 days before Felipe

passed away. I, along with several other Members on this committee, remain concerned that DHS still isn't doing enough to protect the children in its custody. Reporting over this past weekend indicates that CBP continues to detain families with young children in need of medical attention well beyond the 72 hours allowed by the agency's own protocols. This is a disturbing pattern that needs to be remedied immediately, or we risk losing more children to preventable deaths in the future. We must act urgently to ensure that the policies and decisions that contributed to these tragic deaths are addressed. I hope the witnesses here today are prepared to explain whether the Department's current approach incorporates the lessons learned after these tragedies, and how they intend to safeguard children in DHS custody going forward. As Members of Congress, we may disagree about immigration policy, but there should be no disagreement that the Federal Government must take responsibility for the human beings in its custody, particularly young children. We must never forget Jakelin, Felipe, Darlyn, Juan, Wilmer, and Carlos. And we must never let this happen to another child again.

Mr. HIGGINS. Thank you, Madam Chair, and I thank our professionals for appearing before us today, the panelists. I thank Chiefs Hastings and Dr. Eastman for your service at the border and for being here today. I look forward to hearing in greater detail about the actions DHS has taken to enhance Customs and Border Protection's ability to handle migrants arriving at our border in deteriorating health and to address preventable deaths in custody.

The crisis that unfolded along our border last year was real, was not the fault of the men and women of Customs and Border Protection, wasn't the fault of the Executive branch, nor the President of the United States. The truth is, this past year, we saw record numbers of family units, unaccompanied minors, large groups of 100 migrants or more—213 groups to be exact—arriving at our border during the height of flu season and during months of extreme heat. At the time, the Border Patrol was referring 50 cases per day to medical professionals.

The border crisis was a result of legal loopholes, activist judges, propaganda from criminal cartels, killers, who smuggle and traffic migrants for profit. In 2014, under the Obama administration, the number of unaccompanied minors encountered at the border was viewed as crisis level, leading to former DHS Secretary Johnson writing an open letter to Central American parents, telling them to not send their children.

It is clear that sufficient, corrective actions were not taken at that time. If that was a crisis, then there are no words to describe what we experienced at the border during fiscal year 2019. Not only were more than 321,000 minors encountered by Customs and Border Protection, family unit apprehensions were more than 590 percent higher in fiscal year 2019 as compared to fiscal year 2014.

Throughout the crisis, most CBP facilities were at or over capacity. Customs and Border Protection personnel were working overtime for more than a month without pay to process the large groups. Resources were depleting at record time as key personnel at the Department were furloughed. Yet Customs and Border Protection law enforcement officers still scraped together enough money out of their own pockets to buy toys and bring extra supplies for the migrants in their custody, many of them parents themselves, caring for and loving to the best of their ability, the children in their custody.

After a 35-day shutdown that began in the end of 2018, the Federal Government reopened in January 2019 and the crisis continued. In light of the growing issues related to the mass influx of mi-

grants, President Trump made an official request to Congress for supplemental funding for the border. Two months went by before we sent that money to the field. My colleagues across the aisle blocked a vote on supplemental assistance more than 15 times. While leaders of the Majority party were repeating the message of tweets like “fake emergency,” the chief of the Border Patrol was testifying in front of Congress that without the funding we may, “lose the border”.

The bipartisan Homeland Security Advisory Council released a report on the crisis stating that the delay in passing a supplemental resulted in unaccompanied minors being held in Customs and Border Protection facilities for dangerous lengths of time. There are Members on this committee who voted against the emergency supplemental.

A “no” vote meant a vote to keep unaccompanied minors in Customs and Border Protection custody instead of at a Department of Health and Human Services facility, suitable for children. It meant releasing thousands of migrants on the streets of border communities. Border county Sheriff Napier testified before this committee that during the crisis, social service resources that should address local issues of hunger and homelessness are now completely unable to do so.

While the men and women of CBP were struggling to keep the lights on at the border, they were the subject of partisan attacks. One Member even claimed that the deaths of children in custody were intentional, an ugly statement, an absurdity that was completely debunked as the DHS inspector general found no misconduct or malfeasance by DHS personnel upon completion of their investigations into the heartbreaking deaths of Jakelin and Felipe in December 2018.

Every life is precious and even 1 death in custody is too many, which is why I was encouraged to learn about the immediate steps CBP took to enhance their ability to diagnose the health of migrants in custody and work with the DHS chief medical officer to make long-needed, long-term improvements.

In December 2018, then commissioner Kevin McAleenan ordered secondary medical checks on every child in custody and initiated an internal evaluation of CBP care policies. Since then, CBP established a phased approach to conducting health interviews on all migrants during initial processing and a subsequent full medical assessment of all unaccompanied minors and at-risk adults.

On top of that, Customs and Border Protection now has over 700 medical personnel and contractors stationed across the Southwest Border to provide medical support to migrants in custody.

Today I look forward to hearing from our witnesses about how CBP’s in-custody medical capabilities have improved since the fall of 2018, the collaboration process between CBP, the office of DHS chief medical officer, and other relevant stakeholders, to bolster Customs and Border Protection’s ability to stop preventable deaths in custody and their expert opinions on how to prevent another crisis in the future.

Madam Chair, thank you for your indulgence, and I yield back.
[The statement of Ranking Member Higgins follows:]

STATEMENT OF RANKING MEMBER CLAY HIGGINS

JAN. 14, 2020

Thank you, Madam Chair.

And thank you Chief Hastings and Doctor Eastman for your service at the border and for being here today.

I look forward to hearing in greater detail about the actions DHS has taken to enhance Customs and Border Protection's ability to handle migrants arriving at our border in deteriorating health and to address preventable deaths in custody.

The crisis that unfolded along our Southwest Border last year was not a fake emergency, it is not the fault of the men and women of CBP, and it is not the fault of the President of the United States, Donald Trump.

The truth is, this past year we saw record numbers of family units, unaccompanied minors, large groups of 100 migrants or more—213 to be exact, arriving at our border during the height of flu season and during months of extreme heat. At the time, the Border Patrol was referring 50 cases per day to medical providers.

The border crisis was the result of legal loopholes, activist judges, and propaganda from criminal killers who smuggle and traffick migrants for profit.

In 2014, under the Obama administration, the number of unaccompanied minors encountered at the border was viewed as crisis-level, leading to former DHS Secretary Jeh Johnson writing an open letter to Central American parents telling them not to send their children. It is clear corrective actions were not taken back then.

If that was a crisis, then there are no words for what we experienced at the border during fiscal year 2019. Not only were more than 321,000 minors encountered by CBP, family unit apprehensions were up more than 590 percent in fiscal year 2019 than fiscal year 2014.

Throughout the crisis most CBP facilities were at or over capacity. CBP personnel were working overtime and for more than a month—without pay—to process the large groups. Resources were depleting at record time as key personnel at the Department were furloughed.

Yet CBP law enforcement officers still scraped together money out of their own pockets to buy toys and bring in extra supplies for the migrants in their custody, many of them parents themselves.

CBP agents and officers, already short-staffed had to refocus their mission from stopping gangs, drugs, murderers, rapists, and even known or suspected terrorists to instead process and care for the hundreds of thousands of people that arrived at our border without the appropriate facilities, resources, and medical support staff to do so.

After a 35-day shutdown that began at the end of 2018, the Federal Government reopened in January 2019 and the crisis continued. In light of the growing issues related to the mass influx of migrants, President Trump made an official request to Congress for supplemental funding for the border. Two months went by before we sent that money to the field. House Democrats blocked a vote on supplemental assistance more than 15 times. While House Democrat leaders were tweeting #FakeEmergency, the chief of the Border Patrol was testifying in front of Congress that without the funding, we may "lose the border."

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Every life is precious, and even 1 death in custody is 1 too many, which is why I was encouraged to learn about the immediate steps CBP took to enhance their ability to diagnose the health of migrants in custody and work with the DHS chief medical officer to make needed long-term improvements.

In December 2018, then-Commissioner Kevin McAleenan ordered secondary medical checks on every child in custody and initiated an internal evaluation of CBP care policies. Since then, CBP established a phased approach to conducting health interviews of all migrants during initial processing and a subsequent full medical assessment of all minors and at-risk adults.

On top of that, CBP now has over 700 medical personnel and contractors stationed across the Southwest Border to provide medical support to migrants in custody.

Today, I would like to hear from our witnesses about how CBP's in-custody medical capabilities have improved since fall of 2018, the collaboration process between CBP, the Office of the DHS Chief Medical Officer and other relevant stakeholders to bolster CBP's ability to stop preventable deaths in custody, and their expert opinions on how to prevent another crisis in the future.

Miss RICE. Thank you, Mr. Higgins. The Chair now recognizes the Chairman of the overall Homeland Security Committee, the gentleman from Mississippi, Mr. Thompson for an opening statement.

Mr. THOMPSON. Thank you very much, Madam Chair. Good morning to those of you who are here on the committee. Today's hearing topic is sobering as it centers on the death of innocent children. In our current hectic and rapidly-changing political environment, it can be easy to move on quickly from past disasters and tragedies. The Trump administration contributes to this situation by piling scandal on scandal, exhausting the public, the media, and the oversight organizations.

It is our oversight responsibility, as Members of Congress, to refuse to allow the most disturbing and upsetting events fade into the past and help ensure that they are not repeated. We are here today to examine the treatment of migrant children in the custody of the Department of Homeland Security in 2018 and 2019, and look at what changes may still be necessary.

Certainly detention of migrants did not begin with the current administration, but in earlier administrations, both Democratic and Republican, officials took steps to avoid risking the health and safety of the most vulnerable people in custody.

Under the Trump administration, we now find the elderly, the infirm, and children in detention facilities such as Border Patrol stations, not designed or equipped to hold people for extended periods of time. When arrivals at our Southern Border began to rise sharply in 2018, the decision to detain everyone led to severe overcrowding. The DHS Office of Inspector General, attorneys, and Members of Congress, including me, observed and reported on the conditions inside these facilities for months.

CBP argued throughout this crisis that they faced severe resource constraints, despite Congress providing billions in humanitarian funding in early 2019. Standing-room-only cells, inadequate hygiene products, and families kept outside in extremely variable temperatures were commonplace at CBP facilities during the height of migrant arrivals last year.

In such an environment, the spread of illnesses such as the flu are inevitable. Whether individual deaths can be directly attributed to specific conditions in a given facility or not, we need to understand whether the policies and resource management decisions made by the administration put lives in jeopardy.

Congress cannot allow DHS and CBP leaders to make poor decisions or ignore existing policies and law for purely messaging rea-

sons. Secure borders are a priority for our country and for all of us on this panel and have been for decades. Part of our responsibility as Members of Congress is to check actions by the Executive branch that are misguided. Hearings such as this are a critical part of that effort. I have strong objections to the policies the Trump administration has in place along our border that continue to endanger the safety of migrant children such as Remain in Mexico.

I hope to hear from our DHS witnesses this morning that the Department will take its responsibility toward people in its custody more seriously going forward. One child death was one too many. I am eager to know what the Department plans to do differently in order to safeguard children's safety while in DHS's custody.

I thank the Chairwoman and Ranking Member for holding today's important hearing, and I yield back.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

JANUARY 14, 2020

Today's hearing topic is sobering, as it centers on the deaths of innocent children. In our current hectic and rapidly-changing political environment, it can be easy to move on quickly from past disasters and tragedies. The Trump administration contributes to this situation by piling scandal on scandal—exhausting the public, the media, and oversight organizations. It is part of our oversight responsibility as Members of Congress to refuse to allow the most disturbing and upsetting events fade into the past and help ensure they are not repeated. We are here today to examine the treatment of migrant children in the custody of the Department of Homeland Security in 2018 and 2019, and look at what changes may still be necessary.

Certainly, detention of migrants did not begin with the current administration. But in earlier administrations, both Democratic and Republican officials took steps to avoid risking the health and safety of the most vulnerable people in custody. Under the Trump administration, we now find the elderly, the infirm, and children in detention facilities, such as Border Patrol stations, not designed or equipped to hold people for extended periods of time. When arrivals at our Southern Border began to rise sharply in 2018, the decision to detain everyone led to severe overcrowding. The DHS Office of Inspector General, attorneys, and Members of Congress—including me—observed and reported on the conditions inside these facilities for months. CBP argued throughout this crisis that they faced severe resource constraints, despite Congress providing billions in humanitarian funding in early 2019. Standing-room-only cells, inadequate hygiene products, and families kept outside in extremely variable temperatures were all commonplace at CBP facilities during the height of migrant arrivals last year. In such an environment, the spread of illnesses, such as the flu, are inevitable.

Whether individual deaths can be directly attributed to specific conditions in a given facility or not, we need to understand whether the policies and resource management decisions made by the administration put lives in jeopardy. Congress cannot allow DHS and CBP leaders to make poor decisions or ignore existing policies and law for purely messaging reasons. Secure borders are a priority for our country—and for all of us on this panel—and have been for decades. Part of our responsibility as Members of Congress is to check actions by the Executive branch that are misguided. Hearings such as this are a crucial part of that effort. I have strong objections to the policies the Trump administration has put in place along our border that continue to endanger the safety of migrant children—such as “Remain in Mexico.”

I hope to hear from our DHS witnesses this morning that the Department will take its responsibility toward people in its custody more seriously going forward. One child death was one too many. I am eager to know what the Department plans to do differently in order to safeguard children's safety while in DHS custody.

Miss RICE. Thank you, Mr. Chairman.

Other Members of the subcommittee are reminded that under the committee rules, opening statements may be submitted for the record.

I welcome the panel of witnesses. Our first witness, Mr. Brian S. Hastings, is chief law enforcement operations, U.S. Border Patrol, U.S. Customs and Border Protection, Department of Homeland Security. Brian S. Hastings is the chief of the Law Enforcement Operations Directorate at U.S. Border Patrol headquarters in Washington, DC. He is responsible for oversight of the day-to-day law enforcement operations at Border Patrol sectors throughout the United States and a principal adviser to the chief of the Border Patrol on enforcement operations. Chief Hastings began his service with the Border Patrol in 1995 and has been stationed in various sectors across all U.S. borders and was promoted to the senior executive service in 2018.

Our second witness, Dr. Alexander L. Eastman, is the senior medical officer for operations within the United States Department of Homeland Security's Countering Weapons of Mass Destruction Office. In this role, he is responsible for operational medicine across DHS in addition to countering threats to the United States worldwide.

Previously Dr. Eastman served as the chief of the Rees-Jones Trauma Center at Parkland Memorial Hospital and as an assistant professor and trauma surgeon in the division of burns, trauma, and critical care at the University of Texas Southwestern Medical Center. Dr. Eastman is also a decorated police officer within the Dallas Police Department.

Without objection, the witnesses' full statements will be inserted in the record. I now ask each witness to summarize his statement for 5 minutes beginning with Mr. Hastings.

STATEMENT OF BRIAN S. HASTINGS, CHIEF, LAW ENFORCEMENT OPERATIONS DIRECTORATE, U.S. BORDER PATROL, U.S. CUSTOMS AND BORDER PROTECTION, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. HASTINGS. Good morning, Chairman Rice, Ranking Member Higgins, and Members of the subcommittee. As part of CBP's mission to safeguard America's borders, we complete initial processing of individuals in our custody before transferring them on our partners. While our holding facilities were designed for only short-term custody, we take seriously our responsibility to protect and care for individuals until they can be transferred.

During fiscal year 2019 CBP apprehended or found inadmissible more than 1.1 million people. In December 2018, we began alerting Congress, the media, and the public that an unprecedented spike in Central American families and children was creating a crisis on our Southern Border. For months, our requests for immediate legal and emergency funding went unanswered, and we began diverting resources from our border security mission to address the crisis.

As I prepared to testify before you today, I reflected on the numerous actions CBP has taken and continues to take in response to this crisis. I could not be more proud of the extraordinary efforts undertaken by the men and women of CBP. I would like to share with you many examples today of the challenges we face and our rapid actions to address them.

First, as the apprehensions skyrocketed, we had more people in our custody than we could quickly process. We continued to

prioritize processing of the UACs first, followed by families, and then single adults. CBP surged more than 1,050 officers and agents to the busiest sectors. As many as 40 to 60 percent of our agents were diverted from securing the border to caring for those in our custody.

Over 700 DHS personnel provided support at our facilities. We expanded our transportation contract and purchased more than 200 buses and vans to expedite transportation of large groups of migrants. We chartered planes and drove busloads of more than 43,000 people from overwhelmed locations to facilities with more processing capacity.

Second, even when processing was complete, ICE and HHS had limited capacity to accept aliens, which contributed to further overcrowding in Border Patrol facilities. In March 2019, Border Patrol began releasing noncriminal family units directly into the United States rather than transferring them to ICE. During fiscal year 2019 a total of 145,000 family members were released. CBP rapidly constructed 6 soft-sided facilities that provided capacity for an additional 6,500 families and adults.

By June, Secretary Azar stated HHS shelters were full and they could not accept UACs from Border Patrol custody. When HHS received supplemental funding in July, the number of UACs in our custody quickly dropped from a peak of 2,700, down to 300.

Third, we addressed the need for amenities that our short-term holding facilities were not designed to provide. We outfitted the new soft-sided facilities and our highest-volume stations with portable showers, toilets, sinks, laundry, climate control system, and kitchen equipment. We expanded our food service contract to provide millions of meals and stock countless snacks, water bottles, clothing, and hygiene items.

Finally, we accelerated the expansion of our medical support program. CBP issued interim medical directive in January 2019, which was superseded by an enhanced medical directive in December. This directive sets forth foundational levels of medical support for CBP.

It utilizes a phased approach through initial observations, medical interviews with a standardized health questionnaire, and medical assessments to identify potential medical issues and low acuity treatment.

In the last year, CBP has dramatically increased the number of contract medical professionals to more than 700. Where we built this capacity, U.S. Coast Guard and Public Health Services medical personnel were dispatched to many of our facilities. Now on any given day, approximately 300 contract medical personnel are engaged at more than 40 facilities along our Southwest Border, providing 24/7 on-site medical support.

Our medical support follows a family practitioner model which has been observed and validated by medical experts. This model ensures our medical providers are trained, licensed, and credentialed to care for all populations in our custody, including children and pregnant women.

Physicians, to include pediatricians, provide oversight in training, consultation for medical direction, and medical quality management. On-site medical personnel may provide care, write pre-

scriptions, or recommend advanced care in the local health care system.

In the last year, nearly 250,000 juveniles and more than 296,000 adults have received medical interviews. Nearly 60,000 juveniles and more than 95,000 adults have received medical assessments. During fiscal year 2019, Border Patrol took a total of 26,000 people to a hospital or a medical facility when advanced care was needed or requested. Agents spent more than 319,000 hours providing transportation to and from medical facilities and on hospital watch.

Today with the help of our interagency partners and our governmental partners in the hemisphere, we have effectively ended catch-and-release at the border. The flow of aliens has dropped by 72 percent. However, these initiatives, like the supplemental funding, are only temporary fixes. As we have said many times before, Congress must close the loopholes in our Immigration Service system that serve as pull factors. Or we risk returning to or exceeding peak levels and overwhelming our immigration system yet again.

Thank you and I look forward to your questions.

[The prepared statement of Mr. Hastings follows:]

PREPARED STATEMENT OF BRIAN S. HASTINGS

JANUARY 14, 2020

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 front-line 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 2019

During fiscal year 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 2 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 fiscal year 2019, USBP Southwest Border apprehensions exceeded 851,000—the highest level since fiscal year 2017. Nearly 65 percent of USBP apprehensions were families and children—more than 473,000 individ-

uals—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 fiscal year 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 6 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, 6 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 2 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 9 Southwest Border USBP sectors and all 4 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 fiscal year 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 front-line 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 on-going 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 dialog 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 on-site contracted medical teams provide early identification and diagnosis via rapid flu testing; they can also provide antiviral treatment and prophylaxis on-site. 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 appro-

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 3 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 fiscal year 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 on-going 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.

Miss RICE. Thank you for your testimony. I now recognize Dr. Eastman to summarize his statement for 5 minutes.

**STATEMENT OF ALEXANDER L. EASTMAN, M.D., MPH, FACS,
FAEMS, SENIOR MEDICAL OFFICER—OPERATIONS, COUN-
TERING WEAPONS OF MASS DESTRUCTION OFFICE, U.S. DE-
PARTMENT OF HOMELAND SECURITY**

Dr. EASTMAN. Good morning, Chairwoman Rice, Ranking Member Higgins, Chairman Thompson, distinguished Members of the subcommittee and guests. It is an honor to be here today to discuss the Department of Homeland Security's efforts to prevent child deaths in custody through our provision and expansion of medical care during the recent migration crisis.

I am Dr. Alex Eastman, the senior medical officer for operations at DHS. I have been a practicing physician for nearly 20 years, and in addition to my role here at DHS, continue to be a practicing trauma surgeon and surgical intensivist.

Immediately prior to coming to DHS, I was the chief at the Rees-Jones Trauma Center at Parkland Memorial Hospital in Dallas, Texas. At Parkland, we cared for human beings from all backgrounds in their most desperate time. You care for everyone without regards to race, color, creed, means, religion. Quickly it becomes apparent that when life and death are on the line, none of these things matter. Providing care for patients, no matter the challenges, was my goal then and is our goal now.

From all your visits to the border—and it is nice to see you all again this morning—I know you are aware that we continue to improve the care for all people in our custody, especially children.

From the medical perspective, the crux of this humanitarian crisis was a massive increase in the potential demand for care, at times nearly 400 percent, a number that would gridlock any conventional health care system.

Additionally, while correctional facilities have embedded detainee health care systems, law enforcement agencies do not. CBP is primarily a law enforcement organization, never designed to have a health care system within its walls. Doing so would be akin to building a minute clinic in every police station in America.

Yet our challenge in the midst of this crushing demand, was an unconventional problem that required an unconventional solution—to help CBP and our other DHS components rise to the task of providing care to an overwhelming number of people, including children, in our custody.

The expansion to where we are today, the system currently in place, and the direction we are headed, represents a Herculean effort in response to an unprecedented challenge. In December 2018, the DHS Secretary directed the provision of immediate assistance with the rising humanitarian demands of the migration crisis.

We immediately deployed, and for the last 13 months, have been working on the border, alongside colleagues from CBP, ICE, Federal agencies like HHS and CDC, as well as State and local public health, medical experts and professionals to improve the care of migrants in custody, with particular attention to the children and the most vulnerable adults the law directs us to hold.

Our first priority was to rapidly and urgently expand our medical capabilities along the Southwest Border, particularly at CBP which had the biggest need. In support of this mission, the United States Coast Guard deployed more than 30 teams to the Southwest Bor-

der providing more than 3,450 medical officer days and more than 8,275 health service technician days of care in the rapid response to this crisis.

The Coast Guard served as our lifeline, our immediate response force from a medical standpoint. America should be grateful for the truly life-saving and timely work of the Coast Guard during this crisis as well as so many others.

DHS also received critical assistance from the United States Public Health Service. Our Nation's Assistant Secretary for Health, Admiral Brett Giroir, himself, a pediatrician and intensivist, was a critical partner as we facilitated the targeted deployment of Public Health Service officers to critical areas along the Southwest Border.

There were more than 475 Public Health Service officers deployed to the border, totaling more than 6,750 days of care provided to migrants. No mission was too difficult, including even loading into helicopters and going to our most remote border regions to immediately begin assessing migrants and providing any care necessary as early as possible.

When large groups overwhelmed us in areas without Public Health Service or Coast Guard assistance, we moved them there. These two organizations gave so freely of their time and expertise. The officers, and physicians, and nurses who came down saved lives directly and continue to do so with the legacy they have left along the Southwest Border.

As the interagency was countering the crushing surge, CBP was diligently working to build the system that would assume care from the emergency responders. As mentioned, that system now includes, among other aspects, more than 700 contracted providers, enhanced countermeasures for influenza and other infectious disease, and a medical directive that begins to lay out the path forward to continue the iterative process that allows the system to evolve as required.

Our approach to improve care has been collaborative, not just by coordinating with Federal interagency partners but also by building and continuing critical State and local partnerships, collaborating with the Mexican government, and calling upon non-Government experts to assist when needed. Several systematic reviews of this developing system have been undertaken in the last year, all agreeing that the approach is sound.

We have a legal, moral, and ethical duty to care for those in our custody. The challenge was unprecedented, required an unconventional solution, and we responded.

At DHS and across the Government, we remain committed to ensuring that individuals, especially our children, receive appropriate medical care.

Thank you very much, and I look forward to answering your questions.

[The prepared statement of Dr. Eastman follows:]

PREPARED STATEMENT OF ALEXANDER L. EASTMAN

JANUARY 14, 2020

Chairwoman Rice, Ranking Member Higgins, and Members of the subcommittee: Thank you for the opportunity to appear before you today to discuss DHS's medical

care of children during the recent migration crisis. As you are aware from this committee's many visits to the United States Southwest Border (SWB), the medical care of children in DHS custody does not occur in a vacuum. It is a system that is complicated, involves many other U.S. Government departments, and is evolving as we speak. Additionally, while the focus of this hearing is on the care of children, we have one system that cares for both adult and children in our custody and hence, at times, we'll discuss both. From a global "strategic" standpoint, our approach is to ensure that all persons in DHS custody, whether children or adults, receive the right medical care, at the right time, at the right place in this complicated, custodial health care system. On behalf of Chief Medical Officer Duane C. Caneva and the Countering Weapons of Mass Destruction Office (CWMD), where the Office of the Chief Medical Officer resides, we are committed to not only implementing this strategy but making sure the system improves daily.

CWMD/CMO SUPPORT TO THE SOUTHWEST BORDER MIGRATION CRISIS

In late December 2018, Secretary Nielsen asked for immediate assistance with the developing crisis along the SWB. Our full attention turned to the border crisis, and we deployed experts to assist both U.S. Customs and Border Protection (CBP) and U.S. Immigration and Customs Enforcement (ICE) with health/medical/public health issues. As directed by the Secretary, our priorities were:

- (1) Eliminate preventable deaths related to the migration crisis along the SWB;
- (2) Ensure the integrity of our bio-surveillance system with regards to protecting the United States from an intentional attack or the unintentional risk from an infectious or communicable disease; and
- (3) Provide the best possible, humanitarian medical care to those in U.S. Government custody along the SWB.

During the past 13 months, CWMD has prioritized its limited resources, personnel, and time to accomplish each of these goals.

CWMD DIRECT SUPPORT TO THE SWB

Faced with the rising humanitarian demands of the migration crisis, and particularly the increasing numbers of children being brought to the United States as part of this crisis, members of CWMD staff deployed immediately to the SWB to assist with coordination of health care and public health response to meet the goals set by the Secretary. CBP provides critical law enforcement functions at our Nation's borders. Migrants taken into CBP custody generally are held in CBP custody for the short period of time required for processing, and then generally transferred to other components of the Department or interagency systems that have the appropriate facilities and carry out more robust health care functions. However, as the numbers of migrants, particularly family units and children, were overwhelming the system's capacity and increasing medical and public health risk, core staff were deployed to the SWB to assist with development and coordination of the medical response to this humanitarian crisis.

During the winter of 2018 and into the spring of 2019, we spent significant time focused on coordinating an interagency medical surge response, first with providers from the United States Coast Guard (USCG), and then with critical assistance from the United States Public Health Service (PHS), all while ensuring close coordination with State and local Public Health Offices and private-sector health care systems. CWMD medical and public health staff assisted with the response coordination, helped the U.S. Border Patrol determine critical needs and coordinated interagency efforts to respond to remote areas where large numbers of migrants were apprehended outside of the developing CBP network of contracted medical support. During the first 6 months of the SWB migration crisis, the USCG deployed 34 independent teams to the SWB. These teams, consisting of one medical officer and two corpsmen, provided 3,468 medical officer days and 8,296 Health Service Technician days of care at the most vital time in this response to this crisis.

Our Nation's Assistant Secretary for Health, ADM Brett Giroir, a pediatric intensivist, was a critical partner as we deployed and placed PHS Officers in Border Patrol Stations along the SWB. As CBP determined its needs and which of its facilities were in critical need of medical support, we facilitated the targeted deployment of PHS officers to those critical areas. At times, in response to critical and emergent operational needs, PHS Officers were flown to remote areas of the SWB aboard CBP aircraft to begin triage and treatment of large migrant groups immediately after apprehension. From December 30, 2018 through October 2, 2019, there were 483 United States PHS officers deployed to the SWB, totaling 6,759 days of care provided to migrants.

UNACCOMPANIED ALIEN CHILDREN AND FAMILY UNITS: A UNIQUE CHALLENGE TO THE SWB HEALTHCARE “SYSTEM” AND THE OVERALL 2019 MIGRATION CRISIS

As described in the CBP testimony submitted for this hearing, the preponderance of unaccompanied alien children (UACs) and family unit aliens (FMUAs) presented us with unique challenges that the existing SWB health care infrastructure was unequipped and unprepared to deal with. Relatively early in the crisis, at the request of the CBP acting commissioner, CWMD employed the services of an experienced, senior pediatrician from Columbia University to serve as our Senior Medical Advisor for Pediatrics. In addition, we consulted and engaged with a variety of other pediatric and health care experts, who made recommendations and helped us shape our on-going efforts with regards to the medical care of children caught in this crisis. Many of these experts came to the SWB to directly observe the conditions and subsequently used these visits and information to provide us with their advice on how to best continue to shape and improve the care of children in custody.

SPECIALIZED EXPERTISE: AVAILABLE 24/7, EVERY DAY

High-quality EMS medical direction and highly functioning EMS systems provide the ability for EMTs and paramedics to reach physician expertise. Early in the SWB migration crisis, focused on DHS EMTs and paramedics but available to any of our medical providers, we recognized the need for a provider involved to have the capacity to be in contact with medical experts especially in the provision of care in austere environments. Established in early 2017, and enhanced for this crisis, we ensured that all DHS EMS and medical providers had the ability to reach the DHS medical officer on-call. Originally requiring a phone call, we expanded this capability to include the ability to reach out via nearly any communication method utilized by DHS LEO EMTs and paramedics. Integrated with the National Law Enforcement Communications Center (NLECC, aka “Sector”), from nearly anywhere in the world, our providers are now available to contact 1 of our DHS EMS physicians at all times.

CONSULTATION, COORDINATION, AND INTEGRATION OF AN INTERAGENCY EFFORT

In addition to the direct operational medical support and pediatric guidance described above, we coordinated and consulted with a variety of medical experts to ensure that our practices met the most appropriate tenets of quality medical care given the operational constraints. The following individuals or organizations, inside and outside of DHS, were consulted, formally visited the border, or were hired to give their recommendations/evaluations of our practices during the crisis:

- (1) Centers for Disease Control and Prevention
 - a. Influenza Division
 - b. Division of Global Migration and Quarantine
- (2) Chief Medical Officer, USCG
- (3) Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services (HHS)
- (4) Assistant Secretary for Health, HHS
- (5) Senior Medical Advisor for Pediatrics, DHS.

As the response effort grew and encompassed the Federal interagency, coordination structures for these efforts leveraged a Unified Coordination Group structure, which included representatives from the appropriate interagency members, established data collection and analysis requirements, and refined thresholds for further action. In addition to the above, CBP’s Senior Medical Advisor has continuously engaged with the court-appointed pediatric consultant to inform CBP’s approach to care for children in custody.

INTEGRATION INTO LOCAL SWB COMMUNITIES: CRITICAL LINKAGES WITH HEALTH CARE SYSTEMS AND PUBLIC HEALTH

While the response to this unprecedented humanitarian migration crisis is clearly Federal, much of the health and public health efforts lie at the feet of our State and local health department and private-sector health care partners. Hence, efforts for more deliberate State and local public health engagement were reinstated in the spring of 2018 and included regular conference calls, presentations at National conferences, and face-to-face meetings. Regular coordination calls and synchronization meetings with the 4 SWB States were started in October 2018 and covered DHS operational component updates, disease surveillance updates, and feedback. At the peak of the crisis in the spring of 2019, these conference calls had more than 250 invited, regular participants from along the SWB. The calls continue today, though are now held monthly or as necessary. Topics covered include coordination

on preparedness and response to disease outbreaks or public health emergencies, investigation of potential infectious disease outbreaks and those migrants that may have been effected, discussions with operational components on issues related to detainee transfer and release, consultation on Non-Government Organization shelters in their States, and on-going public health engagement to address specific public health issues including disease surveillance, disease outbreak preparedness and response coordination, information sharing, and general health care issues of concern locally. In addition to these critical coordination calls, members of CWMD staff held, and continue to hold, in-person visits and coordination meetings with State and local public health officials from the State to the individual community level in Texas, New Mexico, Arizona, and California.

IMPROVED COORDINATION AND INTEGRATION OF A SWB HEALTH CARE SYSTEM

After nearly 6 months of responding to the humanitarian crisis response at the SWB, it was clear that this unconventional health care infrastructure developing in CBP to urgently to meet unprecedented demand required better integration and coordination. CBP is distinctly different than ICE and HHS that have developed and embedded health care systems. The CBP health care infrastructure is complicated by vast geography, an international nexus, and the varying roles of multiple departments and agencies of the U.S. Government. Recognizing this, CWMD and CBP have identified the need to develop systems of coordination jointly. This work is ongoing at present. From an overall DHS SWB health care architecture, close coordination of health care systems along the SWB, including ICE Health Service Corps, CBP contract services, HHS Office of Refugee Resettlement Agency for Children and Families (ORR ACF), and local health care systems continues to represent a significant challenge that we work to address daily.

INTERNATIONAL ENGAGEMENT

International engagement with the Government of Mexico's Ministry of Health began informally with a meet-and-greet visit. Regular updates of conditions across the border were provided from Department of State partners from U.S. consulates near the border and through HHS international offices. As result of these initial meetings, and concerns expressed along both sides of the SWB, we organized a multi-agency delegation that visited Mexico in May and outlined a path forward to identify U.S. Government leads and partners for on-going engagement. The delegation identified issues and outlined solutions to ensuring migrant access to medical care, sharing information on disease surveillance, options for medical records, and vaccination strategy options. The visit also included meetings with international NGO's operating to assist the migrant population in Mexico and hearing their observations and concerns. The binational engagement occurs through three international agreements already in place. The Binational Technical Working Group (CDC leads) shares epidemiology trends along the SWB at the local and State level, coordinating disease surveillance and outbreak investigations. The North American Plan for Animal and Pandemic Influenza (NAPAPI) Health Security Working Group (ASPR leads) is a tripartite agreement including Canada focusing on coordination for animal and human influenza outbreaks. Ultimately, continued binational integration efforts continue through the HHS-led Border Health Commission, which provides international leadership to improve health and quality of life along the SWB.

FUTURE DIRECTIONS

We are working diligently to meet the requirements enumerated in the fiscal year 2020 Homeland Security (DHS) Appropriations Act and the Joint Explanatory Statement. In addition, we continue to address the integration of health care along the SWB to include, to the degree possible, integrated health record systems, disease surveillance, access to and continuity of quality health care for those in our Department's care and custody. We are also working to update the Land Mass Migration Plan for surges and mass migration along the SWB that will include a Medical Annex. The effort includes developing solutions that prevent the back-up of migrants in custody occurring in Border Patrol Stations. Like, and in conjunction with the update to the Maritime Mass Migration Plan and Medical Annex, this will address interagency, State, local, and private-sector roles, responsibilities, and authorities, thresholds for phased implementation of the responses, and requirements identified for further resourcing.

At DHS, we remain committed to ensuring that individuals in custody receive appropriate care, including medical support, but these efforts do not address the ongoing challenges we face due to continued migrant flows and changing demographics. Once again, we urge Congress to take a comprehensive look at the immi-

gration 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.

Miss RICE. I thank all the witnesses for their testimony. I will remind each Member that he or she will have 5 minutes to question the panel. I will now recognize myself for questions.

Chief Hastings, early last month, *ProPublica* released video footage of Carlos Hernandez Vasquez, who was being held in Border Patrol custody in May 2019. The video shows in heartbreaking detail the last hours of Carlos' life. He was 16 years old at the time. He died in his cell just hours after a nurse practitioner apparently recommended immediate medical care. In fact, his body was first discovered by his cellmate who was another child who was being held in detention. Understanding that this specific case is still under investigation, what can you tell us about the lesson CBP has learned from this particular case?

Mr. HASTINGS. So ma'am, I would start by saying, dignity and care of those are of the utmost importance. I am a father. I have a granddaughter as well. I watched the video. I saw the same video from the media report, and the video itself was troubling. As you know, the case is still under OIG investigation. I can't speak to what their findings are. One thing I can add is that I know that all of the video has been turned over, all of the items that we had. The video of all the cells has been turned over to OIG, and they have all the video, not just a piece, as I understand, that was pulled from the sheriff's department.

Miss RICE. So are you insinuating that there is more—I am not sure what you are insinuating.

Mr. HASTINGS. So as I said, all of the video that we had throughout the station that day has been turned over to OIG.

Miss RICE. What did it show?

Mr. HASTINGS. I haven't seen it, ma'am. I just know that we have turned it over and provided to OIG, who is the independent investigator.

Miss RICE. I was just curious about what you were insinuating by saying, we just saw a little snippet but that—

Mr. HASTINGS. I am just insinuating we have turned over all the evidence and all the video.

Miss RICE. OK. So broadly speaking what do you think could have been done differently, without talking about what was done, your review of the case, what do you think could have been done differently?

It has been indicated that welfare checks were conducted on this young boy, young teen, but the video shows an increasingly sick Carlos in pain, vomiting up blood, writhing around in pain until he falls unconscious to the floor of his cell, and this happened over a course of hours.

So I am wondering, is there a finding by just your internal review that maybe it wasn't understood, the level of medical attention that he needed when he was in the cell at that time?

Mr. HASTINGS. So again, it is on-going, and certainly any lessons learned from any of the investigations, this investigation or any others, we will look at to make changes. I can tell you that we did

put out guidance to the field that any of those—and I believe this was July—a memorandum from then-Commissioner Saunders went out—any subject in our custody were receiving welfare checks every 15 minutes and being documented in our system of record.

Miss RICE. You mean person, not subject, in your custody.

Mr. HASTINGS. Person, yes, ma'am.

Miss RICE. Because that is what they are, they are people, not subjects.

Mr. HASTINGS. People, ma'am.

Miss RICE. Can you tell us what policies are in place to ensure that recommendations that you received from medical professionals are actually followed and what measures exist to protect health care professionals who refuse to clear patients for detention?

I mean, I am assuming that a CBP officer has to stay with any child or human in detention if they go to a health facility. Is that correct?

Mr. HASTINGS. That is correct.

Miss RICE. Are you aware of pressure that CBP officers are putting on medical professionals to release patients so that they can get back to their job at the border or whatever facility to which they are assigned?

Mr. HASTINGS. No, ma'am, I am not. In fact, in reviewing some of the IG investigation material I saw the contrary where one of our agents actually asked for additional care and stood up for one of the children that was sick until the fever was down. So we have seen the opposite of that.

Miss RICE. Well, that is a good story to hear, but there have also been indications that health professionals feel intimidated and pressured by CBP personnel to release patients to detention even when it is not medically indicated. To me, it seems like a doctor should be the ones making these decisions, not CBP officers.

What policies are in place to ensure that recommendations of medical professionals are followed? I mean, are there policies? I mean—

Mr. HASTINGS. So yes, we have multiple policies, and we work closely with both CWMD as well as our own office of support. We have medical staff at our—that we have hired to oversee the contract and to make sure that we are providing the best care we can in the family practitioner model.

Miss RICE. Dr. Eastman, it is good to see you again. As the senior medical officer in the Department of Homeland Security, when you make recommendations for the medical care of individuals in CBP's custody, are they followed by CBP?

Dr. EASTMAN. Nice to see you as well, ma'am, and yes, we work collaboratively with CBP to advise and help implement the recommendations that we offer. In fact, we have our employees, CWMD employees, the senior medical adviser at CBP, and this team works collaboratively to implement the recommendations that are made with a hardy respect to the fact that there are operational considerations as well.

Miss RICE. If you look at some of the cases involved with the children that I mentioned, every single one of them was very, very sick and should have been hospitalized and never released back into CBP custody.

So there has to be, I would hope, some effort to review where these mistakes were made, that these children who were very, very sick, one of whom had a temperature of 105.7, when they were initially examined, I mean, I just don't understand how that could even be possible.

I mean, are CBP officers trained to—I know they are not medical professionals, but it doesn't take—you don't have to be a doctor to see that a child has a 105.7 temperature. So what—

Dr. EASTMAN. Ma'am, we do the absolute best we can to provide the best care possible to the children in our custody, but there is not a mechanism for us, as the Department of Homeland Security, to review the care that is provided outside our system in community hospitals all along the border. I think—

Miss RICE. Well, I am talking about that initial—I mean, it was a nurse practitioner, I believe, who examined Carlos and gave him Tamiflu because that is what he was diagnosed with. But have you recommended flu vaccines for detained migrants?

Dr. EASTMAN. Ma'am, our approach to the flu vaccine is a comprehensive one, that encompasses all of the settings where care is delivered along the Southwest Border. In fact—

Miss RICE. So is everyone given, is every detained migrant given a flu shot?

Dr. EASTMAN. The Department of Homeland Security's vaccination strategy has resulted in more than 60,000 vaccinations being given, predominantly in the ISL service core. Our goal is to give the right vaccine to the right person at the right time.

Miss RICE. Have you spoken with the Acting Secretary about ways to ensure that CBP follows your medical recommendations?

Dr. EASTMAN. Ma'am, like I said, the direction from leadership, from the Secretary to all the Acting Secretaries I have worked has been the same, to do the right thing for the people in our custody and for all of us to work together to do just that.

Miss RICE. I understand. I am just asking you—and you can just say yes or no—have you specifically spoken with the Acting Secretary about ways to ensure that CBP follows your medical recommendations?

Dr. EASTMAN. Yes, ma'am. Prior to his current role as the Acting Secretary, we spoke along the border.

Miss RICE. Do you continue those conversations?

Dr. EASTMAN. Yes, ma'am. Absolutely.

Miss RICE. Thank you. I now recognize the Ranking Member, Mr. Higgins.

Mr. HIGGINS. Thank you, Madam Chair.

Chief Hastings, the President requested emergency supplemental assistance to address the crisis at the border on May 1, 2019. It took 2 months for that money to be approved by Congress and to get that money to the field to provide relief.

Meanwhile, the Department of Health and Human Services ran out of money for unaccompanied minor bed space. Please explain to the committee, and the Americans watching this hearing, the immediate impact that supplemental funding had on Customs and Border Protection operations at the border and CBP's ability to move unaccompanied minors out of CBP facilities and into ones more suitable for children, including professional medical care.

Mr. HASTINGS. Thank you for the question, sir. So as everyone is fully aware, we dealt with 321,000 total children last fiscal year. Those were both UACs and in families. We have never seen those kind of numbers before. That quickly overwhelmed the entire system. Specifically in May and June time frame, 144,000 apprehensions in May, or arrests, and the inadmissibles as well. The system got backed up.

We were still processing in about, on average, 25 hours per average per UAC, but the UAC couldn't move. HHS was out of funding, they were out of money, and they were telling us they couldn't move those in our custody. By law, there is nothing more we can do with the UAC either, other than turn them over to HHS.

Mr. HIGGINS. Thank you for that clarification. In the interest of perspective for the American citizens viewing this hearing and for my colleagues on the committee, let me just say that there has been an undercurrent or insinuation that Customs and Border Protection has in some way been neglectful of caring for children.

I believe we all accept that the medical facilities of the United States of America, the hospitals of America, will provide some of the finest care in the world, arguably the finest care in the world. We will investigate any death of any child that is in the custody of Customs and Border Protection, and those deaths should be investigated. Every loss of a child is tragic, and we should take a deep breath and look at that.

But for the sense of perspective, let me say that in 2017 alone, 28,308 juveniles died in professional medical facilities in the United States of America. Many of these children arrive at the border, they are very sick. They are struggling, not telling what they have been through. CBP does their best to take care of them. But tragically sometimes children die, including 28,308 children in American hospitals in 2017 alone. Those are Government numbers from the CDC.

In our juvenile detention facilities, it is not uncommon historical data from the Government to show an average of about 10 deaths in a 6-year period. These are juveniles in juvenile detention facilities in America, much better designed and equipped to care for the children in their custody. The men and women that wear badges care about the children that come under our care.

I lost my first-born daughter in a hospital. I lost many more on the street, children in my arms, a young teen hit in the head by an axe handle over an unpaid drug debt. I sat there in that dark street and held that young man's head, whispering prayer into his ear as the life light left his life. Infant child, unresponsive, hysterical parents, I did my best to perform infant CPR to resuscitate that child. She didn't make it.

Dr. Eastman, in my remaining 25 seconds, sir, please respond to the spirit with which Customs and Border Protection addresses any sick child that comes into our custody.

Dr. EASTMAN. In my experiences, sir, CBP officers, Border Patrol agents, they are law enforcement officers, most of them are parents as well, and they act exactly as you describe, to do the best they can under the circumstances they are dealt.

Mr. HIGGINS. Thank you, gentlemen, for appearing today.

This is a painful and necessary hearing, and I thank Madam Chair and the Chairman of the whole committee, for allowing us to discuss how we can improve the care for the children that come through our border.

Let us not forget that we must operate based upon the cornerstones that have defined America as we attempt to care for all of our children.

So I thank you again, Madam Chair, for holding this hearing, and I yield.

Miss RICE. Apropos of that, Mr. Hastings, would you—oh, I am sorry. Apropos of what my friend, Mr. Higgins, was asking you, would you agree that taking \$3.5 billion from the military counter-drug program would be problematic? Because there is reporting today indicating that the President is planning to divert \$7.2 billion in Pentagon funding to build his wall. Would you find that to be problematic in terms of addressing the issues that you testified about?

Mr. HASTINGS. So ma'am, I would also add, though, on the other hand, we had a very large influx of families and children. We also had an influx of single adults. We saw those numbers go up. I would also add that we had 147,000 got-aways that we know of last year.

So we had not only asylum seekers turning themselves in, but people trying to elude as well. We need—this is a whole-of-Government approach to many things that we need to protect and safeguard our borders.

Miss RICE. Do you think taking \$3.5 billion from a military counter-drug program would be a problem to address the issues that you are—yes or no?

Mr. HASTINGS. We need a border wall, I can tell you that.

Miss RICE. I didn't ask you that. Can you answer the question I asked you?

Mr. HASTINGS. Can you ask the question again?

Miss RICE. Sure. Do you think it is problematic that the President wants to take \$3.5 billion from military counter-drug program?

Mr. HASTINGS. I think we—again, I would say—

Miss RICE. Is there a reason why you can't just say yes or no.

Mr. HASTINGS. No, I don't.

Miss RICE. So you don't think—that is not problematic?

Mr. HASTINGS. For our needs, there are needs that we have on the border as well to secure our border, and wall and construction is one of those.

Miss RICE. I now recognize Chairman Thompson for 5 minutes.

Mr. THOMPSON. Thank you very much, Madam Chair. The title of our subcommittee hearing today is "Assessing the Adequacy of DHS's Efforts to Prevent Child Deaths in Custody." My comments talked about one death in custody is too much.

I understand that since the deaths have occurred, there is an interim medical directive that talks about, that we will no longer do medical assessments for children under 18. Are you familiar with that, Mr. Hastings?

Mr. HASTINGS. Sir, our new policy that just went into effect says we are doing health interviews for all of those less than 18, and

we are doing health assessments, which is basically like a physical, for all of those 12 and younger, or anyone who says that they have a health condition or a medical issue.

Mr. THOMPSON. So, Dr. Eastman, are you familiar with that policy?

Dr. EASTMAN. Yes, sir. Yes, sir, I am.

Mr. THOMPSON. Explain it a little bit for the committee.

Dr. EASTMAN. Yes, sir. CBP uses a phased approach to meet the medical needs of the population in our custody.

The first phase involves recognition of illness and the encouragement of migrants to report to us that they have an issue.

The second phase is a health interview that has been standardized across Customs and Border Protection, using a questionnaire, able to be administered by a law enforcement officer but developed in concert with experts at the CDC and across the Government, with a two-fold purpose—to identify an emergent medical condition, but also to identify the potential of an infectious disease that might harm the migrant or threaten the United States.

The third phase of that approach is a medical assessment from a qualified provider. That medical assessment in the final medical directive is given to anyone with a positive finding on the health interview, or to any child under 12, or to anyone who requests it.

Mr. THOMPSON. So—

Dr. EASTMAN. I would also add, sir, just 1 second, the last phase of that care plan is for any true world emergencies, you know, someone that would need cardiac care, we are obviously utilizing the local health care system where the migrants area.

Mr. THOMPSON. So why would you determine 12 as the cut-off for an assessment?

Dr. EASTMAN. Yes. So the way the directive was derived was a collaborative approach from all of us involved from DHS and CBP and the other experts, and the way the directive was approached, was felt that a teenager would be able to seek and request medical care when necessary.

Mr. THOMPSON. So what outside groups did you talk to when you did this assessment?

Dr. EASTMAN. Yes, sir. We have incorporated advice from the Assistant Secretary for Health, as I mentioned, several members of his staff who are seasoned pediatricians. In addition, we worked with a number of Public Health Service officers along the border who help give us—who are pediatricians themselves, with vast experience in everything from disaster response to responding to ebola.

In addition, we hired a senior medical adviser for pediatrics, an outside pediatrician with vast disaster experience to come assist us. We also—and we continue to listen to the groups that are involved in the care, including the American Academy of Pediatrics, the family practitioners, and other organizations who have given us advice on this topic. We continue to utilize that advice to form our policies and procedures.

Mr. THOMPSON. Well, I am happy that you mentioned the American Academy of Pediatrics. Madam Chair, I have a letter from the American Academy of Pediatrics that says there is no medical justification to only assess children younger than 12.

So I want you to seriously consider the group you talked about, because they are the one dealing with children, and they are saying 12 is not a magic number. Some of us are concerned that between 18 and 12 is a vast shortage of opportunity for us to help children that we are talking about here today.

So I just want to put that in the record, Madam Chair.

Miss RICE. So received.

[The information follows:]

STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS

JANUARY 14, 2020

Chairwoman Rice and Ranking Member Higgins, thank you for the opportunity to provide written testimony about the adequacy of the Department of Homeland Security (DHS)'s efforts to prevent child deaths in custody. The American Academy of Pediatrics (AAP) is a non-profit professional membership organization of over 67,000 primary care pediatricians and medical and surgical pediatric subspecialists dedicated to health and well-being of all infants, children, adolescents, and young adults. The mission of the AAP is to protect the health and well-being of all children, no matter where they or their parents were born. As pediatricians, our primary responsibility is to support families in order to optimize child health. We strive to help all children to grow, develop, and reach their full potential to contribute to our collective America.

As we testified to before your subcommittee in March 2019, AAP continues to believe that current conditions and protocols in Customs and Border Protection (CBP) custody are inconsistent with evidence-based recommendations for the appropriate care of children. Children simply should not be subjected to these facilities. For over a year, we have been calling on DHS to implement specific meaningful steps to ensure that all children in CBP custody receive appropriate medical and mental health screening and necessary follow-up care by trained providers. We have also sought to provide expert advice to DHS and CBP about how to best care for and treat children in custody and continue to offer this expertise to the agencies.

The deaths of so many children in CBP custody, the horrifying video of Carlos Gregorio Hernandez Vasquez's last hours in a CBP jail cell, and the observations of the AAP leadership, DHS Office of Inspector General, and others should be a call to action for DHS. We once again urge CBP and DHS to increase medical staffing with individuals who have pediatric training at its facilities so they can monitor, screen and, where possible, treat children who are sick. We urge CBP and DHS to require that all children under age 18 are medically screened by a medical professional with pediatric training, to have plans for appropriate space to isolate ill individuals, and to prioritize the transfer of unaccompanied children to the Office of Refugee Resettlement (ORR) as quickly as possible. We are aware that the Centers for Disease Control and Prevention (CDC) issued a report to DHS based on findings by 3 CDC teams who visited DHS Border Patrol facilities in December 2018 and January 2019. CDC's recommendations are reasonable, routed in public health, and, if implemented, would greatly reduce the risk of infectious disease transmission and ensure more appropriate screening and treatment for children while in CBP custody. We urge the subcommittee to conduct oversight on whether any of CDC's recommendations have been implemented and continue to conduct robust oversight on how the hundreds of millions of dollars that Congress has already appropriated to DHS/CBP specifically for medical and humanitarian care through the regular and supplemental appropriations process have been spent.

UNIQUE NEEDS OF CHILDREN

As pediatricians, we know that children are not little adults. Children's vital signs (breathing rate, heart rate, blood pressure) have different normal parameters than adults, and these parameters vary by age. When children begin to get sick, they present with subtle findings, and they tend to get sick more quickly. For example, children can become dehydrated more quickly than adults. They require greater amounts of fluid per pound of body weight than adults, and high fevers and fast breathing can cause children to lose fluid quickly. Children also need encouragement to drink when they are ill, and this encouragement is exceedingly difficult to provide to frightened children.

The flu can be particularly serious for children and can escalate quickly. Signs differentiating a child with mild illness from a child with severe illness are quite

subtle. A child can be happily playing, even running around, while her body systems begin to shut down. When a child is having difficulty breathing, she may breathe more quickly or her ribs may pull in with each breath; these signs would often not be easily visible, especially not to an untrained eye. Additionally, children are more prone to muscle fatigue, including the breathing muscles, and are thus at greater risk for respiratory failure.¹ Even the dosing of common medications is different in children than it is in adults; rather than standard dosing, children are dosed based on their weight.²

Sepsis, for example, must be treated early in children. According to the Society of Critical Care Medicine (SCCM), sepsis is a complicated disease causing the body to be compromised by serious systemic infection leading to multiple organ failure.³ The importance of recognizing and treating sepsis early in children cannot be underestimated; each hour of delay in treatment dramatically increases mortality. Because sepsis can be so serious and so difficult to recognize in children, the SCCM has a separate set of guidelines for recognizing and treating sepsis in children that are different than for adults.⁴ For these reasons, it is essential that the individuals who interact with children apprehended at the border are trained to recognize signs and symptoms of distress and know when to urgently refer children to additional care.

RECENT CBP ACTIONS

Unfortunately, CBP's recently released Medical Directive is wholly inadequate to ensure the proper care of children in custody and represents a step in the wrong direction as compared to the Interim Medical Directive dated January 28, 2019. For example, the new Directive no longer requires medical assessments of all children under 18. Although the directive indicates that tender-age children (ages 12 and under) will receive a medical assessment, that is heavily caveated. As medical providers for children, there is no medical justification to only assess children younger than 12. All children should be routinely screened and treated, as necessary. Further, the directive no longer defines a medical assessment as including taking vital signs severely weakening what an actual medical assessment is and gives no definition to the required qualifications of "health care providers" including that anyone interacting with a child have any pediatric training.

We understand that CBP has hired 4 contracted pediatric advisors for the entire Southwest Border to provide pediatric expertise and consultation, support medical quality management efforts, advise pediatric protocols and support training. However, it does not appear that the contracted pediatricians will actually be providing care to children in CBP custody. In order to ensure proper care of children in CBP custody, there must be a robust pediatric medical presence at the border.

AAP RECOMMENDATIONS

1. Because conditions at CBP processing centers are inconsistent with AAP recommendations for appropriate care and treatment of children, children should not be subjected to these facilities.⁵ The processing of children and family units should occur in a child-friendly manner, taking place outside current CBP processing centers and conducted by child welfare professionals, to provide conditions that emphasize the health and well-being of children and families at this critical stage of immigration proceedings.⁶
2. All children, throughout the immigration process, should have access to comprehensive, trauma-informed care, including preventative care, chronic condition management, dental care, and mental health treatment, when indicated. Humanitarian standards should also be implemented to ensure that immigrants receive proper nutrition, hygiene, and sanitation while in CBP custody. Pediatricians stand with the immigrant families we care for and will continue to advocate that their needs are met and prioritized.

¹ Woollard M, Jewkes F. 5 Assessment and identification of paediatric primary survey positive patients. *Emergency Medicine Journal*. 2004;21:511–517.

² Palchuk MB, Seger DL, Recklet EG, Hanson C, Alexeyev A, Li Q. Weight-based pediatric prescribing in ambulatory setting. *AMIA Annu Symp Proc*. 2006;2006:1055.

³ Weiss SL. Five Important Things to Know about Pediatric Sepsis. Society of Critical Care Medicine. <https://www.sccm.org/Communications/Critical-Connections/Archives/2018/Five-Important-Things-to-Know-About-Pediatric-Sepsis>. Accessed March 4, 2019.

⁴ Dellinger RP, Levy MM, Rhodes A, et al: Surviving Sepsis Campaign: International guidelines for management of severe sepsis and septic shock: 2012. *Crit Care Med*. 2013; 41:580–637.

⁵ Linton JM, Griffin M, Shapiro AJ. Detention of Immigrant Children. *Pediatrics*. 2017;139(5).

⁶ Ibid.

3. CBP agents, including those who are not trained as EMTs or paramedics and those who work in remote areas along the border, should be trained to know how to identify the signs of a child who is in medical distress and needs immediate medical attention. Ideally, such training would be both on-line and in-person. While it may not be possible to provide pediatric medical training to all CBP agents, we can work to ensure that they are better prepared to identify a sick child and to get that child into appropriate care. We must also ensure that CBP provides its agents with necessary basic supplies such as oral hydration, food, first-aid kits, and other supplies that could be life-saving should those agents encounter a sick child. The AAP is pleased to support S. 412, the Remote, Emergency, Medical, On-line Training, Telehealth, and EMT (RE-MOTE) Act, which addresses many of these recommendations.

4. The Academy is urging CBP to ensure that all children under 18 years of age receive evidenced-based medical screening and care from professionals trained in pediatric care. We must have medical professionals who are trained in the care of children screening and treating vulnerable children who are in the custody of our Government.

5. Children who are identified as needing additional medical care should be immediately referred for evaluation and treatment, at a children's hospital if there is one available. Procedures should be in place to ensure that when children need treatment, they are quickly able to receive appropriate care and have access to professionals trained in the care of critically-ill children during transport.

6. Screening and treatment should occur in the child or parent's preferred language so as to ensure the family is able to understand what is happening and accurately answer questions. This means that trained medical interpreters should be used in all clinical encounters with children and their families.

7. Sick children, children who have been hospitalized, or children with special health care needs should not be returned to a CBP processing facility. When a child is diagnosed with an illness in a pediatrician's office or is discharged from an emergency room or a hospital, he or she is sent home to recover with plenty of rest and a parent to care for them. Parents of children being detained in CBP processing centers do not have that luxury; rather, the conditions in the centers themselves exacerbate children's suffering, and without medical professionals who understand the signs and symptoms to look for to assess a child's condition, these children are at further risk. A sick child should recover in the comfort of a home or child-friendly setting under the care of a parent or caregiver, not on a cold, concrete floor in Federal custody.

8. Independent oversight of locations in which children are temporarily housed, detained, or sheltered is critical. Licensure of those locations is important to ensure appropriate care and oversight. As these locations are selected, we encourage DHS and HHS to consider their remoteness as that can impact proximity and access to trained pediatric providers.

9. Medications should not be confiscated from a child unless approved by a pediatrician at a CBP facility. Children with chronic or acute medical conditions rely on life-saving or life-sustaining medications. Children whose medications have been confiscated by CBP may go days or weeks without needed medications as these medicines are not always replaced by CBP in a timely manner. Pediatricians throughout the country have reported children needing to be hospitalized, sometimes in the intensive care unit, as a result of the conditions in CBP facilities including the confiscation without replacement of their medications.

10. The AAP has called for a thorough, independent investigation of the Government's detention practices, including the appointment of an independent team comprised of pediatricians, pediatric mental health providers, child welfare experts, and others to conduct unannounced visits to Federal facilities including CBP processing centers, ICE family detention centers, and ORR shelters to assess their conditions for children, capacity to respond to medical emergencies involving a child, and to ensure that immigrant children receive optimal medical and mental health care. These experts need unfettered access to sites where children are held in Federal custody to ensure that they receive suitable care while there.

Thank you for the opportunity to provide written testimony. We look forward to working with you to ensure that all children who reach our border receive appropriate medical and mental health screening and treatment.

Mr. THOMPSON. All right.

So Mr. Hastings, why did it take the Department as long as it did to revise this directive? Are you familiar with that?

Mr. HASTINGS. So we did put out an interim directive immediately, in December. Then we worked with these various components as was mentioned earlier, internally and externally, our stakeholders, to make sure that we got this right. But the interim policy was in effect since December 2018.

Additionally we didn't wait to take actions. We were taking many other actions, including increasing our contract personnel even before that.

Mr. THOMPSON. So are you familiar with the clause "subject to availability of resources and operational requirements" in that directive?

Mr. HASTINGS. Resources and obligations?

Mr. THOMPSON. Resources and operational requirements.

Mr. HASTINGS. Am I—I am not sure what you are referring to, which part, sir.

Mr. THOMPSON. The same directive you talked about that has been developed.

Mr. HASTINGS. Well, for one thing, sir, we need funding—and it does mention funding in there—to continue our assistance with resources, is funding basically to continue the assistance with our contract medical providers.

Mr. THOMPSON. So who makes decisions as to whether resources are available?

Mr. HASTINGS. It is based on budgetary need. The other thing—

Mr. THOMPSON. So who makes that decision?

Mr. HASTINGS. So if we continue to receive funding to provide the current services we are, contract services will continue to do that.

Mr. THOMPSON. Well, do you make the decision or who?

Mr. HASTINGS. Sir, we have to be funded to continue for one—

Mr. THOMPSON. I am not talking about—I am not talking about—I am saying, who makes the decision, what individual, in the implementation of this directive?

Mr. HASTINGS. So, as I said, we have implemented the directive. When we would have had difficulty, what you are referring to in staying with the directive, would have been very difficult when we were backed up and had 7,500 children—

Mr. THOMPSON. So when you said "we," is that you?

Mr. HASTINGS. That is the Border Patrol.

Mr. THOMPSON. So who at the Border Patrol makes that decision?

Mr. HASTINGS. We would make it operationally and provide a heads-up to Congressional.

Mr. THOMPSON. So there is no individual by name that you can give this committee?

Mr. HASTINGS. Sir, we constantly brief what we have going on on the border, as far as the amount of numbers we are seeing and the resources that we are using down there.

We consistently brief up what we are seeing on the border and the situation, and throughout the crisis, we continue to brief those numbers. We were overwhelmed is my point.

Mr. THOMPSON. Well, but that is—I am talking about the directive. I am not talking about the conditions. You put a directive in place.

Mr. HASTINGS. We have.

Mr. THOMPSON. You said “subject to the availability of resources and operational requirements.” I am asking you, who makes that determination, what individual?

Mr. HASTINGS. So we will continue to do that. I would imagine that would go to the highest levels. It would probably go to the chief or the commissioner to stop something as important to this, and we would certainly notify their entities if we were forced into a situation, overwhelmed or not budgeted for this. We would certainly notify—

Mr. THOMPSON. I am having real difficulty with you not giving us a name. I mean, I am just—it is not a gotcha question. You got a requirement that you pushed out. Someone has to be responsible for making decisions on that requirement.

I am just asking, for my sake and I hope for other Members of the committee, who that individual is.

Mr. HASTINGS. It would be the chief in consultation with the commissioner. We would advise, like I said—

Mr. THOMPSON. Is that you?

Mr. HASTINGS. No. I am not the chief of Border Patrol. I am the chief of operations. I oversee all the operations in field.

Mr. THOMPSON. So the chief of Border Patrol would interpret the policy we are talking about now, in terms of resources and other things?

Mr. HASTINGS. When we did not have the resources to fulfill that obligation, that is what you are referring to, I believe.

Mr. THOMPSON. No. I am talking about the new policy that was put in place in response to the death of the children, and it said that it is subject to the availability of resources and operational requirements. I am just trying to get a sense of who is in charge of making those determinations?

Mr. HASTINGS. So we—again, it would be—we have to be properly resourced to be able to carry this out with our contract employees. We have to be properly—we have to have the proper funding to do that.

Operationally, it would be the chief and the commissioner that would pass this down in close work with the field commanders and the chiefs in the field.

Mr. THOMPSON. Madam Chair, I think my problem is, we have had a problem, and we have had some proposed solutions, but we are not—I am not comfortable with who is responsible for carrying it out, to the point that we might end up with another situation because the directive is unclear and subject to anyone’s interpretation. I am just trying to make sure these problems don’t happen again.

Mr. HIGGINS. Will the gentleman yield for 10 seconds?

Mr. THOMPSON. Be happy to.

Mr. HIGGINS. Thank you, Mr. Chairman, Madam Chair. I believe that the witness is attempting to answer the question to the best of his ability. You asked him for one name, and the answer was that there are many names.

Chain of command is a multitude of men and women that make these decisions on an operational basis based upon what they are dealing with in the field at that time, and they report up chain and down chain. So the answer is not one name.

Ultimately, the gentleman referred to at the highest level is responsible, but the implementation of a new policy would be based upon the work done throughout the chain of command. So it is many people, it seems to me.

Mr. THOMPSON. Well, you didn't help either with the response. So I am still, for clarity's sake, if we have come up with a new policy, Madam Chair—and we might just have to follow up with some subsequent language requests—

But I think it is not unreasonable, if a policy is put out on an issue this critical, for us not to have those individuals who are tasked with the responsibility of making sure they are carried out.

So I yield back.

Miss RICE. Thank you. The gentleman from Pennsylvania, Mr. Joyce, is now recognized.

Mr. JOYCE. Thank you, Mr. Chairman, Madam Chair, Mr. Ranking Member.

Dr. Eastman, in the fiscal year 2019, more than 200 large groups of 100 people or more, often of various ages, arrived along our Southwest Border. Many of these large groups arrived during the height of the flu season, and during months of intense high heat.

Can you give an estimate of how many of these migrants likely arrived at the border with a preexisting illness or infectious disease in fiscal year 2019?

Dr. EASTMAN. On an individual basis, most of the migrants we saw overwhelmingly were well, but there were notable cases that were not. I will take that back for the record to try to get you a more exact number, because I think, you know, we have got the data. I don't have a specific number.

But mostly, overwhelmingly, they were well, but your point is exactly accurate, that folks are coming to us after a long journey, many of them with the flu or another infectious disease that needed to be addressed.

Mr. JOYCE. For those who were traveling hundreds of miles to our border, what was the likelihood that they had access to medical treatment along their journey?

Dr. EASTMAN. Sir, I am not the expert on the care that occurs from—prior to them reaching, you know, our Southern Border. We have worked collaboratively with the government of Mexico to try to, you know, help them do everything they can to improve conditions on the Mexican side of the border.

I know the Department has a number of efforts in Central and South America to facilitate other parts of this, but I am certainly not the expert on what happens prior to the migrants reaching our border.

Mr. JOYCE. Thank you. You mentioned that potential infectious diseases have been with these migrants as they presented to our border. Can you tell us more about that, please?

Dr. EASTMAN. Yes, sir. Predominantly, what we have seen is seasonal influenza. We have also seen sporadic cases of tuberculosis, chickenpox, you know, varicella-zoster virus. We have seen some

mumps. Knock on wood—I am superstitious and hesitant to say this—we have not seen a case of the measles. But those are predominantly the diseases that we have seen.

Mr. JOYCE. In contrast to children who have presented with grave illnesses, can you tell us how many children that you estimate have been saved by the medical attention provided under the United States Government's custody?

Dr. EASTMAN. Sir, that number is a difficult one to pin down directly, but from the beginnings of my work along the border, we know that about 10 percent of the migrants that come across will end up going into the medical assessment process. Again, those are rough very early numbers in the crisis.

How many were saved directly, I can't pin down. It is hard to predict. But there are certainly lives that have been saved by the response to this crisis.

Mr. JOYCE. Dr. Eastman, continuing, during this crisis, the CBP received medical surge assistance from interagency partners, like the United States Coast Guard medical teams, and personnel from the United States Public Health Service. How important is having additional medical staff on-site at CBP facilities?

Dr. EASTMAN. Sir, it is important to remember that, you know, CBP is a law enforcement organization. We think that health care is best provided in health care settings. However, by virtue of the unprecedented crisis we faced, we had to mount an unprecedented solution.

That care, you know, assessment and care that was initially provided by our first responders, the Coast Guard, by our intermediate responders, the Public Health Service, and then now subsequently that is placed onto the backs of CBP's contracted medical providers, that care is vital. It is vital because we have got an unprecedented problem in the system, and that is a very unconventional solution. I know of no other law enforcement agency that I have ever interacted with or heard of that has such a developed health care infrastructure inside it.

Mr. JOYCE. So, in face of this unprecedented crisis, you have been able to provide vital health care. Is that the message that I am hearing from you, sir?

Dr. EASTMAN. Well, I wouldn't say I, I would say we. This has been a collaborative interagency approach. At the heat of the crisis, I spoke to Admiral Jawa and the chief medical officers of the Coast Guard, who have changed hats recently, but I spoke to them daily.

We, the Department, received help from them and many other entities to provide what is clearly an unconventional solution to this unprecedented problem.

Miss RICE. We thank you for doing that. Thank you both for coming here today, for testifying in front of us.

I yield the remainder of my time.

The Chairman. Thank you.

The gentlewoman from New Mexico, Ms. Torres Small, is now recognized for 5 minutes.

Ms. TORRES SMALL. Thank you, Madam Chair. Thank you, Mr. Ranking Member, and thank you, Chief Hastings and Dr. Eastman, for being here today.

In December 2018, Jakelin Caal Maquin and Felipe Gómez Alonzo died while in CBP custody after being detained in the district that I represent. Subsequently, the DHS Office of Inspector General opened an investigation into their deaths. Three months later, in this committee hearing room, former Secretary Nielsen testified that she directed the CBP's Office of Professional Responsibility and the inspector general to work as quickly as possible to complete these investigations.

Then in May 2019, my colleagues and I, again, urged the Department and the inspector general to complete the investigations in a timely manner. The OIG responded to our request saying it was working to complete the investigations as expeditiously as possible. But it was only last month, nearly a year later after these tragic deaths that the investigations were completed and provided to Congress. Even more concerning, the OIG limited its investigation scope to only determine whether there was malfeasance by personnel and did not consider whether CBP's policies and procedures are adequate to prevent migrant child deaths.

As I have said from the beginning, the reason for these investigations is not to punish people; it is to keep this from happening again. It is to make sure that we have the protocols in place in case we are faced with this challenge again.

It is the committee's understanding that the investigations did not even interview medical professionals outside of the offices of the medical examiner and the Department. This is unacceptable, especially given the significant number of family units and unaccompanied children that traveled to the Southwest Border last year.

Now, Chief Hastings, I deeply appreciate the work that the men and women of Border Patrol do every single day and have done in the past year to mitigate the situation we saw at the Southern Border, and I want to find out whether the policies and procedures of the agency are setting our agents up for success to keep migrant children safe.

So, Chief Hastings, has CBP received the full reports of these investigations?

Mr. HASTINGS. Ma'am, I have not seen a full report. I have seen an abbreviated report from our Office of Professional Responsibility.

Ms. TORRES SMALL. Thank you, Chief Hastings. That is deeply concerning. The committee was told by the OIG that CBP has received the reports. So that is something we will follow up on.

Mr. HASTINGS. I have not personally. I have not.

Ms. TORRES SMALL. From the information that you received, have you identified specific lessons learned that CBP took from the reports and have recommended protocol changes to enforce them?

Mr. HASTINGS. So I think one of the lessons learned is we needed a standardized health form across the board for all of CBP. One of the things that we saw, there were multiple forms being used in the field throughout this entire year. That is now standardized.

Ms. TORRES SMALL. And you have the updated form?

Mr. HASTINGS. Yes, ma'am.

Ms. TORRES SMALL. Any other lessons?

Mr. HASTINGS. That is one of the bigger ones. You visited the location where we lost Jakelin. You are well aware of the remoteness and the amount of time it would take to get even our own agent out of that area, so I think you are very well-versed with the issues of remoteness and rugged terrain that we had out there as well as transportation. We have also added a large transportation contract, buses and many other things to help get folks from the border.

Ms. TORRES SMALL. Thank you. That is a great lesson learned, and it is certainly something I saw, so I am pleased that Border Patrol is addressing that. Do you have multiple buses now under contract?

Mr. HASTINGS. We do, under contract and our own personal that we have purchased, vans and buses, as I mentioned earlier.

Ms. TORRES SMALL. What about pediatric equipment? One of the lessons learned for me with Jakelin's passing is not having the appropriate cuff to take her blood pressure. Is there pediatric equipment across the board along the border that is available, if necessary?

Mr. HASTINGS. So we dedicated a large portion of the supplemental funding to our EMTs. We have over 1,500 EMTs in the field, and we have since updated them with equipment and made sure that they have everything to meet their daily needs.

Ms. TORRES SMALL. That is also part of protocol, so it is required. If there is a deficiency, an agent has the ability to alert, to fill that deficiency?

Mr. HASTINGS. That is correct.

Ms. TORRES SMALL. Thank you. I want to shift now to preventing the spread of infectious diseases in CBP stations.

Chief Hastings, what are the protocols that CBP has in place to protect both migrants and CBP personnel from the spread of infectious diseases, such as the flu inside Border Patrol stations, processing centers, and ports of entry?

Mr. HASTINGS. So, with our contract personnel that we have in all 9 Southwest Borders, and about 40 locations, put those personnel based upon the highest vulnerable populations, highest flow that we were seeing, as well as the least amount of medical assistance in the general area, that is how we decided where to put them. They are fully trained, and are able to care and provide any type of antiviral flu and do flu testing. They are able to do that. They are able to do acute care and other things that aren't referred to secondary care.

Ms. TORRES SMALL. You have written protocols that support that need? Just yes or no, because I am out of time.

Dr. EASTMAN. Yes, ma'am, absolutely we do.

Ms. TORRES SMALL. If you can supply those to supplement the record, I would appreciate it.

Dr. EASTMAN. We will work to get that to you, yes.

Ms. TORRES SMALL. Thank you.

My time is expired. Thank you.

Miss RICE. Thank you. We now recognize the gentleman from Mississippi, Mr. Guest.

Mr. GUEST. Thank you, Ms. Chairman.

Chief Hastings, I want to speak to you on the overall immigration crisis that we have and are currently experiencing along our

Southwest Border. I note on page 7 of your written testimony, you referred to fundamental flaws in the immigration system.

You go on to say: "CBP has pleaded with Congress to address the layers of existing law and judicial systems 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." And you list there the *Flores* settlement, the TVPRA, and the asylum assertion.

Could you just take a few moments to expand on each of these factors that you have listed there in your report and how it impacts your Department's ability to secure our border?

Mr. HASTINGS. So we need the ability—under *Flores*, we need the ability to be able to hold in a setting that provides fair and expeditious immigration proceedings. *Flores* is a major issue for us, completing that under the current 20-day process that is required.

When we released over 149,000 families, when we were interviewing these individuals, they literally told us that we were told bring a child and we will be released. That is what is encouraging this large flow that we continue to see. We believe that they should be housed in an FRC together with all of the adequate things that have been provided, medical, dental, pharmacy, education, all the many other things.

The double standard for noncontiguous UACs, being able to return a UAC to Guatemala, Honduras, other countries like we are currently with Mexico and Canada, that would assist with the large number of UACs that we are seeing cross our borders today, again, a vulnerable population.

Last, tightening the asylum bar, the low asylum bar for credible fear, as we see the massive backlog of over 1 million cases right now.

Mr. GUEST. Would you agree, Chief, that if Congress were to address these 3 issues that you have set forth in your report, that it would help stem the flow of illegal immigration that we have recently seen across our Southwest Border?

Mr. HASTINGS. Yes, we believe it absolutely would.

Mr. GUEST. Chief, you were asked a question earlier about moving, or the shifting of money that was designated for the Department of Defense to our Southwest Border for the purpose of border wall construction.

Do you feel like that the construction of the border wall system has improved your agency's ability to protect our homeland?

Mr. HASTINGS. Absolutely. So, again, a border wall system is more than just a wall: It comes with technology, it comes with roads, gives us situational awareness, gives us impedance and denial and time to respond. I have seen it work personally in the many areas I have been in the field. I have seen what it does for us, and I strongly support it.

Mr. GUEST. Thank you. Just last, Chief, is there any other recommendations that you would make to this committee as to how we can better help your Department, again, to secure our homeland, and then those individuals that are within our custody that we can do our best to make sure that they are protected and receive the care that they need?

Mr. HASTINGS. I just would request if we are not coming to an agreement on some of the recommendations we gave that we continue to fund HHS, so we can move those UACs through the cycle and get them into the proper environment for care.

I would also request assistance with ICE funding as well for single adult bed space, because that is another demographic that we see backing up in our facilities at times. ICE needs proper funding for single adult bed space.

Mr. GUEST. Chief Hastings, thank you for your service to our Nation.

Madam Chairman, I yield back.

Miss RICE. Thank you.

I now recognize the gentlewoman from New York, Ms. Clarke.

Ms. CLARKE. Thank you, Madam Chair, and I thank our witnesses for testifying here before us today.

Chief Hastings, last year, you testified before the Judiciary Committee, and my colleague, Congressman Lieu, asked you whether a 3-year-old girl could pose a criminal or National security threat, and you responded, "I don't know." I think attitude goes a long way in addressing the multitude of issues that you have before you, but specifically, preventing child deaths in custody. I believe that we shouldn't be surprised when children don't receive medical attention they need, particularly when we don't know whether a 3-year-old can pose a criminal or National security threat.

Having said that, last fall, I introduced H.R. 3777. It is the National Commission to Investigate the Treatment of Migrant Families and Children Act, which would create an independent commission to study issues like family separation, as well as the death of children in CBP custody.

But short of passing my legislation, we have to rely on the Inspector General to get to the bottom of these matters. In a report recently released by DHS OIG, it states that a Border Patrol supervisor had to pay out of their own pocket for an over-the-counter medication for 8-year-old Felipe, because Border Patrol's insurance did not cover it. In addition, the CBP EMT was unable to take a blood pressure of Jakelin, age 7, because they lacked a pediatric cuff.

What steps has CBP taken to ensure access to basic medical necessities and equipment across the Southwest Border?

Mr. HASTINGS. Ma'am, thank you for the question. So we did, indeed, see an issue or a problem with Border Patrol or CBP OFO, being able to fund nonprescriptions, over-the-counter prescriptions. We have since fixed that. We have a contract through ICE to be able to purchase any needed over-the-counter remedy that is prescribed. So we have that. Then additionally, as I mentioned earlier, thank you for the supplemental funding that we were able to provide much-needed equipment for our EMTs out in the field. So those have been fixed.

Ms. CLARKE. Wonderful. I appreciate that. But, you know, in the decade prior to 2018, there was not one single child death in custody. So I am a bit concerned that, you know, there just seems to be a callousness taking place.

I am glad that we are focused on this. However, if we are able to shift funding for a border wall, we should be able to shift fund-

ing to save human lives, particularly the lives of children. We need to understand what went wrong in 2018 and 2019.

If a CBP official failed to take reasonable steps to prevent the death of a child, what kind of disciplinary measures do you think would be appropriate?

Mr. HASTINGS. Ma'am, I haven't seen anything—

Ms. CLARKE. I am just asking hypothetically.

Mr. HASTINGS. I would have to see all the—everything that went into the report. I would have to see the specifics. But if it was negligible, we would certainly take immediate action.

Ms. CLARKE. That is good to know. Has any CBP official faced accountability for the death of children in custody?

Mr. HASTINGS. No, ma'am. There has been no negative findings of malfeasance.

Ms. CLARKE. OK. Fine, no problem. How does CBP determine what expenses qualify as consumables or medical care?

Mr. HASTINGS. How do we determine—I am sorry, I didn't hear you.

Ms. CLARKE. How does CBP determine what expenses qualify as consumables or medical care?

Dr. EASTMAN. Ma'am, let me help Chief Hastings with that. We use the MedPar system, which is actually administered through ICE. It is the DHS system that pays for care for migrants in our custody.

In addition to that—

Ms. CLARKE. Could you hold on 1 second. Could you just provide us examples of the types of projects or activities for which consumables and medical care funds have been obligated or expended since the supplemental was enacted?

Dr. EASTMAN. Absolutely, ma'am. Again, thank you for the supplemental funding. In response to that, at our more than 40 locations that now have contracted medical support, they have a standardized formulary of medications and equipment that is used to care for the migrants in custody.

So that is a clear example of how money has been appropriated from the supplemental to help further the care of children in our custody.

Ms. CLARKE. How is that replenished? How do the subcontractors—

Dr. EASTMAN. There is a—the contractor—I am not an expert in their supply chain management, ma'am, but they have a system that replenishes those. Again, the supplemental pays for that.

Ms. CLARKE. Very well.

Madam Chair, I yield back the balance of my time.

Miss RICE. I now recognize the gentleman from California, Mr. Correa.

Mr. CORREA. Thank you, Madam Chair. Gentlemen, thank you for being here today.

I am a Member of both this committee as well as the House Judiciary Committee, where we have had numerous oversight hearings concerning the dangerous detention facilities' inadequate standards of care for migrants, including young children.

Like my colleagues here, I am troubled by the multiple reports of overcrowded facilities. I have actually toured some of those facili-

ties. There is a general agreement that CBP, your facilities are not meant to handle the influx of children and families that we have seen over the last 2 years.

So my question is, what contingency plans does the Department have in place to ensure the safety of those within your custody?

Mr. HASTINGS. So, sir, there are a couple things I would add. As I mentioned in my opening—

Mr. CORREA. Yes, sir.

Mr. HASTINGS [continuing]. We have 6 soft-sided facilities with complete wraparound, medical/food services, shower, pretty much all amenities. Additionally, we have planned long-term to put central processing centers up in our busiest areas, primarily the Rio Grande Valley, the El Paso sector, and the Yuma sector. Those are modular buildings that are being completed now or will be completed and started in the spring for Yuma, but they are actually being completed right now for El Paso.

So, in other words, having those facilities and those wraparound services is something that we are planning for now, and we have a long-term solution.

Mr. CORREA. Mr. Hastings, I know you are chief of operations, but if I can pull back a little bit, when General Kelly was Secretary of Homeland Security, here in this committee, he testified—and I am going to paraphrase him—that border security goes beyond our border. I am thinking to myself, you don't wake up one morning and say, Oh, my gosh, look at all those folks at our doorstep. I have to imagine you coordinate with other agencies and Federal Government with other governments and begin to see that flow of refugees, that flow of migrants moving.

So, my thought is, how do you prepare, or are you preparing for those ensuing waves of refugees that are coming not only from south of the border, not only from Central America, but other parts of the world? I don't see this as a one instant phenomena but, rather, as the world areas of conflict continue to escalate, as you have folks in harm's way, this is going to continue to be a challenge, migration, refugees from around the world. Are you doing anything to anticipate these kinds of situations, near future, long-term?

Mr. HASTINGS. Yes. So we are embedded with multiple different governments, work closely with the Northern Triangle and have agents on the ground down there working with them now. Also work very strongly with our Mexican law enforcement partners as well on a day-to-day basis, the chiefs in the field.

Mr. CORREA. Let me ask you—

Dr. EASTMAN. Sir, may I just add something?

Mr. CORREA. Yes. Go ahead, Mr. Eastman.

Dr. EASTMAN. In addition to what the Border Patrol does, the National Biosurveillance Information Center, which is a CWMD entity, you know, with the chief medical officer, works continuously with our partners, not just Mexico, but our partners south of the border and world-wide, to identify and begin to recognize and counter, you know, health-based threats to the United States. That is part of the package.

Mr. CORREA. So a little while ago, my colleagues talked about the flu vaccinations. Essentially, your response, I believe—and you can confirm this or not—operational challenges have prevented you

from really vaccinating a lot of those individuals that need it, yes/no?

Dr. EASTMAN. No, sir, that is definitely not my response. Just to be clear—

Mr. CORREA. What is your response, sir?

Dr. EASTMAN. Our approach is comprehensive. There are migrants who have come into United States custody that have gotten vaccinations, including and up to this entire CDC catchup protocol at HHS. We have administered more than 60,000 independent vaccines, predominantly in the—

Mr. CORREA. So you are moving in that direction. This discussion we have had of independent doctors volunteering to get you up to speed to get there, that is not a factor? You couldn't use them or you are doing fine on your own?

Dr. EASTMAN. Medical volunteers is a challenge to medical organizations, not just ours. Because of the difficulties in utilizing volunteers and the difficulties with licensure and administration, we have actually encouraged them to volunteer in the local Government shelters. CBP has some—and both CBP and our office have done work to try to vector those volunteers into places that can utilize them more easily than we can.

Mr. CORREA. I am running out of time, Madam Chair, but I would like to follow up on this issue of the challenges of having licensed doctors integrated into your system of actually being able to vaccinate some of these children and deliver medical services that maybe CBP is not able to deliver because of, you know, limited capacity.

Finally, Madam Chair, if I can get 30 seconds. Dr. Eastman, you made a statement that Mexico is trying to improve, on their side of the Mexican border, some health care. Are we coordinating at all with the Mexican authorities, in terms of making sure that health care—disease does not respect a border but, rather, it addresses both sides. So are we addressing both sides of the border?

Dr. EASTMAN. Absolutely, sir. We made a visit. The chief medical officer made a visit to counterparts in Mexico City last year. We continue the dialog and we continue to work together to make the situation as good as possible.

Mr. CORREA. Finally, Madam Chair, if I can, I would like to have written testimony on that later on for review.

Dr. EASTMAN. We will take the questions for the record.

Mr. CORREA. Thank you very much. Thank you, gentlemen, for being here today.

Miss RICE. Thank you, Mr. Correa.

I now recognize the gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Madam Chair. I greatly appreciate the opportunity. I thank the witnesses for appearing as well.

To both of you, do you take the President seriously when he makes the comments?

Mr. HASTINGS. Sir, I don't know what comments you are referring to. I generally—

Mr. GREEN. He is our President. You hear his comments.

Mr. HASTINGS. When we receive—I don't know what you are referring to.

Mr. GREEN. Well, about the wall.

Mr. HASTINGS. Yes, I think the wall works, from my experience, from what I have seen it do in the field first-hand.

Mr. GREEN. So you take him seriously then?

Mr. HASTINGS. On the wall.

Mr. GREEN. On the wall.

Mr. HASTINGS. I think the wall works.

Mr. GREEN. So you think Mexico should pay for the wall?

Mr. HASTINGS. Sir, all I can tell you is the wall works.

Mr. GREEN. You take the President seriously, don't you?

Mr. HASTINGS. I can just tell you that I know the wall works.

Mr. GREEN. The President said Mexico should pay for the wall.

Mr. HASTINGS. I am not involved in funding the wall. I am just telling you that the wall works.

Mr. GREEN. Well, you take the President seriously. Let's go on. How many lives would the wall have saved?

Mr. HASTINGS. I don't know the answer to that question, sir. That would be speculative.

Mr. GREEN. Well, let me ask you this: Are asylees criminals?

Mr. HASTINGS. Are the what? I am sorry, sir.

Mr. GREEN. Are the people who seek asylum criminals?

Mr. HASTINGS. People who cross the border illegally—

Mr. GREEN. I didn't ask you about people crossing the border illegally. You know what an asylee is, do you not?

Mr. HASTINGS. We have people—

Mr. GREEN. Do you know the definition of asylee?

Mr. HASTINGS. I do.

Mr. GREEN. Then my question is, are asylees, asylees, people who are seeking asylum, asylees, are they criminals?

Mr. HASTINGS. We are asking them to go to a port of entry to receive—

Mr. GREEN. That has little to do with my question, sir. My question is, are they criminals? Why are you evading? Why will you not state what you know to be the truth? Why are you doing this?

Mr. HASTINGS. If they cross the border illegally, they have committed a crime.

Mr. GREEN. Are asylees, people seeking asylum criminals?

Mr. HASTINGS. Again, if they cross the border illegally, it is a crime.

Mr. GREEN. Where do you find this in the law to support your position that people who are seeking asylum are criminals? Are the babies criminals? This is why you treat them the way you treat them, you perceive them as criminals? Babies aren't criminals. They have no malice aforethought.

What would you recommend we do to prevent future deaths?

Mr. HASTINGS. As I have discussed, sir, we are taking a lot of those actions and have been taking those actions for quite some time. I think we are taking the right steps now to prevent further deaths. It will be difficult, as we have explained, to say we are going to prevent every death.

The people that we encounter on the border, many of whom have traveled over 2,000 miles or more, some have never seen health care. Some have never had treatment. Some may not have eaten or drink anything. But we are running into them, obviously, at many times in their worst condition and worst-case scenario, and

we are doing everything we can to get them immediate treatment and aid when that is the case.

Mr. GREEN. Again, what can we do, meaning Congress?

Mr. HASTINGS. As I mentioned earlier, I think taking some of the actions for the double standards for noncontiguous UACs, that is one; to quit drawing UACs up to our border because we are unable to return them unless it is Mexico or Canada. Then, I think, as I mentioned earlier, the *Flores* fix, being able to hold everyone together, the entire family in the proper setting while they go through their expeditious hearing.

Mr. GREEN. For edification purposes, UAC I find to be a pejorative.

Mr. HASTINGS. It is in the law in TVPRA.

Mr. GREEN. I understand, but I still find it to be a pejorative. These are children. UACs.

Madam Chair, I am going to yield back the balance of my time. Thank you.

The Chairman. Thank you.

I now recognize the gentlewoman from Illinois, Ms. Underwood.

Ms. UNDERWOOD. Thank you, Madam Chair, for holding this hearing to continue this committee's important oversight work on the humanitarian situation at our Southern Border.

During my 3 oversight trips to the border last year, I saw and heard first-hand about the need for resources to improve medical record keeping. As a nurse, I know how important clear record keeping is when it comes to both patient outcomes and ensuring health care providers can most effectively do their jobs.

In response to what I saw at the border, I am so proud that we based bipartisan legislation last year to provide CBP with an electronic health record. Just a few days ago, President Trump signed an appropriations package that includes \$30 million in dedicated funding for that electronic health record.

Dr. Eastman, as a physician, can you tell us more about why EHRs are so important to your work at the border?

Dr. EASTMAN. Yes, ma'am. Thank you very much. Again, thank you for passing the funding we need. EHRs serve a very specific function. They not only allow us to effectively document the care that is provided, but they also allow us easy access to the data to do things like quality assurance. It ensures that we are able to measure the care that we are providing. It ensures that we are able to assess the quality of that care, and it ensures we are able to learn lessons from that.

In addition, another system that we intend to develop will improve our ability to conduct disease and health disease surveillance, using artificial intelligence techniques that will trigger the presence potentially of an infectious disease before a human being could pick it up.

Ms. UNDERWOOD. Again, from your perspective as a medical provider, how do EHRs help providers better communicate about patient care?

Dr. EASTMAN. Yes, ma'am. So electronic health records, you know, they are a complicated topic, but they allow us to describe the care that we have provided from the point of apprehension to the point of release from our custody, not only internally, they don't

only help us communicate internally across multiple settings, but they also allow us to communicate to external partners.

One of the things that I think is important in this hearing to mention is that the system that is provided not only protects migrants, the system that has been put together. It also protects the integrity of the health care systems in local communities, that were we not absorbing some of the blow, some of those local community health care systems would be overrun by the amount of care that is required.

Ms. UNDERWOOD. ICE and ORR already have electronic health records, and we know that DHS has already begun the process of building one for CBP. Along with the dedicated funding, Congress directed DHS to come up with an implementation plan for this EHR within 90 days.

So, Dr. Eastman, can you give us an update on where DHS is in this process, and what specific actions have been taken so far?

Dr. EASTMAN. Yes, ma'am, I can. Right now we are in the process, sort-of the first phase of this, which is to identify some immediate solutions that can integrate the existing technology that is out there. That work is on-going immediately. We are also working to plan for the long term.

We have hired a chief medical and informatics officer who we think has the talent and the expertise to help us build a system that will not only create an effective customized solution for us, but will harness our ability to help our operators do their job more effectively. Everything we do has to take into account the effects that it has on the individual operator who is doing the job at the border, at processing centers, and in ports of entry along the border.

Ms. UNDERWOOD. So then what is next? What are the next phases in the implementation of this EHR?

Dr. EASTMAN. The next phase is we work our fingers to the bone to try to get this plan together to come back to brief you in 90 days as to where we are headed.

Ms. UNDERWOOD. Excellent. So you mentioned you hired this informatics officer.

Dr. EASTMAN. Yes, ma'am.

Ms. UNDERWOOD. What date were they hired?

Dr. EASTMAN. I will have to take the specifics as a question, but he has been around 5 or 6 months.

Ms. UNDERWOOD. OK. In your medical opinion, why is it so important to ensure CBP's EHR is interoperable with those used by ORR and other DHS components?

Dr. EASTMAN. Thank you, ma'am. Again, we want to make sure that we are able to provide a seamless picture of all the care that is provided from the point of apprehension to the point of discharge. It is important for a provider at ICE to know what happened upstream of that when the person is—for the care that is provided under Border Patrol.

Now, that being said, we are working hand-in-hand with the Border Patrol to make sure that the solutions that we craft together not only accomplish the goals of the EHR, but also are user-friendly and don't add to the load, the processing load, the time that the operators have to put forth to take care of the migrants in our custody.

Ms. UNDERWOOD. Well, I appreciate those operational benefits, but the other benefit of an electronic health record is obviously saving lives. We are not missing information. We are not losing patients, and we are not missing opportunities to identify infectious diseases or changes in current status.

We are heading into another flu season that is projected to be severe. Dr. Eastman, you noted in your testimony that you are working with CDC, ASPR, and other public health agencies to improve CBP's response. So what specific steps has DHS taken to strengthen its ability to respond to flu outbreaks at the border during this current flu season, which we know has been particularly harmful and deadly for children throughout the United States?

Dr. EASTMAN. No question, this flu season, according to the CDC and other experts, appears that it may be rough. We have worked hand-in-hand with CBP to help craft enhanced flu control measures that were crafted with input from experts from the CDC when they performed a 3-phase assessment along the border, or very early on in the crisis.

In addition, we have helped provide CBP with the ability to rapidly diagnose and treat the flu in our facilities at CBP. Again, that capability is present now in over 40 facilities along the Southwest Border, and I would challenge folks to find another law enforcement agency that diagnoses and treats the flu on the law enforcement side, not the custodial side.

Ms. UNDERWOOD. Madam Chair, if I may, just one last follow-up. What date? Was it new for this flu season that that rapid capability has been deployed, because it is not our committee's understanding that that capability was present last year. So can you—

Dr. EASTMAN. That has been developing all along through the course of 2019. So as the contract support has been developing, that flu capability has been put into place, you know, continuously over the year.

Ms. UNDERWOOD. Thank you so much, Madam Chair, and to our witnesses for appearing today.

I yield back.

Miss RICE. Thank you. I ask unanimous consent that Representative Jackson Lee be permitted to sit and question the witnesses. Without objection.

I now recognize the gentlelady from Texas, Ms. Jackson Lee, for 5 minutes.

Ms. JACKSON LEE. Madam Chair and Ranking Member, thank you very much for this important hearing, and let me thank the witnesses for being present today. I think it is very important.

Mr. Hastings, let me just be clear that you handle law enforcement operations covering both U.S. Border Patrol and Customs and Border Protection. Is that—

Mr. HASTINGS. No, ma'am, just Border Patrol.

Ms. JACKSON LEE. All right. So this is a light typo. It has you in both positions and you are not. I just wanted to clarify that for the record.

Mr. HASTINGS. Just Border Patrol, ma'am.

Ms. JACKSON LEE. All right. Let me just for the record take note of the fact that a number of children had died in 2018, that, in fact, no child had died in CBP custody for the entire decade before 2018.

We lost, in particular, Jakelin, Felipe, and a number of children that proceeded to get medical care and who were detained and placed in CBP, and, ultimately, 4 migrant children passed away while in or shortly after being released from Federal custody.

Both of you, whether you have children or not, or are around children or around relatives, acknowledge that the death of any child is a crisis and tragic. Mr. Hastings?

Mr. HASTINGS. Ma'am, as I have said earlier, I am a father and a grandfather, and it is a tragedy.

Ms. JACKSON LEE. Dr. Eastman.

Dr. EASTMAN. Ma'am, I am a parent, and the death of any child is devastating. But I think it is important to not only note that it is not just devastating to the parents, but I was in our facility in Lordsburg and I went and sought our personnel who tried valiantly to save Jakelin, and, despite their best efforts, they weren't successful, that is brutal on the caregivers as well.

Ms. JACKSON LEE. Well, you go right to my point, that dying in the custody of individuals who are basically law enforcement, but seeing when they are basically committed to defend and protect alongside of the immigration responsibilities, their chief responsibilities, that that is both a crisis and tragic for them to have died in Federal custody or having just been released. Is that your opinion?

Dr. EASTMAN. Ma'am, the death of any child, any person in law enforcement custody is tragic. As you know, you know, law enforcement officers across this country take very seriously their responsibility that when we place our handcuffs on someone, we know we have an ethical, moral, and legal duty to care for them as well.

Ms. JACKSON LEE. A child is particularly vulnerable. I assume, Mr. Hastings, you agree with that as well, that any death in Federal custody of a child is tragic and on the brink of a crisis?

Mr. HASTINGS. It is tragic, and yes.

Ms. JACKSON LEE. The idea of those line officers I call, and I have been and seen the efforts that they have made during some very difficult times, buying diapers, getting formula. I think that should be put on the record.

But I think the key point—and I appreciate some of the many great steps that Congresswoman Underwood has made. We traveled together to the border, and several times thereafter. But my question would be, is it time now, as you present reports pursuant to the legislation passed, to stand up a very effective parallel medical system, based on the present policies of this administration, meaning that asylum is being denied. They are not being able to access asylum in the way that they should. There are migrant camps just on the border in Mexico where disease is rampant, or to be rampant, and so that means that when they come over, they may be sick.

Do we have an effective medical system that is parallel to your law enforcement system that can do additional things besides, you know, the records that are being done and some of the other aspects of reporting, an effective almost semi-quasi-health center for these individuals that are coming in?

Dr. EASTMAN. You want me to start?

Ma'am, I think we have to be very cautious that we confabulate a health care facility with a law enforcement facility. We firmly believe at DHS, and it is my personal belief as a physician that health care is best provided in a health care setting.

So what we ought to continue to do is to facilitate the movement of people through our system to the best place to care for them. For children, that is at HHS. For single adults, that is in ICE custody. But we have to continue to harden the system for the times that we face unprecedented demand for care, and I believe that is exactly what we are doing right now.

Ms. JACKSON LEE. Mr. Hastings—Madam Chair, can I just have a quick follow-up?

Mr. Hastings, your point on this parallel health system?

Mr. HASTINGS. No, I would agree completely. We want, the Border Patrol and CBP wants to see UACs, vulnerable populations out of our custody as quickly as possible, that is what we want to see, through the proper places where they can receive the needed care.

Ms. JACKSON LEE. Well, let me ask this quick question, because it might have been misinterpreted that I wanted a hospital established, and that is not the case.

First of all, the children were not out of your custody as soon as possible. We have some challenges now with a system that I helped set up, which is the HHS system, so we will put that aside.

My point is, is that there be some process that is more substantial than the law enforcement that can do immediate care besides putting someone in a police car and trying to rush them to the next or the nearest hospital.

The question is, do we have an effective emergency response on-site that can deal with some of these crises, such as one of the young men, a 16-year-old was found nonresponsive, and there was not much to deal with his nonresponsiveness. So quickly to Mr. Hastings and Dr. Eastman.

Mr. HASTINGS. To answer your question, we are certainly going in the right direction. As I alluded to earlier, we went from 3 sectors covered by a medical personnel contract, medical support personnel, to now 9. They are in our busiest locations where we need them. We are constantly monitoring to make sure we have them where we need them, and will continue to do so. On top of that, we have got 1,500 EMTs that can provide support and do provide support. I believe that we are taking all the right steps that we need to.

Ms. JACKSON LEE. Dr. Eastman.

Dr. EASTMAN. Likewise, ma'am. Our strategy is to provide the right care to the right person at the right time. I believe we are taking the right steps currently to do that. We, you know, reserve—and certainly I reserve the right to reassess this system continuously as conditions change. But it is our belief at DHS and it is my belief personally that we are moving in the right direction.

Ms. JACKSON LEE. I look forward to that report coming in so I can understand how the system is working.

Dr. EASTMAN. Yes, ma'am.

Ms. JACKSON LEE. I thank the Chair for her indulgence, and I yield back.

Miss RICE. Thank you.

The Chair now recognizes the gentlelady from Texas, Ms. Garcia.
 Ms. GARCIA. Thank you, Madam Chair, and thank you for your vote waiving me in to sit on this committee. Thank you to the witnesses.

I have been following this issue for a great number of years, beginning with the first influx when I was the chair of the Senate Hispanic Caucus in Texas. I visited probably about 10 facilities, either under the jurisdiction of CBP or ORR. I have seen the differences in a lot of the medical protocols, a lot of the medical care that is provided in all those different facilities.

I must say that I have never found them to be adequate. I have never certainly found them to be a clinic or a hospital. To just borrow the words of my colleague to the right, Congresswoman Lee, no one is asking for a hospital.

Dr. Eastman, I know you have made reference to you can't put a clinic in every single, I think you used the word substation or police department facility. I don't think we are asking for that either. But I think what we do want is what many of us have been talking about is the right protocols, the right screening, to make sure we get on it as quickly as possible.

I was completely stunned at the lack of any kind of screening that was done in the New Mexico facility. I know my colleague Torres Small talked about the one in her district. That is the one I visited when Jakelin died. I mean, they literally took a microwave off a table to let her lay there, because there was nowhere else to put her. This was where they were waiting until they could get the transportation and the bus to go on to the facility where perhaps she could get more treatment. Then, of course, she ended up going to the hospital.

Are you telling me that under today's protocols that has now changed? I know you said you visited Lordsburg also.

Dr. EASTMAN. Congresswoman, I am telling you that we do the absolute best we can under the circumstances we are provided. In my opening statement, I told this committee and America that when we were faced with unprecedented demand for care to large groups—

Ms. GARCIA. But, sir, the question is, has that changed in that facility now? They won't have to remove the microwave to just put her on that table?

Dr. EASTMAN. Ma'am, the system—

Ms. GARCIA. I mean, they will have a screening method so that they can detect it sooner to get her on some bus or somewhere that is—

Mr. HASTINGS. Ma'am, if I can take that one. So a lot of our areas have changed. The soft-sided facilities that we have placed, put in place in many of those areas, including El Paso. El Paso has a soft-side, soon to have a modular facility as well, that will give some increased capability and some increased space that we need. But still, many of our stations in many of our different locations, they haven't changed. They were built for a completely different demographic. They have not changed. We have added as much as we can in those locations in the way of food, health care products, those types of things, but, I mean, they were not built to house for long periods of time at all.

Ms. GARCIA. Well, I appreciate your answering, but I still would like Dr. Eastman to.

Dr. EASTMAN. Just to be clear, just to be clear, the system that is in place today, by virtue of the growth and the hard work of a lot of people across the Government and CBP bears little resemblance to what it looked like at Christmastime 2018.

Ms. GARCIA. But I am asking specifically about some of these remote stations, because many people are using that since a lot of the port of entries that they were used to using. They, frankly, aren't even allowed to get even close enough to make entry. They are using other more remote areas.

So the question is, has that one now been improved? If someone presented themselves with high fever, you know, chills, the typical flu symptoms—

Dr. EASTMAN. So I will give you two tangible examples.

Ms. GARCIA [continuing]. Would that person be put on the same microwave table?

Dr. EASTMAN. I will give 2 tangible answers to answer your question. First of all, the expansion of contracted health care allows the Border Patrol to use their 1,500 EMTs in the role they were designed, which was not to be screening personnel inside facilities, but to be outside in the field caring for our personnel and anyone else they encountered.

The second thing—

Ms. GARCIA. So that is a no?

Dr. EASTMAN. Ma'am, the second thing is that there is now contracted support in multiple locations along the border, and we will take for the record to get you back the exact details of where that contracted support exists today.

Ms. GARCIA. So along the entire border of Texas now, there is some screening protocols to ensure that this would never happen again?

Dr. EASTMAN. Yes, ma'am. The tiered approach that I described earlier in this hearing is in place all along the Southwest Border.

Ms. GARCIA. All right. What about the medical assessment, or screening, are there any in place for the folks that are coming through in the Migration Protection Protocols, the Remain in Mexico program? Are they screened at all? Because I am hearing that there is a lot of people on the other side of the border that have been turned away under this new program that are very, very sick.

Dr. EASTMAN. The care that occurs south of the United States' Southern Border is outside my scope, and I am not sure what is being done on the Mexican side of the border.

Mr. HASTINGS. But, ma'am, so I would add they will go through medical clearance prior to us putting them into MPP and returning them. So they will go through this same process prior to being returned under MPP.

Additionally, there is a map up there that kind-of outlines where we are today as far as those 40 different locations that we have contract medical service. I realize we are looking at a bunch of dots on a map, but the fact is over 300 individuals on duty at any given time providing that additional medical support through our agents in the field. That map, we can't see—

Ms. GARCIA. So you are telling me that although they are being turned away to go back to Mexico, that you do screen them?

Dr. EASTMAN. Can I just take that one, sir?

Mr. HASTINGS. Go ahead.

Dr. EASTMAN. The approach to the health interview and medical assessment applies to everyone that is in our custody, with the parameters we described earlier.

Ms. GARCIA. Well, these folks are not in custody, sir. You are turning them away.

Dr. EASTMAN. Ma'am, if they are in our custody, they get the assessments and the care that was described. As I said, it is outside my scope to know what happens to them south of the border.

Ms. GARCIA. Madam Chair, obviously, apparently the witness is not understanding the question. I am talking about the folks that are being turned away under the Remain in Mexico program.

Miss RICE. You are going to have an opportunity to ask that again.

Ms. GARCIA. Thank you.

Miss RICE. Mr. Ranking Member, do you have any additional questions?

Mr. HIGGINS. Yes, Madam Chair.

Madam Chair, before I ask my second round of questions, I ask unanimous consent to submit the Homeland Security Advisory Council final report by the CBP Families and Children Care Panel, which was published in November 2019. I ask unanimous consent to submit it for the record.

Miss RICE. So received.*

Mr. HIGGINS. Mr. Hastings, would you like to clarify the medical screening that all human beings that cross the border and come in our custody, regardless of what program they are then subject to, would you clarify for my colleague, Ms. Garcia, and for the rest of the committee?

Mr. HASTINGS. Thank you for the opportunity, sir. So that is correct. Ma'am, anyone that comes into our facility, regardless of what program or initiative that they are going into, will go through all of that medical assessment, medical screening, and interview.

Mr. HIGGINS. So are you clarifying that minors, including children, all individuals that are returned to Mexico under the program prior to being returned receive medical screening?

Mr. HASTINGS. Prior to return, we still have to process them. So during processing, we go through that.

Mr. HIGGINS. What if they are sick? Let me extend my colleague's line of questioning here. What if they are sick?

Mr. HASTINGS. Then they will go to the hospital or the appropriate medical care.

Mr. HIGGINS. If the screening determines that they are sick, to the extent that they need professional medical attention, we are getting them that medical attention before we send them back to Mexico?

Mr. HASTINGS. Yes, as evident by the 26,000 we took to the hospital last—

*The information has been retained in committee files and is available at https://www.dhs.gov/sites/default/files/publications/jccp_final_report_1.pdf.

Mr. HIGGINS. That is our policy across the border or only at one location?

Mr. HASTINGS. That is across the border, sir.

Mr. HIGGINS. Thank you, sir, for clarifying that.

Dr. Eastman, in your testimony you mentioned the close working relationship between CBP and the Office of DHS Chief Medical Officer. Can you go into a little more detail, sir, about the specialized nature of your team's assistance to Customs and Border Protection? Also, based upon your observations, how committed has CBP leadership been to expeditiously address in-custody medical capabilities?

Dr. EASTMAN. Sir, with regards to your first question—and thank you—the relationship literally is hand-in-hand. Our office and the Border Patrol and CBP communicate constantly. In fact, the CBP senior medical adviser is an employee from our office that is embedded into CBP to help facilitate these issues. The relationship is hand-in-hand, and we communicate literally at multiple levels probably, it is safe to say, daily.

With regards to your second question, my direction has been clear and our direction has been clear from every leader in the Department, whether that is at DHS or CBP, that the direction I was given and we—

Mr. HIGGINS. What about the direction that you have received from up chain, all the way to the top?

Dr. EASTMAN. Yes, sir. The direction I have received has been clear and has been unanimous: Do the right thing.

Mr. HIGGINS. Do you feel like the Executive branch and our President is committed by their leadership to expeditiously address in-custody medical capabilities?

Dr. EASTMAN. Sir, I have not spoken to him directly, but my directions come from the Secretaries and the commissioners of CBP that I have worked with, and it has been clear, loud, and unanimous: Do the right thing, break down barriers, and take good care of the people in our custody.

Mr. HIGGINS. That message has been pushed throughout the chain of command?

Dr. EASTMAN. Yes, sir. It has been unanimous and loud and clear from everyone I have worked with.

Mr. HIGGINS. Thank you for your clarification.

Madam Chair, thank you for the second round of questioning, and I yield.

Miss RICE. Thank you, Mr. Ranking Member.

I now recognize the gentlewoman from Illinois, Ms. Underwood.

Ms. UNDERWOOD. Thank you, Madam Chair.

I have a couple follow-up questions, based on what we have heard today and what was submitted in the written testimony. In Mr. Hastings' written testimony on page 6, I am just going to read a couple statements. It says: "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 arrival at a CBP facility."

Mr. Hastings, can you further delineate whether those CBP facilities include all Border Patrol stations?

Mr. HASTINGS. It does include all Border Patrol stations, yes, ma'am.

Ms. UNDERWOOD. OK. So then just to circle back on what was just recently discussed by Ms. Garcia and Mr. Higgins, then if it includes the Border Patrol stations for individuals that are brought into apprehension, with the idea that they will be put into this Migrant—the MPP policy, then you consider that under U.S. custody, correct? Because they are being—

Mr. HASTINGS. That is correct, ma'am.

Ms. UNDERWOOD. So those individuals all get a health interview?

Mr. HASTINGS. That is correct.

Ms. UNDERWOOD. OK. If those individuals are seen as having some kind of medical flag, to use a casual term, then they will get a medical assessment?

Mr. HASTINGS. That is correct, yes, ma'am.

Ms. UNDERWOOD. Dr. Eastman, can you confirm that that is happening in all facilities?

Dr. EASTMAN. Absolutely, ma'am. In the locations where we don't have contracted medical support, yes—

Ms. UNDERWOOD. Correct.

Dr. EASTMAN [continuing]. As that continues to develop, we utilize local resources to get that assessment. So if the interview occurs and if folks need health care, and we don't have it there, they will get it in a local system.

Ms. UNDERWOOD. OK. So just to reiterate, the individuals that are coming to the United States that under current policy under DHS, you-all want to send them back to remain in Mexico or go through the MPP, and they present with a health care issue, you are saying that they are getting both an interview and a screening, and if at that local facility, they don't have the medical staff on-site to do the screening, you-all are sending them externally to get that medical assessment completed?

Dr. EASTMAN. If they have a medical need, we will certainly utilize the local health care system, yes, ma'am.

Ms. UNDERWOOD. OK. OK. My follow-up question then is, on page 4 of Mr. Hastings' testimony, he says that 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, and that support is now available at all 9 Southwest Border USBP sectors, so U.S. Border Patrol sectors, and all 4 Southwest Border OFO field offices.

So, based on that, would you then consider there to be 100 percent coverage?

Mr. HASTINGS. No, ma'am, I would not. So, as I mentioned earlier, we believe we have about 10 more locations that we need to cover that we are working rapidly to get coverage now. How we determined where this went was where the highest flow of vulnerable populations was.

Ms. UNDERWOOD. I understand.

Mr. HASTINGS. Where we had the least medical support in our nearest areas, and the highest flow rate that we were seeing. We have about 10 more locations that we are looking to expand to now still.

Ms. UNDERWOOD. Do you have the current funding to support that expansion?

Mr. HASTINGS. We do have the current funding to support that, yes, ma'am.

Ms. UNDERWOOD. OK. So then the numbers that are submitted in your testimony are current as of what date? So these individuals and locations were staffed as of what date?

Mr. HASTINGS. December, end of December 2019.

Ms. UNDERWOOD. OK. Thank you, Madam Chair, I yield back.

Miss RICE. Thank you. Where are the 10 additional locations?

Mr. HASTINGS. I would have to look at the chart, ma'am. I can get back to you. I don't have the chart in front of me.

Miss RICE. OK, thank you. I now recognize the gentle woman from Texas, Ms. Garcia.

Ms. GARCIA. Thank you, Madam Chair. Just a quick follow-up. Mr. Hastings, what is the average stay these days for a child in custody?

Mr. HASTINGS. So that varies, ma'am, from day to day, hour to hour, but on average, the average time in our custody right now is approximately 39 hours, the last time I looked.

Ms. GARCIA. Thirty-nine hours?

Mr. HASTINGS. The last time I looked, yes, ma'am. Juveniles are leaving our custody quickly since HHS is funded.

Ms. GARCIA. OK. Do you remember what month that was? I mean, that is obviously not the numbers I am seeing. So—

Mr. HASTINGS. It has been a while since I have looked at the TIC time, it is one of—the time in custody time, that is one of the many variables that we look at, but the point being is—

Ms. GARCIA. It is shy of 2 days.

Mr. HASTINGS. Pardon me?

Ms. GARCIA. It is shy of 2 days.

Mr. HASTINGS. We are doing very well with individuals getting—

Ms. GARCIA. Right. Well, let me ask you this. I don't know the age of your grandchildren, but would you be comfortable with having your grandchild in custody in one of your own facilities for 39 hours?

Mr. HASTINGS. I wouldn't want—I don't want any child in my facilities for that long, ma'am. For—

Ms. GARCIA. But would you be comfortable—

Mr. HASTINGS. I am sorry. In the crisis. For right now, for 39 hours, I trust that our employees are taking good care of the detainees that they are charged with oversight.

Ms. GARCIA. So you would be comfortable if your grandchild was there?

Mr. HASTINGS. I think we are providing—we are doing very well providing proper services for all those in our custody right now. During the crisis, no, I wouldn't. I don't want them in our—

I wouldn't want my granddaughter in custody anywhere, but I think we are doing the best we can with everything we have out there on the border right now, with all the improvements that we have made and how quickly we are getting these unaccompanied alien children out of our custody.

Ms. GARCIA. Right. What about you, Dr. Eastman? I know you mentioned—I don't know if you have children or grandchildren or little nieces and nephews like I do, but would you feel comfortable with a member of your family being in custody in your facility?

Dr. EASTMAN. With no offense to Chief Hastings, ma'am, I am a little young for grandchildren, but I will tell you—

Ms. GARCIA. I never make assumptions, I have learned in this business.

Dr. EASTMAN. Right, I understand. I understand, ma'am. I want to be clear with Chief Hastings, that it would be my preference that we don't ever hold children in our custody. However—however—

Ms. GARCIA. Well, that certainly is my preference in that a child has not committed any crimes, as my colleague from Texas—

Dr. EASTMAN. Well, again, however—well, let me be clear from my perspective as a physician, that we provide our care irrespective of circumstances. It does not matter to us what they have or have not done. Our care is provided to every human being in our custody the same, no matter what the circumstances are.

Ms. GARCIA. Right.

Dr. EASTMAN. To answer your question, ma'am, I would be very comfortable with my children receiving care in this system if it were necessary, and I know that we are going to continue to do everything we can to improve it every day.

Ms. GARCIA. Right. Let me follow up on my colleague Mr. Correa's questions. Like him, I also serve on the subcommittee of Judiciary Committee on immigration. He was asking about volunteer doctors. I know that—I am from Houston. We have a large medical center, which means we have a lot of doctors around. Many of them do a lot of good volunteer work in a number of areas and been able to do missions abroad.

They have mentioned to me that, you know, they have tried to help and tried to volunteer, tried to even bring especially the flu vaccine to some facilities. I mean, what is the real beef if they are Texas facilities or Texas doctors and they are willing to help, why wouldn't you allow them to help?

Dr. EASTMAN. So, just to be clear, ma'am, I am a Texas doctor, as well.

Ms. GARCIA. I know that, I saw your resume.

Dr. EASTMAN. But the provision of volunteer medical support presents challenges not just to the Department of Homeland Security but to medical organizations in this country, in every State.

So while we sometimes have difficulty with the licensure and administrative requirements, we certainly—and we have done this—we have tried to vector volunteers who want to provide that help, to some of the other locations that aren't as fortunate to have medical support like we are, like the NGO shelters along the Southwest Border. So when we have had Texas volunteers, we have tried to vector them into the Texas NGO's that need help.

Oftentimes, while that is not my role as the DHS senior medical officer, we have been thrust into that, because in many ways, we are the intermediary between those medical volunteers. For example, you are from Houston. I talk to Dr. Maddox almost daily, and we talk routinely about things like this.

We talk to—and one of the things I think that is really important is that during the course of this crisis, we have worked with State and local health departments and doctors all across the Southwest Border, and it has been a hand-to-hand, direct, face-to-face meetings and working together to solve problems as they arise.

We have tried to be the best partner possible to the State and local health departments along the Southwest Border, and I think some of you saw evidence of that when you came and visited the border and saw some of those interactions. We will continue to do that, you have got my word. We are going to continue to try to be the best partner as possible.

Ms. GARCIA. What impediments or challenges are there, and would there be anything that we can do in terms of legislation, to be able to provide, you know, better access to volunteer doctors?

Dr. EASTMAN. Yes. My suggestion, ma'am, is that we take this off-line and we work together because the provision of volunteer services in disasters in this—volunteer medical services in disasters in this country is something that we are interested in. It is a tiny bit outside of scope of this hearing, but I would love to work together with you to try to help solve this problem on an actual basis.

Ms. GARCIA. Well, I think it is in the scope not only for this hearing that is focused on CBP, but also we have the same challenge and even volunteers who want to help children that are in our facilities, even something as simple as taking them to the movies.

I mean, some of these facilities won't even allow people to come visit the children in any way to try to assist in terms of, particularly their mental health, well-being. So, sure, we will take it off-line, and Dr. Maddox is a good friend, so we will wake it a three-way call.

Dr. EASTMAN. He would love that, ma'am.

Ms. GARCIA. Thank you. Thank you. I yield back.

Miss RICE. Thank you.

Let me just say that I—and I think I can speak for my good friend, Mr. Higgins, the Ranking Member, but I want to thank Mr. Hastings and Dr. Eastman for coming today.

There are people in positions above you who don't show up, who don't answer the call, which is their duty. So the fact that you two showed up and took some difficult questions, you know, I am grateful. I am very grateful because you could have done what they did. We are well within our Constitutional obligation of having a role in oversight.

I want to thank the Ranking Member on this subcommittee because we have been trying to address this issue. Before anyone is a Republican, a Democrat, black, white, male, woman, we are all human beings and we are all Americans. I know that I think I can speak for everyone in this room and certainly on this committee that even one death in custody is a tragedy.

Dr. Eastman, I remember meeting you before you even got the position, because it was one of the issues we tried to address is how quickly we can bring qualified people like you in to help solve this problem. I want to thank you. I know that you have had contact with my colleague, Ms. Underwood, who has a medical background,

and it is relationships like this that are going to help us all address these tragedies and ensure that they don't happen again.

These are children who are being brought here for a better life, which is all any of us want for our children.

Dr. EASTMAN. Thank you, madam.

Miss RICE. I thank the witnesses for their valuable testimony and the Members for their questions.

The Members of the subcommittee may have additional questions for the witnesses, and we ask that you—some of which we spoke about during the questioning, and we ask that you respond as expeditiously as possible in writing to those questions.

Without objection, the subcommittee record shall be kept open for 10 days.

Hearing no further business, the subcommittee stands adjourned. [Whereupon, at 12:12 p.m., the subcommittee was adjourned.]

APPENDIX

QUESTIONS FROM CHAIRWOMAN KATHLEEN M. RICE FOR BRIAN HASTINGS

Question 1a. On December 30, 2019, CBP issued an Enhanced Medical Support Directive, to among other things, mitigate risk to and sustain enhanced medical efforts for migrants in custody along the Southern Border.

Has CBP developed training for CBP personnel to identify children in distress during initial encounter as required by the Directive? If so, please provide documentation of this training and the number of CBP personnel by sector and field of office that have completed this training as of January 14, 2020.

Answer. Response was not received at the time of publication.

Question 1b. The Directive states that Border Patrol and OFO will ensure a medical assessment is conducted on certain categories of detained migrants, subject to availability of resources and operational requirements. What is the threshold level of resources needed to ensure that medical assessments are provided to the migrant categories identified in the Directive?

Answer. Response was not received at the time of publication.

Question 1c. What oversight mechanisms does CBP have in place to ensure the directive is followed as required and on a consistent basis?

Answer. Response was not received at the time of publication.

Question 2. In your oral testimony, you noted that \$1.1 billion of the *Emergency Supplemental Appropriations for Humanitarian Assistance and Security at the Southern Border Act of 2019* was allocated for humanitarian support, border operations, and mission support. As of January 14, 2020, how much of this funding has been allocated and how much of these funds remain unspent and available for use by CBP?

Answer. Response was not received at the time of publication.

Question 3. You stated in your written testimony that many of the improvements made to address the migrant crisis rely on the existence of emergency supplemental funds. What funding level is required for CBP to implement the Directive's requirement that every migrant under the age of 18 will receive a health interview? What funding level is required to ensure that resources are available to ensure that a medical assessment is conducted on all children under the age of 12 held in CBP custody and the other categories of migrants noted in the Directive?

Answer. Response was not received at the time of publication.

Question 4a. In your testimony, you noted that CBP currently has medical support professionals engaged at facilities along the Southern Border.

What is the staffing breakdown of CBP's medical contract, including the number of contracted professionals, their job titles, and job descriptions?

Answer. Response was not received at the time of publication.

Question 4b. In what locations on the Southern Border are medical support professionals deployed to and what is CBP's rationale for staffing the number of medical professionals at these locations?

Answer. Response was not received at the time of publication.

Question 4c. What funding levels are required to ensure implementation of this contract along the Southern Border?

Answer. Response was not received at the time of publication.

Question 4d. How many trained emergency medical technicians and Border Patrol agents certified as emergency medical technicians operate on the Southern Border?

Answer. Response was not received at the time of publication.

QUESTIONS FROM CHAIRMAN BENNIE G. THOMPSON FOR BRIAN HASTINGS

Question 1. In your written testimony, you noted that the Enhanced Medical Directive ensures that CBP will provide a health interview for all migrants less than 18 years old. What questions will be asked to migrants during this interview and

will CBP personnel be permitted to ask additional questions if the circumstances of a migrants' health warrant?

Answer. Response was not received at the time of publication.

Question 2. The Directive states that CBP Form 2500 will be used to conduct health interviews. Please provide the committee with a copy of this form. Does CBP plan to periodically review and amend this form if circumstances warrant changes to it?

Answer. Response was not received at the time of publication.

Question 3. The Directive states that it applies to both CBP steady-state and surge operations. This Directive also appear to apply to crisis operations when additional interagency resources and support will be required. What is CBP's criteria for determining "major surge/crisis-level operations" and what additional agency resources will CBP seek to ensure requirements within the Directive are met?

Answer. Response was not received at the time of publication.

Question 4. In your testimony, you stated that CBP would notify Congress if they decide not to follow the Directive based upon operational requirements. What exact criteria will CBP assess to determine whether resources are, or are not, available to abide by the Directive? Who within CBP will make the decision that the Directive must or must not be followed based upon the previous assessment?

Answer. Response was not received at the time of publication.

Question 5. Please provide the committee with the written guidelines for notifying Congress when CBP determines that the Directive will or will not be followed.

Answer. Response was not received at the time of publication.

QUESTIONS FROM HONORABLE SYLVIA GARCIA FOR BRIAN HASTINGS

Question 1. What is CBP's policy for providing medical treatment to migrants that CBP agents identify as sick that are subjected to the Migrant Protection Protocols?

Answer. Response was not received at the time of publication.

Question 2. What are CBP's written protocols in place to protect CBP personnel and migrants from the spread of infectious diseases, such as the flu, inside processing centers, Border Patrol stations and ports of entry? Please provide these documented protocols.

Answer. Response was not received at the time of publication.

QUESTIONS FROM CHAIRWOMAN KATHLEEN M. RICE FOR ALEXANDER L. EASTMAN

Question 1. What is DHS policy for providing medical treatment to migrants that are subjected to the Migrant Protection Protocols? What kind of engagement is done with the Government of Mexico?

Answer. Response was not received at the time of publication.

Question 2. What are DHS protocols to protect DHS personnel and migrants from the exposure of illnesses, such as the flu, inside processing centers, Border Patrol stations and ports of entry? Please provide these documented protocols.

Answer. Response was not received at the time of publication.

QUESTIONS FROM HONORABLE LAUREN UNDERWOOD FOR ALEXANDER L. EASTMAN

Question 1. What is the status of implementing an electronic health record (EHR) system for migrants on the Southern Border?

Answer. Response was not received at the time of publication.

Question 2. What is the estimated time to complete this EHR system?

Answer. Response was not received at the time of publication.

Question 3. What entities, including Federal, State, local, and private stakeholders have DHS engaged with on implementing this EHR system?

Answer. Response was not received at the time of publication.