CHILDREN IN CBP CUSTODY: EXAMINING DEATHS, MEDICAL CARE PROCEDURES, AND IMPROPER SPENDING

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

SECOND SESSION

JULY 15, 2020

Serial No. 116–77

Printed for the use of the Committee on Homeland Security

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

43–865 PDF WASHINGTON : 2021

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CHILDREN IN CBP CUSTODY: EXAMINING DEATHS, MEDICAL CARE PROCEDURES, AND IMPROPER SPENDING

Wednesday, July 15, 2020

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON HOMELAND SECURITY,
Washington, DC.

The committee met, pursuant to notice, at 12:05 p.m., via Webex, Hon. Bennie G. Thompson (Chairman of the committee) presiding.

Present: Representatives Thompson, Jackson Lee, Richmond, Payne, Rice, Correa, Torres Small, Rose, Underwood, Slotkin, Cleaver, Green of Texas, Titus, Barragán, Rogers, Katko, Higgins, Lesko, Green of Tennessee, Joyce, Crenshaw, Guest, and Bishop.

Chairman THOMPSON. The Committee on Homeland Security will come to order. The committee is meeting today to receive testimony on "Children in CBP Custody: Examining Deaths, Medical Care Procedures, and Improper Spending." Without objection, the Chair is authorized to declare the committee in recess at any point.

The committee is convening today to examine 3 critical related and deeply troubling issues: The terrible death of young children in the custody of Customs and Border Protection; CBP's failure to consistently implement the revised medical screening procedures it adopted after children died in its custody; and CBP's improper expenditure of the emergency funds appropriated by Congress for the care of migrants.

In December 2018, 2 children died in CBP custody. A 7-year-old girl named Jakelin, and an 8-year-old boy named Felipe. Last year, another 3 children died in CBP custody, or shortly after being released. On January 4, 2019, I sent a letter to the Department of Homeland Security requesting documents related to the deaths in 2018, after the Department failed to produce all documents responsive to the committee's request. In November 2019, the committee issued a narrowly tailored subpoena by voice vote for many of the documents originally requested in my letter 10 months prior.

In December 2019, the DHS inspector general's office publicly issued 2 1-page summaries into the investigations into the death that had occurred a year earlier. Unfortunately, the inspector general's investigations left us with more questions than answers.

Earlier this year, I sent a letter to Inspector General Cuffari detailing the concerns we identified with the report. My entire letter is available on the committee's website. Among the concerns I raised were the following: Inspector general's report and public summaries proclaim that there was no malfeasance or misconduct

by DHS personnel. It is unclear why that standard was used, because there do not appear to have been any allegations of malfeasance or misconduct on the part of the agents.

In fact, all available evidence indicates that Border Patrol agents showed great compassion for both children. However, the inspector general's report appeared to presume that since its investigation found no malfeasance or misconduct, that is the end of the story. The report fails to examine the many troubling questions that these deaths raise regarding CBP's ability to care for children in custody, including questions about the adequacy of the agency's policies, procedures, and training.

Further, while the inspector general's office certainly conducted many interviews, it appeared that key documents and evidence were not collected and reviewed. My letter also identified omissions in the public summary of one of the inspector general's report that was so severe as to render the summary inaccurate and potentially misleading. The inspector general revised a public summary after receiving my letter.

Over the past 6 months, DHS has produced some documents in response to the committee's subpoena, but these productions are clearly incomplete. For example, the inspector general's report referenced documents that have never been provided to the committee. DHS has also made extensive and improper redactions in the documents it has produced.

Through its refusal to comply fully with the committee's subpoena, and through its many redactions, the Department is intentionally impeding the committee's investigation. Despite these hurdles, the committee has worked to advance our investigation. To help with that effort, we asked a pediatrician and a medical examiner to conduct independent examinations of the 2 deaths that occurred in December 2018. We will receive that testimony today. Today, the Government Accountability Office is also releasing a report we requested. It examines both CBP's use of emergency funding appropriated to care for migrants, as well as the agency's implementation of new medical screening procedures it announced after the deaths in 2018. GAO's report finds that after CBP claimed it urgently needed emergency funding to provide care for migrants taken into custody, the agency misspent money it received. The Border Patrol agents who cared for Felipe, while he was in custody, had to pay for medicine for him out of their own pockets, but CBP used some of the emergency funding that Congress appropriated for the specific purpose of paying for medical care, to instead buy jet skis, and dirt bikes, and even dog food.

There is something seriously wrong with this picture, just as there is something seriously wrong with the administration's approach to caring for migrants, including children.

I note that GAO's report also finds that although CBP adopted new policies governing medical assessments for children following the tragic deaths of the 2 children in late 2018, CBP did not consistently implement these policies.

We welcome Dr. Fiona Danaher and Dr. Roger Mitchell before the committee, as well as Rebecca Gambler from GAO. I am glad that after initially refusing to do so, inspector general has agreed to testify before the committee, so that we can explore the many

questions regarding the work of the inspector general's office. We also invited CBP's acting commissioner, Mark Morgan to testify.

In a letter to the committee, he stated that because of the White House baseless rules prohibiting administration witnesses from attending virtual hearings, he could not appear.

As I close, let me say that I fully recognize the sensitivities of the issues we are discussing. I encourage all Members to be very careful and thoughtful in how we approach this subject. With that said, it is clear that this administration will do everything it can to avoid oversight. Therefore, we must continue to do everything we can to hold this administration accountable. Given the 18 months of obstruction we have endured and have sought documents and information about the death of children in custody, as well as issues like the administration's child separation policy, I see no other way to advance our investigation and to identify changes needed in CBP's policies and procedures than to convene today's hearing.

Before I recognize the Ranking Member, I am going to read statements from the fathers of the 2 children who died in CBP custody in 2018.

Mr. Caal Cruz, the father of Jakelin, provided the following statement: "I would like to say what I have always believed, it is better to check on all children when they are sick, and even if they are not sick, to speak up and say something even if you are afraid. The most important thing is to check on the children so the thing that happened to my daughter doesn't happen to anyone ever again. I offer my thanks to the committee for taking the time to look into my daughter's case and I am very grateful to you all."

The father of Felipe, Mr. Gomez Perez stated: "I want justice. I want to know why my son didn't receive medical care in time. I don't want other children to go through the same thing. This is painful for me today, and it will be painful for the rest of my life. Every night I ask myself why my son didn't receive medical attention in time. Felipe's treatment was inhumane."

I ask unanimous consent to submit their letters into the record.

Without objection, so admitted.

[The information referred to follows:]

July 14, 2020.

Representative BENNIE G. THOMPSON,
Chairman, Committee on Homeland Security, H2–176 Ford House Office Building, Washington, DC 20515.

Statement of Mr. Caal Cruz Regarding the Committee's Investigation into the Death of Jakelin Caal Maquin, age 7

Dear CHAIRMAN THOMPSON: We are providing this statement on behalf of our client, Mr. Nery Caal Cruz, to whom we provide pro bono legal and social services. Please find below Mr. Caal Cruz's statement in response to the Committee on Homeland Security's current investigation into the death of his daughter, Jakelin Caal Maquin, then age 7, in CBP custody.

"I would like to say what I have always believed. It is better to check on all children when they are sick and even if they are not sick. To speak up and say something even if you are afraid. The most important thing is to check on the children. So the thing that happened to my daughter doesn't happen to anyone ever again. I offer my thanks to the Committee for taking the time to look into my daughter's case and I am very grateful to you all."

Thank you for your attention and consideration to this important issue.

Sincerely,

BRIDGET CAMBRIA, ESQ. [.]

July 15th, 2020.

To whom it may concern, The Tennessee Immigrant and Refugee Rights Coalition (TIRRC) is a State-wide member-led advocacy organization dedicated to empowering immigrants and refugees to defend their rights. In the Spring of 2019, the Guatemalan consulate put us in touch with Agustin Gomez Perez after the death of Mr. Gomez Perez's son in CBP custody. Over the past year, we have developed a close relationship with Mr. Gomez Perez and assisted him through connecting him with community resources and getting him settled into his home. We have also helped him collect necessary documents for the legal proceedings and facilitated the communication between Mr. Gomez Perez and various attorneys. For his part, Mr. Gomez Perez has become an active TIRRC member through attending our community meetings. Mr. Gomez Perez would like for his statement to be read aloud.

Agustin Gomez Perez's statement:

"I want justice. I want to know why my son didn't receive medical care in time. I don't want other children to go through the same thing. This is painful for me today, and will be painful for the rest of my life. Every night I ask myself why my son didn't receive medical attention in time. Felipe's treatment was inhumane."

We are proud to support Mr. Gomez Perez in his fight for justice for his son and the improved treatment of immigrants. All people deserve to be treated with basic human dignity and respect.

Sincerely,

LISA SHERMAN-NIKOLAUS,
Executive Director.

[The statement of Chairman Thompson follows:]

STATEMENT OF CHAIRMAN BENNIE G. THOMPSON

JULY 15, 2020

The committee is convening today to examine 3 critical, related, and deeply troubling issues: The terrible deaths of young children in the custody of Customs and Border Protection (CBP); CBP's failure to consistently implement the revised medical screening procedures it adopted after children died in its custody; and CBP's improper expenditure of emergency funding appropriated by Congress for the care of migrants.

In December 2018, 2 children died in CBP custody—a 7-year-old girl named Jakelin and an 8-year-old boy named Felipe. Last year, another 3 children died in CBP custody or shortly after being released.

On January 4, 2019, I sent a letter to the Department of Homeland Security requesting documents related to the deaths in 2018. After the Department failed to produce all documents responsive to the committee's request, in November 2019, the committee issued a narrowly-tailored subpoena by voice vote for many of the documents originally requested in my letter 10 months prior.

In December 2019, the DHS inspector general's office publicly issued 2 1-page summaries of its investigations into the deaths that had occurred a year earlier. Unfortunately, the inspector general's investigations left us with more questions than answers.

Earlier this year, I sent a letter to Inspector General Cuffari detailing the concerns we identified with the reports. My entire letter is available on the committee's website. Among the concerns I raised were the following: The inspector general's reports and public summaries proclaim that there was no malfeasance or misconduct by DHS personnel.

It is unclear why that standard was used, because there do not appear to have been any allegations of malfeasance or misconduct on the part of agents. In fact, all available evidence indicates that Border Patrol agents showed great compassion for both children. However, the inspector general's reports appear to presume that since its investigations found no malfeasance or misconduct, that's the end of the story.

The reports fail to examine the many troubling questions that these deaths raise regarding CBP's ability to care for children in custody, including questions about the adequacy of the agency's policies, procedures, and training. Further, while the in-

spector general's office certainly conducted many interviews, it appears that key documents and evidence were not collected and reviewed.

My letter also identified omissions in the public summary of one of the inspector general's reports that were so severe as to render the summary inaccurate and potentially misleading. The inspector general revised the public summary after receiving my letter. Over the past 6 months, DHS has produced some documents in response to the committee's subpoena—but these productions are clearly incomplete. For example, the inspector general's reports reference documents that have never been provided to the committee. DHS has also made extensive and improper redactions in the documents it has produced. Through its refusal to comply fully with the committee's subpoena—and through its many redactions—the Department is intentionally impeding the committee's investigation. Despite these hurdles, the committee has worked to advance our investigation.

To help with that effort, we asked a pediatrician and a medical examiner to conduct independent examinations of the 2 deaths that occurred in December 2018. We will receive their testimony today.

Today, the Government Accountability Office is also releasing a report we requested. It examines both CBP's use of emergency funding appropriated to care for migrants as well as its implementation of the new medical screening procedures it announced after the deaths in 2018. GAO's report finds that after CBP claimed it urgently needed emergency funding to provide care for migrants taken into custody, the agency mis-spent money it received.

The Border Patrol agents who cared for Felipe while he was in custody had to pay for medicine for him out of their own pockets. But CBP used some of the emergency funding that Congress appropriated for the specific purpose of paying for medical care to instead buy jet skis and dirt bikes, and even dog food. There is something seriously wrong with this picture—just as there is something seriously wrong with this administration's approach to caring for migrants, including children.

I note that GAO's report also finds that although CBP adopted new policies governing medical assessments for children following the tragic deaths of the 2 children in late 2018, CBP did not consistently implement these policies. We welcome Dr. Fiona Danaher and Dr. Roger Mitchell before the committee, as well as Rebecca Gambler from GAO. I am glad that after initially refusing to do so, the inspector general has agreed to testify before the committee, so that we can explore the many questions we have regarding the work of the inspector general's office.

We also invited CBP's acting director, Mark Morgan, to testify. In a letter to the committee, he stated that because of the White House's baseless rules prohibiting administration witnesses from attending virtual hearings, he could not appear.

As I close, let me say I fully recognize the sensitivities of the issues we are discussing. I encourage all Members to be very careful and thoughtful in how we approach this subject. That said, it is clear that this administration will do everything it can to avoid oversight. Therefore, we must continue to do everything we can to hold this administration accountable.

Given the 18 months of obstruction we have endured as we have sought documents and information about the deaths of children in custody—as well as issues like the administration's child separation policy—I see no other way to advance our investigation and to identify changes needed in CBP's policies and procedures than to convene today's hearing.

Chairman THOMPSON. The Chair now recognizes the Ranking Member of the full committee, the gentleman from Alabama, Mr. Rogers, for an opening statement.

Mr. ROGERS. Thank you, Mr. Chairman. Can you hear me?

Chairman THOMPSON. Yes.

Mr. ROGERS. Great.

I appreciate you holding this hearing and thank you, again, for granting our request to use the committee room. I am, too, saddened by the loss of Felipe and Jakelin. Both children and a teenager died while in the custody of CBP, or shortly after entering custody, which is totally unacceptable. The Department has taken measurable steps to improve migrant care, but it is up to us in Congress to address the root cause of the problem. That can only happen in a bipartisan manner. It means that we must fix immigration loopholes. We must provide real and adequate resources to

both CBP and ICE. We must not encourage illegal immigration to our border. We must disrupt the cartels and their human smuggling partners, and I hope we never have to hear of another tragedy at the borders like what happened with these 3 minors.

Mr. Chairman, I am disappointed at some of the events leading up to this hearing, Acting Commissioner Morgan should be at this hearing so this committee can directly hear from him. It is important we understand what happened and what CBP has done since those 2 deaths. The Majority did invite Acting Commissioner Morgan, but they also knew he couldn't participate in a remote hearing. OMB as provided guidance to senior administration officials forbidding them from participating in remote hearings. They are permitted to appear in person, Acting Commissioner Morgan did before the Senate committee on June 25. I ask unanimous consent to insert into the record Acting Commissioner Morgan's response to the Chairman's invitation.

[The information follows:]

July 8, 2020.

The Honorable BENNIE G. THOMPSON,
Chairman, Committee on Homeland Security, U.S. House of Representatives, Washington, DC 20515.

DEAR CHAIRMAN THOMPSON: Thank you for the invitation to testify before the House Committee on Homeland Security on July 15, 2020, via Cisco Webex regarding "Children in CBP Custody: Examining Deaths, Medical Care Procedures, and Improper Spending." However, based on guidelines established by the Office of Management and Budget (OMB) and the White House Office of Legislative Affairs (WHOLA), I must decline this invitation.

As previously outlined by OMB, Federal officials are required to appear in person before a committee to testify, with the Chairman also appearing in person. OMB also requires that the Committee adhere to normal procedures regarding hearing notice, quorum, and question-and-answer periods. In light of these requirements and the Committee's notice that this hearing will be held via Cisco Webex, I will not be able to participate in this hearing in this format.

Additionally, on July 15, 2020, the Departments of Homeland Security (DHS) and Treasury will be holding the quarterly Commercial Customs Operations Advisory Committee (COAC) meeting. As you are aware, the COAC is a Federal Advisory Committee Act (FACA) committee that advises the Secretaries of the Treasury and DHS on all matters involving the commercial operations of CBP. The CBP Commissioner is the co-chair of the COAC, and I will be co-chairing the quarterly COAC meeting on July 15, 2020.

The CBP Office of Congressional Affairs notified your staff of these requirements and my prior commitment. Additionally, my staff indicated my willingness to work with the Committee to identify a mutually agreeable date so that I can participate in a hearing that complies with OMB and the WHOLA guidelines. Unfortunately, we have not heard back from your staff to identify a different date for the hearing. So I must reiterate that I will not be able to participate in the hearing on July 15, 2020.

I look forward to finding a mutually agreeable date and format that complies with the requirements outlined by OMB to testify before your Committee on this important topic.

Sincerely,

MARK A. MORGAN,
Chief Operating Officer and Senior Official Performing the Duties of the Commissioner.

Mr. ROGERS. In that letter, Morgan requests to appear before the committee in person in accordance with OMB guidance. If we want productive hearings, I would suggest to the Majority that we find time to hear from him in the next 2 weeks when we are in the District of Columbia.

Further, getting to the bottom of those 2 deaths is something that this committee has worked together on. We voted unanimously

last November to subpoena the Department on information related to the deaths of Felipe and Jakelin. Our filing the subpoena, it appears the Majority requested and received additional information from the University of Mexico, Office of Medical Investigations.

It appears the Majority didn't share this information with witnesses here today, and who knows who else, avoid informing the Minority of its existence. One witness claims to have received the information on June 30. The Minority got it on July 12. It is very disappointing to partner with you on things like this, just have them turn out to be partisan in less than a week before the hearing.

I am also alarmed by the autopsy information the Majority requested. I don't see any legitimate reason why this committee, or any committee of Congress, would need human tissue samples from a deceased 8-year-old boy. I am concerned the Majority's motive of requesting and then sharing with their witnesses these autopsy specimens is to try and place blame for those deaths on the men and women of Border Patrol. If that is true, it is deplorable.

The IG found that there was no misconduct or malfeasance in any of the actions of DHS or its employees surrounding these unfortunate deaths. I understand that answer doesn't provide any political satisfaction, but those are the facts.

If the Majority requested and shared human tissue samples of a deceased child just to advance political narrative, it would mark an appalling new low for this committee. I hope that is not the case. We must remember that for months, Congress refused to address the border crisis that precipitated these deaths. Record numbers of families and children crossed our border last year. Groups of hundreds to thousands of migrants came across it at once. Migrants traveled over 2,000 miles at the whims of cartels and human smugglers to get to our border. Many told of abuse, assaults, and worse, on the journey to our border. Food, nutrition, access to medicine was not adequate if at all provided.

As a result, many, like Jakelin, arrived in extremely poor health. At the height of the crisis, Border Patrol agents spent over half their time transporting migrants to hospitals. But for months last year, the Majority refused to acknowledge the problem, going as far as to call it a manufactured crisis. Even after the children died, the Majority insisted there was no crisis at our border. At one point last year, the Majority's response to the border crisis was to send 316 tweets, 11 press releases, and hold 6 hearings. None of that solved anything.

Finally, after months of denying it, the Majority finally admitted there was a crisis. A supplemental appropriations bill was brought forward to the House, yet that bill had so many poison pills attached to it, the Senate had to strip them out before it can head to the border.

Unfortunately, that bill was, at best, a stopgap measure. The Homeland Security Advisory Committee recently concluded that until Congress takes action to address the root cause of last year's crisis, it is only a matter of time before another one occurs. I hope, at some point, we can get off the political messaging game and work together to fix the immigration loophole that encourage par-

ents to send their children on a dangerous, and, oftentimes, deadly trek to our border.

Thank you, Mr. Chairman. I yield back.

[The statement of Ranking Member Rogers follows:]

STATEMENT OF RANKING MEMBER MIKE ROGERS

Thank you, Mr. Chairman, for holding this hearing today.

And thank you again for granting our request to use the committee room.

I'm saddened by the loss of both Felipe and Jakelin.

Both children and a teenager died while in the custody of CBP or shortly after entering custody—which is unacceptable.

The Department has taken measurable steps to improve migrant care, but up to us in Congress to address the root cause of the problem.

That can only happen in a bipartisan manner.

It means that we must fix immigration loopholes.

We must provide real and adequate resources to both CBP and ICE.

We must not encourage illegal immigration to our border.

We must disrupt the cartels and their human smuggling partners.

I hope we never have to hear of another tragedy at the border like what happened to these 3 minors.

Mr. Chairman, I am disappointed at some of the events leading up to this hearing today.

Acting Commissioner Morgan should be here so this committee can hear directly from him.

It's important that we understand what happened and what CBP has done since these 2 deaths.

The Majority did invite Acting Commissioner Morgan, but they also knew that he couldn't participate in a remote hearing.

OMB has provided guidance to senior administration officials forbidding them from participating in remote hearings.

They are permitted to appear in person, as Acting Commissioner Morgan did before a Senate Committee on June 25.

I ask Unanimous Consent to insert into the record Acting Commissioner Morgan's response to the Chairman's invitation.

In that letter, Morgan requests to appear before the committee in person in accordance with the OMB guidance.

If we want a productive hearing, I would suggest to the Majority that we find time to hear from him in the next 2 weeks when we are in the District of Columbia.

Further, getting to the bottom of these 2 deaths is something this committee has worked on together.

We voted unanimously last November to subpoena the Department on information related to the deaths of Felipe and Jakelin.

However, following that subpoena, it appears the Majority requested and received additional information from the University of New Mexico Office of the Medical Investigator.

It appears the Majority then shared this information with the witnesses here today, and who knows who else, before informing the Minority of its existence.

Mr. Chairman, can you tell me when this information regarding Felipe's autopsy was provided to the committee?

I yield to the Chairman.

Thank you, Mr. Chairman.

One witness claims to have received the information on June 30.

We got it on July 12.

It's very disappointing to partner with you on this only to have it be made partisan less than a week before the hearing.

I am also alarmed by the autopsy information the Majority requested.

I don't see any legitimate reason why this committee or any committee of Congress would need the human tissue samples from a deceased 8-year-old boy.

I am concerned the Majority's motive in requesting, and then sharing with their witnesses, these autopsy specimens is to try to place the blame for these deaths on the men and women of the Border Patrol.

If true, I think that's deplorable.

The IG found that there was no misconduct or malfeasance in any of the actions of DHS or its employees surrounding these unfortunate deaths.

I understand that answer doesn't provide any political satisfaction to the Majority, but those are the facts.

If the Majority requested and then shared the human tissue samples of a deceased child just to advance a political narrative, it would mark an appalling new low for this committee.

I hope that's not the case.

We must remember that for months, Congress refused to address the border crisis that precipitated these deaths.

Record numbers of families and children crossed our border last year.

Groups of hundreds to thousands of migrants came across at once.

Migrants traveled over 2,000 miles, at the whims of the cartels and human smugglers, to get to the border.

Many told of abuse, assaults, and worse on the journey to our border.

Food, nutrition, access to medicine was not adequate, if provided at all.

As a result, many, like Jakelin, arrived in extremely poor health.

At the height of the crisis, Border Patrol agents spent over half of their time transporting migrants to hospitals.

But for months last year, the Majority refused to acknowledge the problem, going so far as to call it a "manufactured crisis."

Even after these children died, the Majority insisted there was "no crisis" at our border.

At one-point last year, the Majority's response to the border crisis was to send out 316 tweets, 11 press releases, and hold 6 hearings.

None of that solved anything.

Finally, after months of denying it, the Majority finally admitted there was a crisis.

A supplemental appropriations bill was brought forward to the House.

Yet that bill had so many poison pills attached to it, that the Senate had to strip them out before relief could head to the border.

Unfortunately, that bill was at best a stop-gap measure.

The Homeland Security Advisory Committee recently concluded that until Congress takes action to address the root cause of last year's crisis, it's only a matter of time before another one occurs.

I hope at some point we can get off the political messaging game and work together to fix the immigration loopholes that encourage parents to send their children on a dangerous and, often times, deadly trek to our border.

I yield back.

Chairman THOMPSON. Thank you very much, Mr. Ranking Member.

Other Members of the committee are reminded that under committee rules, opening statements may be submitted for the record. Members are also reminded that the committee will operate according to the guidelines laid out by myself and the Ranking Member in our July 8 colloquy.

[The statement of Honorable Jackson Lee follows:]

STATEMENT OF HONORABLE SHEILA JACKSON LEE

JULY 15, 2020

Thank you, Chairman Thompson for convening this opportunity for the Homeland Security Committee to provide oversight of "Children in CBP Custody: Examining Deaths, Medical Care Procedures, and Improper Spending."

I thank today's witnesses and look forward to their testimony:

- Fiona S. Danaher, M.D., MPH, a pediatrician with Massachusetts General Hospital—Chelsea Pediatrics and Massachusetts General Hospital Child Protection Team and an instructor in Pediatrics, Harvard Medical School;
- Roger A. Mitchell, Jr., M.D., chief medical examiner, D.C. Office of the Chief Medical Examiner, clinical professor of pathology, the George Washington University and associate professor of surgery, Howard University;
- The Honorable Joseph V. Cuffari, inspector general, U.S. Department of Homeland Security;
- Ms. Rebecca Gambler, director, Homeland Security and Justice Team, U.S. Government Accountability Office.

As a senior Member of this committee I have learned a great deal about the capacity and strength of the men and women who work at the Department of Homeland Security.

I hold them in the highest regard for their dedication and service to our country.

This Nation depends on the men and women of the Department of Homeland Security (DHS) to protect citizens from those who wish to do them harm.

Because of the dedication of DHS professionals, we are better prepared to face these challenges as one Nation united against a common foe.

The Department of Homeland Security was not created to protect the Nation from desperate people escaping violence and poverty, seeking asylum in our country.

The saddest, most tragic situation is the plight of tens of thousands of unaccompanied children or those who were taken from their parents or removed from the care of responsible adults.

My primary domestic security concerns are:

- Making sure that our immigration policies in word and deed reflect the best of our Nation's values and institutions;
- Separating fact from fiction in the debate over U.S. immigration and border policy;
- Controlling access to firearms for those who are deemed to be too dangerous to fly;
- Countering international and home-grown violent extremism;
- Preserving Constitutional rights and due process for all persons;
- Protecting critical infrastructure from physical and cyber attacks, including technology used in public elections;
- Creating equity and fairness in our Nation's immigration policies by addressing fairness for TPS and DACA recipients; and
- Strengthening the capacity of the Department of Homeland Security to meet the challenges posed by natural disasters—including pandemics.

As a former Chair and Ranking Member of the Homeland Security's Subcommittee on Border Security, my commitment to securing our Nation's borders and protecting the homeland from terrorist attacks remains unwavering.

The United States has a Federal policy supported by laws that govern how noncitizens are to be treated, and the rights and well-being of the most vulnerable are to be met when in U.S. custody.

I visited CBP facilities when tens of thousands of unaccompanied children were arriving at the border weekly during the previous administration and observed how DHS met the challenge of receiving them, feeding them, and placing them safely in the custody of the Department of Health and Human Services was routinely met.

I was shocked to learn in December 2018, that 2 children died in separate incidents while in the custody of the U.S. Border Patrol, which were the first deaths of children in Border Patrol custody in more than a decade.

Following the deaths of the 2 children in 2018, U.S. Customs and Border Protection, the Border Patrol's parent agency, issued an interim directive in January 2019 establishing new medical screening and assessment procedures for children taken into custody.

CBP issued a final directive regarding enhanced medical screening procedures in December 2019. At the committee's request, the Government Accountability Office (GAO) reviewed CBP's compliance with its new procedures. GAO will issue its findings in a report to be released to the public the day of the committee's hearing.

In January 2019, this committee requested documents related to these deaths.

After the Department of Homeland Security (DHS) failed to produce all requested documents, the committee issued a subpoena for the documents in November 2019.

DHS has still not produced all the documents demanded by the subpoena, and documents that have been produced have had extensive and improper redactions.

The DHS inspector general conducted reviews of the 2 children's deaths and issued public summaries of its reviews a year after the children's deaths.

The committee has identified significant deficiencies with both reviews.

The committee also found that the inspector general omitted key information from the public summary of one of its reviews, rendering the summary inaccurate and potentially misleading.

Because of the deficiencies of the inspector general's investigations of the children's deaths and the on-going failure of DHS to comply with committee document requests, we lack full and complete information regarding the circumstances in which these deaths occurred.

In addition, many questions regarding the adequacy of CBP medical procedures remain unanswered.

It is important that those within the Department of Homeland Security, including its component agencies, comply with the law and respond to the oversight authority of Congressional and Senate Oversight Committees.

BORDER SECURITY

Real border security cannot be achieved by building a wall on the Southern Border, blocking asylum seekers, or separating children from their parents.

These things are in fact making border security more difficult, creating unnecessary tensions with our neighbors in Mexico, Central, and South America while here at home these policies appeal to anti-American nativist views.

Our Nation must and should look at all threats, from those who seek to cross our borders by air, who may try to exploit our maritime borders, or who cross either of our land borders with intent to smuggle or do harm, and develop a strategy to implement thoughtful, proven, and fair solutions to keep America secure.

To further strengthen security along our border, the practice of impeding persons outside of our borders in Mexico undermines the enforcement of immigration law, treaties, and proper application of Federal regulations intended to assure safety and security.

This practice is called "metering", and it is creating unnecessary hardship for people seeking entry and fermenting a toxic environment where men, women, and children are being held under conditions that can easily lead to deteriorating health and safety conditions.

TEMPORARY PROTECTED STATUS AND DREAMERS

I strongly advocate for a crucial legislative fix for debate and vote that will provide permanent legal residence and a path to citizenship to the more than 800,000 Dreamers, including the 124,000 who live in Texas, whose lives have been turned upside down because of this administration's cruel, unwise, and reckless termination of DACA, the Deferred Action for Childhood Arrivals program.

And in connection with legislation to protect Dreamers, I will insist that the administration rescind the revocation of Temporary Protected Status (TPS) for Haiti, El Salvador, and Honduras, or failing that, TPS for those countries be extended by Congressional legislation.

There are 44,800 residents of Texas who are TPS holders from El Salvador (36,300), Honduras (8,400), and Haiti, who combined are parents of 53,800 U.S.-born children in Texas and 14,000 of whom have home mortgages.

These TPS holders are integral members of the Texas's social fabric, having lived in Texas an average of 20 years, and contribute an aggregate $2.2 billion to the Texas economy.

I look forward to today's hearing and learning more from our witnesses.

Thank you. I yield back the balance of my time.

Chairman THOMPSON. I now welcome our panel of witnesses. Our first witness is Dr. Fiona—I hope I get it right, Danaher a pediatrician at Massachusetts General Hospital, Chelsea Healthcare Center, and a member of the hospital's child protection team. She's also an instructor in pediatrics at Harvard Medical School. Dr. Danaher is a graduate of Mount Sinai School of Medicine.

Our second witness is Dr. Roger A. Mitchell, Jr., the chief medical examiner for Washington, DC. Dr. Mitchell, Jr. is board-certified in anatomic and forensic pathology by the American Board of Pathology and a fellow in the National Association of Medical Examiners. He began the study of forensic science as a forensic biologist for the Federal Bureau of Investigation in 1997. Dr. Mitchell is a graduate of the New Jersey Medical School.

Our third witness is the Honorable Joseph V. Cuffari. He was confirmed as the Department of Homeland Security's inspector general on July 25, 2019. Dr. Cuffari previously served as a policy adviser for Military and Veteran Affairs for the Governors of Arizona. He also served more than 40 years in the United States Air Force. Dr. Cuffari earned a Ph.D. in management in 2002.

Our final witness is Ms. Rebecca Gambler, a director in the Government Accountability Office, Homeland Security and Justice team. Ms. Gambler joined GAO in 2002, and currently leads the agency's work on border security immigration and election issues.

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

STATEMENT OF FIONA S. DANAHER, M.D., M.P.H., PEDIATRICIAN, CHELSEA PEDIATRICS, CHILD PROTECTION TEAM, MASSACHUSETTS GENERAL HOSPITAL, INSTRUCTOR IN PEDIATRICS AT HARVARD MEDICAL SCHOOL

Dr. DANAHER. Good morning, Chairman Thompson, Ranking Member Rogers, and Members of the committee. Thank you for the opportunity to testify before you today.

I am Dr. Fiona Danaher, a pediatrician at Massachusetts General Hospital for Children, where much of my clinical work focuses on the care of children in immigrant families. It is a privilege to participate in this committee's efforts to improve the care of children in U.S. Customs and Border Protection custody.

As you know, in December 2018, 2 young children fleeing entrenched poverty in their rural Guatemalan villages became the first migrant children without underlying medical conditions to die in U.S. custody in a decade. Jakelin Caal Maquin, age 7, died from septic shock, which, because it went untreated over many hours, cascaded into multiple organ failure. Felipe Gomez-Alonso, age 8, died from untreated influenza complicated by pulmonary hemorrhage in the context of bacterial pneumonia and sepsis.

Their deaths as well as those of 4 other children in Government custody between September 2018 and May 2019 underscore the deficiencies in an immigration system poorly designed to protect the well-being of vulnerable children.

Review of available records makes clear that Jakelin and Felipe both suffered terrifying and painful deaths that could potentially have been prevented by timely access to pediatric medical care.

In both cases, medical examiners determined the children had died of natural causes and the OIG concluded there was no misconduct or malfeasance by DHS personnel. However, death by natural causes does not mean that death was inevitable. Lack of misconduct or malfeasance or even the great efforts several agents went to in assisting the children does not absolve CBP as an agency of perpetuating systems that placed children at risk for medical neglect.

CBP responded to Jakelin and Felipe's deaths by issuing an interim enhanced medical efforts directive in January 2019 to ensure that all children under the age of 18 received health interviews and medical screenings while in CBP custody. However, the final enhanced medical support efforts directive issued by CBP in December 2019 removed many of the safeguards instituted under the interim guidance, weakening it so much that, had it been in place at the time of Jakelin and Felipe's presentations, it is unlikely its provisions would have prevented their deaths.

Children are not little adults. Their remarkable physiological resilience can mask severe disease from those untrained to recognize it. Any period of detention is inherently unhealthy for children's long-term physical and emotional development, but detention in substandard conditions places children's very lives at risk.

If children are to be detained in CBP facilities, it is incumbent upon the agency to strengthen its medical infrastructure. Jakelin and Felipe's deaths illustrate the need for CBP to eliminate bureaucratic hurdles that unnecessarily prolong detention and delay access to medical care. They also highlight the urgency of addressing detention conditions that promote illness and its spread.

Children in detention need timely access to comprehensive medical screenings in their native language conducted by clinicians with pediatric expertise, followed by referral, as appropriate, to pediatric medical centers.

Those diagnosed with illnesses or underlying medical conditions should not return to detention facilities, which are fundamentally unequipped to provide safe observation or promote children's recuperation.

Teams of agents working in remote areas must include EMTs with enhanced pediatric training. And all forward operating bases and Border Patrol stations must be stocked with basic pediatric medical equipment and with staff trained in its use. CBP must implement the Centers for Disease Control and Prevention's recommendations for the prevention of influenza and COVID–19 at its facilities.

Independent oversight of the quality of medical care provided to detainees needs to occur regularly, as the OIG indicated in its own capping report that it does not possess the necessary medical expertise for the task.

Given the current COVID–19 epidemic and the impending arrival of another influenza season, time is of the essence. Action must be taken now to apply the lessons learned from Jakelin and Felipe's tragic deaths so that other children do not meet similarly painful and preventable fates while in custody of the U.S. Government.

Thank you, and I look forward to taking your questions.

[The prepared statement of Dr. Danaher follows:]

PREPARED STATEMENT OF FIONA S. DANAHER

JULY 15, 2020

INTRODUCTION

In December 2018, 2 young children fleeing entrenched poverty in their rural Guatemalan villages became the first migrant children without underlying medical conditions to die in U.S. custody in a decade. Jakelin Caal Maquin, age 7, died from septic shock which, because it went untreated over many hours, cascaded into multiple organ failure. Felipe Gomez-Alonso, age 8, died from untreated influenza complicated by pulmonary hemorrhage in the context of bacterial pneumonia and sepsis. Both children suffered terrifying and painful deaths that could potentially have been prevented by timely access to pediatric medical care. Their deaths, as well as those of 4 other children in Government custody between September 2018 and May 2019, underscore the deficiencies in an immigration system poorly designed to protect the well-being of vulnerable children.

SYSTEMIC INADEQUACIES

Review of the circumstances surrounding Jakelin and Felipe's deaths suggests that multiple systemic inadequacies in CBP's management of child detainees align to place them at risk for grave harm.

- *Inadequate screening.*—Initial medical screening for Jakelin consisted of one agent shouting to the large group of migrants with whom she was apprehended that those who were sick should come forward. This cursory process assumed that all the migrants would hear the agent, understand Spanish, and feel com-

fortable disclosing their medical concerns in front of many other people. Not surprisingly, Jakelin was not the only sick child in the group who went unidentified as a result. Completing any further health screening at the forward operating base where she was apprehended was not standard operating procedure at the time. Additional screening did not occur until after the first bus, which was supposedly reserved for medically vulnerable migrants, had already left the remote base for the Border Patrol station. The screening form used for the health interview did not ask about specific symptoms of illness like fever or vomiting, nor did it ask about chronic medical conditions. The CBP agents who completed Jakelin's health interview while she waited for the second bus did not have appropriate qualifications to do so, did not base their finding that Jakelin was "mentally alert" on the child's current presentation (she was asleep), and did not conduct the interview in the family's native language.

It is unclear from available records whether Felipe received any medical screening during the 6 days in CBP custody before he began to show signs of illness.

- *Inadequate training*.—In both Jakelin and Felipe's cases, CBP agents' lack of basic understanding of pediatric disease processes led to deadly delays in accessing medical care. Jakelin was suffering from sepsis, an overwhelming, systemic infection that can rapidly progress to multiple organ failure. Early signs of sepsis can be subtle and particularly challenging to identify in children, who compensate well for the ensuing cascade of organ dysfunction until their bodies have exhausted all metabolic reserves. It is well-established in emergency and critical care medicine that every hour of delay in accessing treatment for sepsis dramatically increases mortality risk, such that it is standard of care for patients to receive antibiotics within 1 hour of presentation. The remote forward operating base where Jakelin was apprehended was not staffed with any EMTs, and standard operating procedure at the time was to defer health interviews until detainees could be transferred to a Border Patrol station nearly 100 miles away. Given the poor screening Jakelin received at the base, it is impossible to know at what point she became critically ill in the approximately 7 hours that elapsed between her apprehension and her father's request for medical assistance, but because the agents did not recognize the urgency of the situation or call an ambulance to meet them en route to the Border Patrol station, an additional 2 hours elapsed before she received any medical attention. By the time she finally received antibiotics—which appears not to have happened until she reached the hospital nearly 12 hours after apprehension and more than 4 hours after her father sought help—she was too sick to be saved.

  The agents at the highway checkpoint where Felipe was detained also seem not to have recognized the severity of his illness. He was observed having abdominal pain and difficulty breathing hours before he became critically ill, yet agents did not push for Felipe to return to the hospital at that time. As he grew sicker, Felipe undoubtedly experienced significant respiratory distress and excruciating pain. Both he and his father stated they thought he was going to die, yet the agents still interpreted no urgency to the situation, allowing 73 minutes to elapse from his father's request for medical care until arrival of transport. Felipe became unconscious as he was loaded into the CBP cruiser and was pulseless by the time he reached the hospital.
- *Inadequate equipment and supplies*.—The medical room at the Border Patrol station where Jakelin first received treatment was not stocked with basic medical equipment like oxygen, airway kits, trauma kits, or defibrillators, forcing EMT agents to leave her side to find them. The station lacked pediatric-sized equipment like a pulse oximeter or blood pressure cuff to assess Jakelin's vital signs. The highway checkpoint where Felipe stayed was not stocked with basic medications like acetaminophen or ibuprofen, and MedPAR would not cover them, forcing CBP agents to pay out of pocket for medications to manage Felipe's fever and pain.
- *Inadequate access to pediatric expertise*.—Before receiving medical attention, Jakelin was transferred almost 100 miles out of the way to a Border Patrol station that was another 160 miles from the nearest children's hospital. Weeks after Jakelin's death, the Hidalgo County Manager sent an urgent request for assistance to the New Mexico congressional delegation and Governor-elect, noting, "Our Hidalgo County Emergency Medical Services team consists of 7 full-time employees and 5 volunteers" to cover 5,000 square miles.[1] About 10 per-

[1] Villagran L. Southern New Mexico medical facilities strained to meet the needs of migrants. Las Cruces Sun News. *https://www.lcsun-news.com/story/news/local/2019/02/05/nm-hospital-health-care-clinic-migrants-asylum-seekers-ice/2743352002/*. Published February 5, 2019. Accessed July 11, 2020.

cent of an EMT's training hours in New Mexico are dedicated to pediatrics, amounting to just 4 hours for an EMT Basic or 6 hours for a paramedic.[2] The Hidalgo County Emergency Medical Services director stated, "Border Patrol needs more than EMTs. They need . . . someone of a higher level, so people get proper screenings. But they are not set up for it. They were never set up for families coming across."[1]

Gerald Champion Regional Medical Center, the local hospital where Felipe received care, does not have a dedicated pediatric emergency department, inpatient unit or ICU. This lack of pediatric expertise is reflected in the management he received during his first emergency room visit, including failure to recognize troubling vital signs, failure to reassess him prior to discharge, prescription of an antibiotic for a viral infection at a dose that would be subtherapeutic for a child even if treating a bacterial infection, failure to prescribe antiviral medication for influenza, and failure to notify CBP of the child's diagnosis despite knowing he was returning to a congregate setting where other detainees might be placed at risk for contracting the disease.[3]

- *Prolonged detention in conditions that promote illness*.—Felipe was detained in CBP facilities for 6 days, twice as long as the 72-hour maximum generally permitted under CBP's National Standards on Transport, Escort, Detention, and Search (TEDS).[4] The maximum incubation period for influenza is 4 days, so Felipe unquestionably contracted influenza while he was in CBP detention. Felipe passed through multiple crowded CBP facilities, and records suggest that he was cold and sleep-deprived, all of which likely contributed to development of his illness. Multiple published reports indicate that conditions which promote vulnerability to infection are common in CBP facilities: Overcrowding, abnormally cold temperatures, inadequate access to shower facilities and basic hygiene products (e.g., soap, toothbrushes, sanitary napkins), open toilets, poor sleep conditions (sleeping on mats, cement benches or floors under mylar blankets with 24 hour artificial light exposure, in some cases without adequate space to lie down), inadequate nutrition, inadequate access to clean drinking water, and confiscation of needed medications without supplying replacements.[5] [6] [7] [8] [9] Such conditions not only promote disease, but also inhibit recovery. As the American Academy of Pediatrics has stated, children like Felipe who are diagnosed with illness or special health care needs should not be returned to CBP facilities, as "the conditions in the centers themselves exacerbate children's suffering" and are not conducive to recuperation.[10]
- *Inability to appropriately isolate and monitor ill detainees*.—The agents responsible for monitoring Felipe when he returned from his first trip to the hospital had limited options for doing so safely: They could either observe him closely in the "bubble" processing area, where he potentially exposed staff and other detainees to infection, or place him in a rear cell where observation was more challenging. It seems that once he was back in his cell, agents only checked on

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[2] New Mexico EMS Bureau. Continuing Education and Renewal Guide for EMT Licensure. *https://www.nmhealth.org/publication/view/guide/1894/*. Published 2019. Accessed July 12, 2020.

[3] Gerald Champion Regional Medical Center. Association of Health Care Journalists website. *http://www.hospitalinspections.org/report/26235.* Accessed July 11, 2020.

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

[5] Linton JM, Griffin M, Shapiro AJ, AAP COUNCIL ON COMMUNITY PEDIATRICS. Detention of Immigrant Children. Pediatrics. 2017;139(5):e20170483. doi: 10.1542/peds.2017–0483.

[6] ACLU and University of Chicago Law School. Neglect and Abuse of Unaccompanied Immigrant Children by U.S. Customs and Border Protection. *https://www.aclusandiego.org/civil-rights-civil-liberties/*. Published May 2018. Accessed July 11, 2020.

[7] Cuffari JV. Office of Inspector General, Department of Homeland Security. Capping Report: CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge. *https://www.oig.dhs.gov/sites/default/files/assets/2020-06/OIG-20-38-Jun20.pdf.* Published June 12, 2020. Accessed July 11, 2020.

[8] Halevy-Mizrahi NR, Harwayne-Gidansky I. Medication Confiscation: How Migrant Children Are Placed in Medically Vulnerable Conditions. Pediatrics. 2020; 145(1):e20192524. doi: 10.1542/peds. 2019–2524.

[9] Peeler KR, Hampton K, Lucero J, Ijadi-Maghsoodi R. Sleep deprivation of detained children: Another reason to end child detention. Health and Human Rights. 2020;22(1):317–320. *https://www.hhrjournal.org/2020/01/sleep-deprivation-of-detained-children-another-reason-to-end-child-detention/*. Accessed July 11, 2020.

[10] Testimony for the Record on Behalf of the American Academy of Pediatrics Before the U.S. House of Representatives Committee on Homeland Security, Subcommittee on Border Security, Facilitation, & Operations. Assessing the Adequacy of DHS Efforts to Prevent Child Deaths in Custody. *https://downloads.aap.org/DOFA/Jan%202020%20Hearing%20Statement%20for%20the%20Record%20%20AAP.pdf.* Published January 14, 2020. Accessed July 11, 2020.

him through the door, even after they were made aware that his condition was declining. (Publicly-released video footage of the influenza-related death of Carlos Gregorio Hernandez Vasquez, another child in CBP custody who was placed in a cell to convalesce, suggests that documented wellness checks may not always in fact occur.)[11]

- *Frequent transfers between crowded facilities promote disease spread*.—Felipe passed through 4 overcrowded facilities in 6 days. Studies have demonstrated that "frequent interfacility transfers, influence disease transmission dynamics. Rapid turnover creates an inflow of people in rapidly consecutive cohorts (a 'revolving doors' effect). An inflow of susceptible people within a closed or semi-open community experiencing an outbreak, has been shown to slow the creation of herd immunity and can act as a transmission amplifier, while interfacility transfers can facilitate disease spread."[12] The infection control challenges posed by overcrowding and frequent transfers are underscored by the fact that Felipe's young cellmate developed influenza symptoms the day after Felipe's death.
- *Bureaucratic barriers to care and release*.—Paperwork seems to have delayed medical evaluation in both Jakelin and Felipe's cases. When Jakelin's group was apprehended, agents at the forward operating base decided to complete the I–779 health interview forms but had to wait for them to be delivered from the Border Patrol station 2 hours away, so the first bus of migrants was already loaded by the time the forms arrived. When an agent first attempted to take Felipe to the hospital, agents had to make multiple phone calls to determine how to find the appropriate paperwork, which was being kept at a station 15 miles away. His second presentation to the emergency room was also delayed because agents collected paperwork before checking in on him.

  Equally troubling are the bureaucratic and technological barriers leading to Felipe's prolonged detention in the first place. Had he been released sooner, his exposure to influenza—which occurred at least 2 days into his detention—might have been prevented.
- *Inadequate language capabilities*.—All verbal communication between CBP agents and Felipe and Jakelin's fathers occurred in Spanish, despite the fact that neither are native Spanish speakers. CBP does not systematically utilize effective tools for identifying speakers of indigenous languages, who often understand limited Spanish but feel pressured to communicate in the language.[13] Felipe's medical providers utilized a CBP agent rather than their own certified medical interpretation service to communicate information in Spanish regarding Felipe's care, significantly increasing the risk of medical errors.[14] All consents and discharge paperwork were provided in English and verbally translated by the CBP agent, which raises the question of how much Felipe's father understood about reasons to seek additional medical care. (Despite documenting in the medical record that Felipe's father verbalized understanding of the discharge instructions, Felipe's nurse later acknowledged to CMS investigators that he could not confirm if the father actually comprehended.)[3] Jakelin's health interview was similarly conducted in Spanish, which likely contributed to delays in identifying her illness.
- *Lack of privacy*.—Expecting detainees to disclose potentially sensitive medical information in front of large groups of other migrants upon apprehension at the border is unrealistic. Despite an agent shouting to the group of migrants with whom Jakelin traveled for those who were ill to come forward, none did, and at least 2 sick children were missed as a result. A recent OIG report includes photographs which suggest that medical screenings in Border Patrol stations also occur in large groups, affording detainees no privacy.[7] Some may hesitate to disclose their medical conditions in front of other migrants with whom they

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[11] Moore R. Six Children Died in Border Patrol Care. Democrats in Congress Want to Know Why. Pro Publica. *https://www.propublica.org/article/six-children-died-in-border-patrol-care-democrats-in-congress-want-to-know-why*. Published January 13, 2020. Accessed July 6, 2020.

[12] Riccardo F, Suk JE, Espinosa L, et al. Key Dimensions for the Prevention and Control of Communicable Diseases in Institutional Settings: A Scoping Review to Guide the Development of a Tool to Strengthen Preparedness at Migrant Holding Centres in the EU/EEA. Int J Environ Res Public Health. 2018;15(6):1120. doi:10.3390/ijerph15061120.

[13] Gentry B. Indigenous Language Speaking Immigrants (ILSI) in the U.S. Immigration System, a technical review. *http://www.amaconsultants.org/uploads/Exclusion__of__Indigenous-%20Languages__in__US__Immigration__System__19__June2015version__i.pdf*. Published May 26, 2015. Accessed July 6, 2020.

[14] Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics. 2003;111(1):6–14. doi:10.1542/peds.111.1.6.

share close quarters, for fear of being stigmatized or receiving blame when other migrants fall ill.

- *Lack of autonomy*.—When Jakelin's father sought assistance for his sick daughter from multiple agents at the forward operating base, he was repeatedly told he would have to wait until they reached the Border Patrol station, so he ceased to advocate during transit even as she began to experience trouble breathing. Detaining families robs parents of the autonomy to make independent decisions about accessing medical care for their children. Families in detention depend upon CBP agents for all necessities and for timely processing; they may even think that their familial integrity depends upon CBP agents' good graces, given CBP's recent history of separating thousands of families under the previous Zero Tolerance Policy. This power dynamic engenders fear and poses a significant barrier to requesting and accessing help.

CBP RESPONSE: ENHANCED MEDICAL DIRECTIVES

In January 2019, CBP responded to Jakelin and Felipe's deaths by issuing an Interim Enhanced Medical Efforts Directive to ensure that all children under the age of 18 received health interviews and medical screenings while in CBP custody.[15] However, the final Enhanced Medical Support Efforts Directive issued by CBP in December 2019 removed many of the safeguards instituted under the interim guidance.[16] The final directive:

- Does not explicitly require the health interview to occur upon initial processing unless a detainee volunteers a medical concern;
- Narrows the scope of a basic medical screening to no longer specify inclusion of vital signs;
- Mandates medical screenings only for children under 12 or those with identified medical issues "subject to availability of resources and operational requirements," instead of for all children under 18—despite the fact that 2 of the children who died in CBP custody in 2019 were 16 years old;
- Seems to reduce the qualifications required for performing medical screenings, stating they will be conducted by health care providers "where available," and that CBP EMS personnel may conduct them "in exigent circumstances and based on operational requirements";
- Permits "basic, acute medical care, referral, and follow up" to occur on-site, which would further limit access to health care providers with pediatric expertise. (CBP has contracted with a small number of pediatric advisors to offer consultation and training along the Southwest Border, but the advisors generally do not provide direct patient care to detainees.)[10]

Neither directive specifies the time frame within which children must receive medical screening, and the final directive again places the onus on parents to advocate to CBP agents for their children to receive timely medical attention.

IMMINENT RISKS

The limited scope of the protocols vaguely outlined in CBP's final Enhanced Medical Support Efforts Directive will do little to protect children in its custody from the threats posed by the upcoming influenza season, the current COVID–19 outbreak, and other medical emergencies that children will undoubtedly experience.

Half of the recent deaths of migrant children in Government custody have been attributed to complications from influenza. Multiple evidence-based strategies exist for preventing such deaths, including offering the influenza vaccine to detainees, mandating vaccination for staff working with detained populations, instituting comprehensive screening and triage protocols, ensuring that those with potential cases of influenza receive antiviral therapy like oseltamivir as soon as possible and no more than 48 hours after onset of symptoms, offering antiviral chemoprophylaxis to vulnerable detainees who may have been exposed to index cases, minimizing overcrowding, providing appropriate space for isolation and convalescence, and ensuring adequate access to basic hygiene supplies like soap, hand sanitizer, and face masks. Teams from the Centers for Disease Control and Prevention (CDC) visited CBP facilities shortly after Jakelin and Felipe's deaths and made similar recommenda-

[15] U.S. Department of Homeland Security, U.S. Customs and Border Protection. CBP DIRECTIVE NO. 2210–003: CBP Interim Enhanced Medical Efforts. *https://www.cbp.gov/sites/default/files/assets/documents/2019-Mar/CBP-Interim-Medical-Directive-28-January-2019.pdf.* Published January 28, 2019. Accessed July 12, 2020.

[16] U.S. Department of Homeland Security, U.S. Customs and Border Protection. CBP DIRECTIVE NO. 2210–004: Enhanced Medical Support Efforts. *https://www.cbp.gov/sites/default/files/assets/documents/2019-Dec/CBP__Final__Medical__Directive__123019.pdf.* Published December 30, 2019. Accessed July 12, 2020.

tions.[17] Yet CBP has explicitly stated it will not offer influenza vaccination to detainees in its custody, and just 6 months after Jakelin and Felipe's deaths, the Government argued in court that maintaining "safe and sanitary" conditions in CBP detention did not even require providing children with soap.[18]

The present COVID–19 epidemic lends even more urgency to improving detention conditions and medical screening protocols. COVID–19 is more contagious than influenza, and can cause extremely rapid and unpredictable deterioration even in previously healthy individuals. While children generally seem less vulnerable to the immediate effects of COVID–19 infection (with notable exceptions among infants and those with chronic medical conditions), some do become seriously ill with COVID–19 symptoms, and others go on to develop the recently recognized Multisystem Inflammatory Syndrome in Children (MIS–C) weeks after primary infection. MIS–C is a poorly understood, dangerous condition that can develop in children who may never have shown previous symptoms of COVID–19. Its symptoms are vague—fever and any of a broad array of cardiopulmonary, gastrointestinal, neurologic, mucocutaneous, and other systemic manifestations—and identifying the condition and its potentially life-threatening complications requires nuanced, pediatric-specific clinical acumen along with extensive laboratory testing. In a recent study of MIS–C cases across the United States—most of which (73 percent) occurred among previously healthy children—80 percent of children required intensive care, 48 percent required medications to maintain adequate blood pressure, 20 percent required mechanical ventilation, 8 percent developed coronary artery aneurysms, and 2 percent died.[19] Children detained in remote settings without adequate medical screening and rapid access to pediatric expertise will be at particular risk for poor outcomes from COVID–19 and MIS–C, including long-term disability and death. The CDC has issued interim guidance on management of COVID–19 in detention facilities—including social distancing, provision of personal protective equipment, and enhanced hygiene recommendations, along with other measures similar to those recommended for influenza prevention—to which CBP should adhere.[20]

CONCLUSIONS

Jakelin and Felipe's deaths could potentially have been prevented had CBP established better systems to ensure adequate medical screening and prompt access to pediatric medical care. The missed opportunities preceding their deaths highlight that:

- Children are not little adults. Their remarkable physiological resilience can mask severe disease from those untrained to recognize it.
- Any period of detention is inherently unhealthy for children's long-term physical and emotional development, as the American Academy of Pediatrics has repeatedly stated, but detention in substandard conditions places children's very lives at risk.
- If children are to be detained in CBP facilities, it is incumbent upon the agency to strengthen its medical infrastructure. CBP must eliminate bureaucratic hurdles that unnecessarily prolong detention and delay access to medical care; address detention conditions that promote illness and its spread; and provide timely access to comprehensive medical screenings in a detainee's native language, conducted by clinicians with pediatric expertise, followed by referral as appropriate to pediatric medical centers. Children diagnosed with illnesses or underlying medical conditions should not be returned to detention facilities, which are fundamentally unequipped to provide safe observation or promote children's recuperation.
- Teams of agents working in remote areas must include EMTs with enhanced pediatric training, and all forward operating bases and Border Patrol stations

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[17] Letter from Director of the Centers for Disease Control and Prevention Dr. Robert Redfield to the Honorable Rosa DeLauro at 10–11. *https://www.warren.senate.gov/imo/media/doc/CDC%20Response%20%20migrant%20vaccination.pdf.* Published November 7, 2019. Accessed July 6, 2020.

[18] Flynn M. Detained migrant children got no toothbrush, no soap, no sleep. It's no problem, government argues. Washington Post. *https://www.washingtonpost.com/nation/2019/06/21/detained-migrant-children-no-toothbrush-soap-sleep/*. Published June 21, 2019. Accessed July 6, 2020.

[19] Feldstein LR, Rose EB, Horwitz SM, et al. Multisystem inflammatory syndrome in U.S. children and adolescents. N Engl J Med. June 29, 2020. doi: 10.1056/NEJMoa2021680.

[20] Interim Guidance on Management of Coronavirus Disease 2019 (COVID–19) in Correctional and Detention Facilities. Centers for Disease Control and Prevention website. *https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.* Updated May 7, 2020. Accessed July 6, 2020.

must be stocked with basic pediatric medical equipment and staff trained in its use.
- CBP must implement CDC's recommendations for the prevention of influenza and COVID–19 in its facilities.
- Independent oversight of the quality of medical care provided to detainees must occur regularly, as the OIG has indicated it does not possess the necessary medical expertise for the task.[7]

While CBP has increased the number of medical providers it employs at the border, few have specific pediatric training, and most screening continues to be performed by CBP agents.[7] CBP has yet to demonstrate any real commitment to improving the care it provides, as underscored both by the weakening of its Enhanced Medical Support Efforts Directive, and by recent revelations that the agency utilized line item appropriations for "consumables and medical care" to fund its canine program and purchase dirt bikes and riot helmets.[21] Action must be taken now to apply the lessons learned from Jakelin and Felipe's untimely deaths, so that other children do not meet similarly painful and preventable fates while in custody of the U.S. Government.

Chairman THOMPSON. Thank you very much for your testimony. I now recognize Dr. Mitchell to summarize his statement for 5 minutes.

STATEMENT OF ROGER A. MITCHELL, JR., M.D., CHIEF MEDICAL EXAMINER, OFFICE OF THE CHIEF MEDICAL EXAMINER, WASHINGTON, DC, CLINICAL PROFESSOR OF PATHOLOGY AT THE GEORGE WASHINGTON UNIVERSITY, ASSOCIATE PROFESSOR OF SURGERY AT HOWARD UNIVERSITY

Dr. MITCHELL. Good afternoon, Chairman Thompson, Ranking Member Rogers, and Members of the Committee on Homeland Security. I am Dr. Roger Mitchell, Jr., and I currently serve as the chief medical examiner of Washington, DC.

It brings me no pleasure to testify today on these deaths in custody, but I appreciate the confidence of the committee in asking me to do so. I have been asked to review the cases of Jakelin Caal Maquin and Felipe Gomez-Alonso from the medical examiner's perspective, specifically postmortem findings, the autopsy report cause, and manner of death.

I have been studying deaths in custody for over 20 years. Although when we think about deaths in custody, we are reminded of deaths like George Floyd and Rayshard Brooks. Deaths in custody occur under a continuum, a continuum that moves through phases like arrest-related, pre-arrest-related, and more importantly, for this case, in custody and incarceration, which is short-term and long-term jail detention.

In addition, I have served as the chair of the Child and Infant Fatality Review Committee for the District of Columbia from 2014 to 2019. This committee had been tasked to review infant and child deaths for the purposes of creating system-centered recommendations intended to improve outcomes. This is the lens in which I reviewed these following cases.

We know that Jakelin Caal Maquin was a 7-year-old female child who was apprehended with her father on the U.S. border and found to have a temperature of 105 and then subsequently airlifted to a hospital where she was pronounced dead over 24 hours later. Jakelin suffered from septic complications from a bacterial infec-

[21] Armstrong TH. U.S. Government Accountability Office. Matter of: U.S. Customs and Border Protection—Obligations of Amounts Appropriated in the 2019 Emergency Supplemental. File B–331888. Published June 11, 2020.

tion. The initial laboratory and autopsy findings are consistent with bacterial sepsis. It is important to note that sepsis can progress to organ failure and shock rapidly. Therefore, early recognition and treatment are critical.

So based upon the materials I had to review, and it is my opinion that the cause and manner of death established by those medical examiners is sufficient.

It is also my opinion that this death was preventable. Although the actions taken by individual Border Patrol agents seemed to be appropriate and timely, the larger Border Patrol system lacks adequate human resources and physical infrastructure to respond to medically fragile detainees, especially children.

If the administration of the initial health assessment questionnaire had been performed by a licensed medical professional, the elevated body temperature would have been detected and maybe have saved a life.

The next case, Felipe Gomez-Alonso, we know is an 8-year-old male child who was apprehended with his father at the U.S. border. They were detained at 3 different Border Patrol stations before it was known that he was sick. He was found to have a temperature of 103. Now, he was transported to a local hospital, diagnosed with an upper respiratory infection, prescribed medication and released, but then had to come back because of a worsening condition and was pronounced shortly after.

Felipe suffered complications of a flu viral infection associated with a superimposed bacterial disease, a bacterial infection again. The bacteria isolated were associated with an aggressive exotoxin in a very highly contagious bacteria that is particularly contagious in close quarters and conditions of overcrowding. This exotoxin leads to severe rapidly progressing hemorrhagic pneumonia, or necrotizing pneumonia. Based upon the review of the materials available, it is my opinion that there should have been highlighting of this necrotizing pneumonia in the diagnosis, but nonetheless, a bacterial infection that led to the death of this young child. The manner of death is natural.

It is my opinion that this death also was preventable. Overcrowding is a known condition of the Border Patrol stations, and I believe that the overcrowding conditions may have played a significant role in the infections that led to Felipe's death. There are many missed opportunities to provide life-saving care to this child, namely, the hospital's mismanagement of this initial presentation.

However, again, if there was a licensed medical professional who would have cared for this patient while at the Border Patrol station during this initial assessment, then there may have been a more informed assessment prior to his initial presentation at the hospital, and may have led to better outcomes.

So what are my recommendations? Well, enforcing control of the population of the U.S. Border Patrol station to protect against overcrowding; utilize medical personnel for the initial health assessment of detainees, especially children; accompany this initial assessment with a brief health screening assessment, like touchless temperature checks and blood pressure, glucose finger sticks or even a COVID nasal swab in this environment; and develop an onsite clinical system for the U.S. Border Patrol that has the ability

to triage pediatric patients. Maybe even electronic health records seeing that these patients move from Border Patrol station to Border Patrol station, and then retraining of our agents.

In conclusion, immediate and timely access to health care assessment by a licensed trained medical professional could have prevented the death of both Jakelin and Felipe. The death of both these 2 children are symptoms of a more extensive system that requires much improvement. No system is perfect, but any system that is established by our Government must have, at its core, the health and safety of all who come into contact with it.

The cases of these 2 children must remind us that deaths in custody are not merely a criminal justice issue, but a public health warning. We must provide timely, accurate, and reliable care, not only in the detention centers of our borders, but, also, the streets of our cities, the jails of our counties, and the prisons of our States.

I appreciate the work that this committee is doing to solve this problem. I pray that this hearing does not only provide an appearance of addressing the issue that I have outlined, but a true call to action with resolutions. This may require your dedication to this Nation beyond what is comfortable for some, but I believe it is attainable.

Thank you, Chairman Thompson, and Members of the committee. I am now available for any questions that you may have.

[The prepared statement of Dr. Mitchell follows:]

PREPARED STATEMENT OF ROGER A. MITCHELL, JR.

INTRODUCTION

Good afternoon, Chairman Thompson, Ranking Member Rogers, and the Members of the Committee on Homeland Security, my name is Dr. Roger A. Mitchell, Jr., and I currently serve as the chief medical examiner for Washington, DC. It brings me no pleasure to testify today on these deaths in custody, but I appreciate the confidence of the committee in asking me to do so. I take seriously the task that has been set before me. I have been asked to review the cases of Jakelin Caal Maquin and Felipe Gomez-Alonso from the medical examiner's perspective; specifically the post-mortem findings, the autopsy report, the cause of death, and the manner of death.

Before we get into the specifics of the cases, I would like to provide some foundational elements related to the role the medical examiner in the investigation, examination, certification, and reporting of deaths in custody.

The medicolegal death investigation (MLDI) system in the United States (U.S.) comprises both coroners and medical examiners. The difference between these 2 types of systems varies based upon the jurisdiction, as there is a lack of uniformity of how the MLDI system is implemented across the Nation. In general, coroners are elected officials who do not possess a medical education. In contrast, medical examiners are board-certified forensic pathologists and are appointed by governmental leadership. Both systems require that sudden and unexpected deaths be reported to ensure proper investigation, examination, and certification. Types of cases include homicides, suicides, accidents, undetermined deaths, and even natural causes of death. Also, most jurisdictions require the reporting of the sudden deaths among children and those who die in the justice system's custody. We see both criteria in the cases that we will discuss today.

I have been studying deaths in custody for over 20 years. Deaths of men such as Amidou Diallo (NY) and Earl Faison (NJ) forced me to think about deaths in custody as a public health issue. Although much of what we think about when we hear the term "deaths in custody" are the recent, prominent cases like the deaths of George Floyd and Rayshard Brooks, we must remember that deaths in custody occur on a continuum. The continuum moves through four (4) distinct phases with the overlap of each period. The deaths in custody phases include: (1) Pre-arrest related (during pursuit); (2) arrest-related (apprehension and transport); (3) in-custody (in short-term holding, detention, and jail); and (4) incarcerated (long-term jail, de-

tention, or prison).[1] [2] Additional deaths in custody can occur during judicial executions and post-custody (death within 1 year of release from jail or prison). Most of the Deaths in Custody occur from natural causes within the correctional system (jail, detention, or prison).[3]

In addition, I served as the chair of the Child and Infant Fatality Review Committee for Washington, DC from 2014–2019. The committee is tasked with the review of infant and child deaths for the purpose of creating system-centered recommendations intended to improve outcomes and prevent future deaths. During my tenure the committee reviewed nearly 700 deaths.

It is with this lens that I review the following cases:

JAKELIN CAAL-MAQUIN

Materials Reviewed.—Department of Homeland Security—Office of the Inspector General, Report of Investigation (I19–BP–ELP–05501).

Brief History/Timeline

On December 6, 2018, Jakelin Caal-Maquin (Caal-Maquin), a 7-year-old female child, and her father were apprehended by U.S. Customs and Border Patrol (US–CBP) attempting entrance into the United States. During the transportation from the location of apprehension to the US Border Patrol (USBP) station (93 miles/2 hours away), US–CBP agents were informed that Caal-Maquin complained of fever and vomiting. US–CBP agents called ahead of their arrival to the USBP station, informing them of a sick child on the bus. Caal-Maquin was found to have a temperature of 105.7 degrees upon arrival at the USBP station were Emergency Medical Technicians (EMT) tended to her, providing oxygen and cold compress. Caal-Maquin was witnessed to have a "seizure." She was subsequently air-lifted to an area hospital from the USBP station. Caal-Maquin was pronounced dead on December 8, 2018.

- December 6, 2018
  - 2115—Caal-Maquin encountered entering the U.S. Border.
- December 7, 2018
  - 0500—Caal-Maquin identified and communicated as sick and vomiting
  - 0630—Caal-Maquin arrives at USBP station; met by EMT
  - 0640—County Emergency Management Services (EMS) arrives at USBP station
  - 0650—Emergency air ambulance service identified and contacted
  - 0730—Emergency air ambulance service arrives at USBP station
  - 0745—Emergency air ambulance service departs USBP station with Caal-Maquin for hospital
  - 0850—Emergency air ambulance service arrives with Caal-Maquin at hospital
  - 1100—Caal-Maquin goes into cardiac arrest and is revived.
- December 8, 2018
  - 0035—Caal-Maquin pronounced dead at the hospital.

Autopsy and Post-Mortem Findings

Cause of Death.—Sequelae of Streptococcal Sepsis.
Manner of Death.—Natural.

Pathological Findings:

I. Sequelae of Streptococcal Sepsis
  a. Clinical Evidence of Disease
    i. Increased Temperature—105.7 degrees
    ii. Disseminated Intravascular Coagulation (DIC)
    iii. Metabolic Acidosis
  b. Required Fluid Resuscitation
    i. Bilateral Pleural Effusions
      1. 160 milliliters—Right
      2. 180 milliliters—Left

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[1] Mitchell RA Jr, Diaz F, Goldfogel GA, et al. National Association of Medical Examiners Position Paper: Recommendations for the Definition, Investigation, Postmortem Examination, and Reporting of Deaths in Custody. *Acad Forensic Pathol.* 2017;7(4):604–618. doi:10.23907/2017.051

[2] Frazer E, Mitchell RA Jr, Nesbitt LS, et al. The Violence Epidemic in the African American Community: A Call by the National Medical Association for Comprehensive Reform. *J Natl Med Assoc.* 2018;110(1):4–15. doi:10.1016/j.jnma.2017.08.009

[3] Russo, Joe, Dulani Woods, John S. Shaffer, and Brian A. Jackson, Caring for Those in Custody: Identifying High-Priority Needs to Reduce Mortality in Correctional Facilities. Santa Monica, CA: RAND Corporation, 2017. *https://www.rand.org/pubs/research__reports/RR1967.html.*

ii. Peritoneal fluid retention
1. 210 milliliters
c. Patchy Bronchopneumonia, bilateral, base
i. Pulmonary Congestion
ii. Histological evidence of acute inflammation and gram-positive cocci
1. Immunohistochemistry staining positive for Streptococcus species
2. Real-time polymerase chain reaction (RT–PCR) positive for Streptococcus species
d. Splenic Involvement
i. Histological evidence of reactive changes
ii. Immunohistochemistry staining positive for Streptococcus species
e. Hepatic Involvement
i. Immunohistochemistry staining positive for Streptococcus species
f. Adrenal Gland
i. Hemorrhage and necrosis consistent with Waterhouse-Friderichsen Syndrome
ii. Immunohistochemistry staining positive for Streptococcus species
iii. Real-time polymerase chain reaction (RT–PCR) positive for Streptococcus species
II. Ascaris Lumbricoides Infection
a. 2–3 dozen nematodes of different sizes in the small bowel
i. Duodenum, proximal jejunum, near the ileocecal valve
1. No bowel obstruction.

SUMMARY OPINION

The decedent is a 7-year-old female child who suffered septic complications from a bacterial infection. The subspecies of Streptococcus were unable to be determined; therefore, it is unclear the specific bacterial cause of the child's infection. Nonetheless, the clinical, laboratory, and autopsy findings are consistent with bacterial sepsis. According to the literature, sepsis is defined as a clinical syndrome resulting from a dysregulated systemic inflammatory response to infection. It is the leading cause of morbidity and mortality in children world-wide.[4] It is important to note that sepsis can progress to organ failure and shock rapidly. Therefore, early recognition and treatment are critical. Initial treatment includes immediate fluid resuscitation. The report also describes the presence of Waterhouse-Friderichsen Syndrome (WFS). WFS is characterized by hemorrhagic necrosis of the adrenal glands accompanying vague symptoms of fever, fatigue, and weakness. According to an article in the Pediatric Infectious Disease Journal, WFS can be linked to streptococcal infections.[5]

Based on the review of the material available to this forensic pathologist, it is my opinion that the cause and manner of death established by the medical examiner are sufficient. It is also my opinion is that this death was preventable. Although the actions taken by individual US–CBP agents seem to be appropriate and timely, the larger US–CBP system lacks adequate human resources and physical infrastructure resources to respond to medically fragile detainees, especially children. If the administration of the initial health assessment questionnaire (I–779) had been performed by a licensed medical professional (nurse practitioner, physician assistant, or nurse), the elevated body temperature would have been detected.

The above opinion is established within a reasonable degree of medical certainty.

Recommendations

- Utilize medical personnel (physician, physician assistant, nurse practitioner, or nurse) for the initial health assessment of detainees, especially children.
  - Update the initial medical assessment form (I–779) to be administered by licensed health care providers.
    - Accompanied by brief initial health screening including touchless temperature check, blood pressure, glucose finger stick, and COVID nasal swab.
- Develop an on-site clinic system for US–CBP that has the ability to triage pediatric patients (i.e. pediatric blood pressure cuffs).
- Establish electronic health record (EHR) for US–CBP.
- Assess and reevaluate training for US–CBP.

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[4] Plunkett A, Tong J. Sepsis in children [published correction appears in BMJ. 2015;350:h3704]. *BMJ.* 2015;350:h3017. Published 2015 Jun 9. doi:10.1136/bmj.h3017

[5] Gertner M, Rodriguez L, Barnett SH, Shah K. Group A beta-hemolytic Streptococcus and Waterhouse-Friderichsen syndrome. *Pediatr Infect Dis J.* 1992;11(7):595–596. doi:10.1097/00006454–199207000–00019

- Develop or improve emergency and acute care access standard operating procedure.

FELIPE GOMEZ-ALONSO

Materials Reviewed.—Department of Homeland Security–Office of the Inspector General, Report of Investigation (I19–BP–ELP–06106), Autopsy Report, Autopsy Photographs, Case Notes, Microbiology Report, Toxicology Report, and Histology Slides.

Brief History/Timeline.—On December 18, 2018, Filipe Gomez-Alonso (Gomez-Alonso), an 8-year-old male child, and his father were apprehended by U.S. Customs and Border Patrol (US–CBP) attempting entrance into the United States. They were detained at the first US-Border Patrol (USBP) station until December 20, 2018. They were transferred to a second USBP station because of limited space. Gomez-Alonso and his father were finally moved to a third USBP station on December 23, 2018. On December 24, 2018, Gomez-Alonso was found to have "a loud, hoarse cough," complaining of a sore throat, upset stomach, and a fever.

Alonso-Gomez was subsequently transported to the local hospital emergency room. Clinicians at the hospital saw him. He was, found to have a temperature of 103° F. A pharyngeal swab was positive for influenza, and he was diagnosed with an upper respiratory infection (URI). Alonso-Gomez was prescribed acetaminophen and an antibiotic and released from the hospital.

Alonso-Gomez was transported back to the USBP station by US–CBP agents. Reportedly, he seemed to improve over the next several hours before an acute decline in his health status. He complained of severe stomach pain and vomiting, which required urgent transportation back to the hospital. Upon arrival at the hospital, Gomez-Alonso was found to be in cardiopulmonary arrest. He was pronounced dead on December 24, 2018.

- December 18, 2018
  - 1525—Gomez-Alonso encountered entering the U.S. Border and transported to the first USBP station
- December 20, 2018
  - 1200—Gomez-Alonso transported to second USBP station due to overcrowding
  - Remained at second USBP station
- December 23, 2018
  - 2317—Gomez-Alonso transported to the third USBP station
- December 24, 2018
  - 0100–0557—Gomez-Alonso arrival and intake process complete at the third USBP station
  - 0900—Gomez-Alonso requires medical attention
  - 0930—Gomez-Alonso arrives at hospital
  - 1345—Gomez-Alonso diagnosed with Influenza B, provided with prescriptions for acetaminophen and amoxicillin and released from the hospital
  - 1700—Gomez-Alonso given medications back at the USBP station
  - 1800—Wellness check of Gomez-Alonso by USBP agents
  - 1930—Wellness check of Gomez-Alonso by USBP agents
  - 2100—Wellness check of Gomez-Alonso by USBP agents
  - 2145—Gomez-Alonso requests to return the hospital
  - 2200—USBP assigned transportation
  - 2258—Gomez-Alonso transported to the hospital
  - 2315—Gomez-Alonso arrives at hospital and receives emergency treatment
  - 2348—Gomez-Alonso is pronounced dead.

Autopsy and Post-Mortem Findings

Cause of Death.—Complications of Influenza B infection with Staphylococcus aureus superinfection and sepsis.

Manner of Death.—Natural.

Pathological Findings

I. Complications of Influenza B infection with Staphylococcus aureus superinfection and sepsis.

a. Clinical Findings at the Initial Hospital Visit
   i. Temperature—103.46°F
   ii. Peripheral Pulse—146 bpm
   iii. Oxygen Saturation (SpO_2)—91 percent
   iv. Influenza B—Test positive (12/24/2018)

b. Necrotizing Pneumonia (Pulmonary Hemorrhage and Edema)
   i. Bronchopneumonia, marked
      1. Diffuse alveolar damage

2. Bacterial blood and lung cultures positive for Methicillin Sensitive Staphylococcus aureus (MSSA)
   a. Immunohistochemical and Real-Time Polymerase Chain Reaction (RT–PCR)—Positive
   b. Panton-Valentine leucocidin (PVL)—Positive
3. Influenza B virus positive by Real-Time Polymerase Chain Reaction (RT–PCR).

Summary Opinion

The decedent is an 8-year-old male child who suffered complications of influenza viral infection associated with a superimposed bacterial disease. According to the Infectious Disease Pathology Branch (IDPB) of the Centers for Disease Control (CDC), the bacteria isolated were methicillin-sensitive Staphylococcus aureus (MSSA) with associated Panton-Valentine leucocidin (PVL) exotoxin. It is a significant factor that led to the death. MSSA is highly contagious, particularly in close quarters or conditions of overcrowding. PVL-positive MSSA is a severe infection, often associated with influenza disease, that leads to rapidly progressing necrotizing pneumonia.[6]

Based upon the review of material available to this forensic pathologist, it is my opinion that the cause of death should read Necrotizing pneumonia due to methicillin-sensitive Staphylococcus aureus complicating Influenza B viral infection. The manner of death is natural.

It is also my opinion that this death was preventable. Overcrowding is a known condition of the USBP stations. I believe the overcrowded conditions played a significant role in the decedent developing the infections that led to his death. Although the actions taken by individual US–CBP agents seem to be appropriate and timely, the larger US–CBP system lacks adequate human resources and physical infrastructure to respond to medically fragile detainees, especially children. There were many missed opportunities to provide life-saving care to this child, namely the hospital's mismanagement of his initial presentation. However, if a licensed medical professional (nurse practitioner, nurse, or physician assistant) would have cared for this patient throughout his stay within the detention station, the patient would have had a more informed assessment before presenting to the hospital during his initial visit and beyond.

The above opinion is established within a reasonable degree of medical certainty.

Recommendations

- Enforce and control the population in USBP stations to protect against overcrowding.
- Utilize medical personnel (physician, physician assistant, nurse practitioner, or nurse) for initial health assessment of detainees, especially children.
  - Update the initial medical assessment form (I–779) to be administered by licensed health care providers.
    - Accompanied by brief initial health screening including touchless temperature check, blood pressure, glucose finger stick, and COVID nasal swab.
- Develop an on-site clinic system for US–CBP that has the ability to triage pediatric patients (i.e. pediatric blood pressure cuffs).
- Establish electronic health record (EHR) for US–CBP.
- Assess and reevaluate training for US–CBP agents.
- Develop or improve emergency and acute care access standard operating procedure.

CONCLUSION

In conclusion, immediate and timely access to a health care assessment by licensed and trained medical professionals could have prevented the deaths of both Jakelin Caal Maquin and Felipe Gomez-Alonso. The deaths of these 2 children are a symptom of a more extensive system that requires much improvement. No system is perfect, but any system established by our Government must have at its core the health and safety of all who come into contact with it. There is an excellent opportunity to make the necessary investment to ensure life-saving medical care to sick men, women, and children. The cases of these 2 children remind us that deaths in custody are not merely a criminal justice issue, but a public health issue. We must treat those who die in the custody of our detention system as preventable, revealing a system that is able to improve.

[6] Karli A, Yanik K, Paksu MS, et al. Disseminated Panton-Valentine Leukocidin-Positive Staphylococcus aureus infection in a child. Arch Argent Pediatr. 2016;114(2):e75–e77. doi:10.5546/aap.2016.eng.e75

In 2017, the National Institute of Justice (NIJ) in collaboration with the RAND Justice Policy Program hosted an expert panel of prison and jail administrators, researchers and health care professionals entitled, *Caring for Those in Custody: Identifying High-Priority Needs to Reduce Mortality in Correctional Facilities.*[3] I had the pleasure of serving on this panel, and what we realized is that those who find themselves incarcerated, for whatever the reason, either arrive with or acquire health conditions that become the responsibility of the institution. We have an obligation to make sure that all who come into our custody receive timely, accurate, and reliable care. We must provide reliable care in the detention centers of our borders, but also on the streets of our cities, the jails of our counties, and the prisons of our States.

I appreciate the work that this committee is doing to solve this problem. I pray that this hearing does not only provide an "appearance" of addressing the issues that I have outlined, but is a true "call to action" with resolutions. This may require your dedication to this Nation beyond what is comfortable, but I believe it is attainable. Thank you, Chairman Thompson and Members of the committee. I am now available to answer any questions that you may have.

Chairman THOMPSON. Thank you, Doctor, for your testimony.

I now recognize Inspector General Cuffari to summarize his statement for 5 minutes.

STATEMENT OF JOSEPH V. CUFFARI, INSPECTOR GENERAL, U.S. DEPARTMENT OF HOMELAND SECURITY

Mr. CUFFARI. Good afternoon, Chairman Thompson, Ranking Member Rogers, and Members of the committee. Thank you for inviting me to discuss our work related to children in CBP custody.

My testimony today will include a discussion of our investigations of the deaths of the 2 migrant children while in CBP custody, the findings of our unannounced inspections of CBP facilities, and an overview of our data-driven, risk-based audits, inspections, and investigations.

No parent should have to go through the devastation of losing a child. My deepest condolences go out to the families who suffered this terrible loss. I am a parent and a new grandparent myself. I find the deaths of both children heartbreaking. Although they died within 18 days of each other and less than 100 miles apart, each circumstance was unique and our office conducted separate investigations. The scope of both investigations was to determine the circumstances of the in-custody deaths of the children, including any form of misconduct by CBP personnel.

We dedicated several special agents to each investigation, along with multiple support staff. We were augmented by CBP, OPR in one case. In total, we conducted 44 interviews between the 2 investigations, we reviewed voluminous medical records and reports. Neither investigation found misconduct or malfeasance on the part of CBP personnel. In fact, both investigations determined that the CBP employees involved exhibited great concern for the children's welfare and obtained medical treatment without delay.

During fiscal year 2019, CBP experienced a surge in families and unaccompanied children crossing the Southwest Border, and apprehended more than twice the undocumented aliens during fiscal year 2019, than in any other previous 4 full fiscal years. Our office has, for many years, conducted unannounced inspections at CBP facilities to evaluate their compliance with CBP's transport, escort, detention, and search standards known as your TEDS standards. During our unannounced visits, we focus our elements of the TEDS

standards that can be observed and evaluated by our inspectors without specialized law enforcement or medical training.

We recently issued a capping report summarizing our 2019 unannounced inspections. Our inspections found medical coverage varied by facility. The facilities we did visit generally met the TEDS standards for access to medical care. Nevertheless, crowded conditions presented health challenges, including containing the spread of contagious diseases. Given these observations, we have initiated an audit of CBP policies and procedures for handling medical intervention and detention. With the surge in apprehension in 2019, we observed more and severe overcrowding, and recommended that DHS take immediate steps to alleviate it. Our capping report supplemented that recommendation and made 2 additional recommendations related to telephone access to unaccompanied children and proper handling of detainee property.

DHS is on track to implement these recommendations by the end of this calendar year. Given our observations of detainees being held beyond the 72 hours generally permitted in TEDS standards, we also initiated a review which is on-going, to identify the key factors contributing to prolonged CBP detention.

We have more than 20 other on-going or planned projects reviewing ICE and CBP. We appreciate the committee's continued interest in our work and for Congress' robust funding this current fiscal year. With your increased funding, we are contracting for medical professionals to supplement our expertise across audits, inspections, and investigations. I am pleased to report this contract will be awarded in the next few weeks.

In October 2019, I personally observed the conditions at the Southwest Border when I visited DHS facilities and operations in both El Paso and the Tucson areas. Our office continues to monitor the situation at the border and recommend improvements to DHS programs and operations.

Mr. Chairman, this concludes my testimony. Thank you for the opportunity to discuss our important work here today and I am happy to answer your or the Members' questions that you may have. Thank you.

[The prepared statement of Mr. Cuffari follows:]

PREPARED STATEMENT OF JOSEPH V. CUFFARI

JULY 15, 2020

Chairman Thompson and Ranking Member Rogers, thank you for the opportunity to testify today about the Department of Homeland Security (DHS) Office of Inspector General's (OIG)'s work related to children in U.S. Customs and Border Protection (CBP) custody. My testimony today will include a discussion of our investigations of the tragic deaths of 2 migrant children while in CBP custody, our unannounced inspections of CBP facilities, and related on-going work.

OIG is organized into 3 operational elements: The Office of Investigations, comprised of special agents who investigate criminal and administrative misconduct on the part of DHS personnel, contractors, and grantees; the Office of Special Reviews and Evaluations, comprised of inspectors, analysts, and attorneys who inspect, evaluate, and review DHS programs and operations; and the Office of Audits, comprised of auditors and analysts who conduct financial, grant, and performance audits.

My testimony today includes work by all 3 of our organizational units; specifically, our special agents who investigated the circumstances of 2 children who died in CBP custody in December 2018; our inspectors who conduct unannounced inspec-

tions of CBP holding facilities; and our auditors who have on-going work relevant to the committee's interests here today.

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

INVESTIGATIONS OF THE DEATH OF CHILDREN WHILE IN CBP CUSTODY

On December 8, 2018, a 7-year-old girl from Guatemala died while in CBP custody. Subsequently, on December 25, 2018, an 8-year-old boy passed away while in CBP custody. DHS OIG Special Agents from our El Paso Field Office conducted 2 separate investigations to determine the circumstances of the in-custody deaths of both children, including any form of misconduct by CBP personnel, and if misconduct was found, to determine if it was criminal or administrative.[1]

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

Although the deaths of these 2 children occurred within 18 days of each other and less than 100 miles apart, each circumstance was unique and our office conducted separate investigations of each death. I will provide the committee a summary of each investigation, beginning with the death of the 7-year-old girl.

INVESTIGATION CONCERNING THE DEATH OF A 7-YEAR-OLD GIRL

The 7-year-old girl and her father entered the United States on December 6, 2018 and were apprehended by Border Patrol agents with a large group of undocumented aliens at Forward Operating Base (FOB) Bounds, near the Antelope Wells, New Mexico, Port of Entry. During intake processing, Border Patrol agents conducted brief medical assessrnents of all detainees in the group and memorialized the assessments on the required form (I–779). DHS OIG reviewed the form for the girl and found that it was signed by her father and reported that both the child and her father were in good health. Border Patrol made arrangements to transport the detained migrants by bus from FOB Bounds to the Border Patrol station in Lordsburg, New Mexico, 93 miles away, for further processing and for short-term detention. Because the group was large, the bus would need to make 2 round trips to transport them. Prior to transport, the group of undocumented aliens, to include the girl and her father, were asked again by Border Patrol agents if anyone was sick, pregnant, or was an unaccompanied child. DHS OIG was told that if anyone met these conditions, it was CBP's practice that they would be assigned to the first bus going to the Lordsburg station for processing. According to the interviews we conducted, no one came forward with these conditions.

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

According to our interviews, during transport to the Lordsburg station, the girl's father did not report to CBP that she was vomiting. However, according to interviews of the other bus passengers, the father did approach several other riders to ask for medicine for his daughter. When the bus arrived at the Lordsburg station, the child and her father were the first ones off the bus and were immediately met by the CBP paramedic on duty.

The girl's father reported to the paramedic that she was not breathing. After the paramedic performed a quick assessment, he determined that the child was breathing, but was having difficulty, and asked someone to call 911. Two additional CBP EMTs joined to assist with assessing and providing care to the child. Her father reported to the EMTs that she had not eaten and had been throwing up for the last

[1] These investigations were not intended to be systemic reviews that would evaluate CBP's policies or procedures for caring for migrants in custody or from which over-arching conclusions about CBP's role could be drawn. While these investigations were not program evaluations of CBP procedures, we do have an on-going audit regarding CBP's procedures for detained migrants experiencing serious medical conditions.

2 to 4 days. The paramedics took her temperature and discovered she had a fever of 105.7 degrees Fahrenheit. They administered oxygen with a mask and applied ice packs and wet towels in an attempt to cool her down. They were unable to provide children's Tylenol to the child because she could not swallow. Similarly, the paramedics were unable to intubate her because a manipulation of her mouth would have caused her to vomit.

County Emergency Medical Services (EMS) arrived approximately 10 minutes after the 911 call. The EMS staff performed life support measures, including oxygen and intravenous fluids, and recommended that the child be transported to the hospital by ground transport, which would have taken approximately 2 hours. Due to her worsening condition, the Lordsburg station paramedic recommended she be transported by air, to get her to the hospital faster. The air support was cleared to f1y and arrived at the Lordsburg station approximately 40 minutes after it was requested. The child was transported to El Paso Children's Hospital—a level I trauma center.

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

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

We dedicated 7 agents and 2 support staff to investigate her death. Our investigation included interviews with approximately 23 individuals who had direct contact with the child and her father, or may have witnessed her condition. These individuals included Border Patrol agents and apprehended detainees who had contact with the child and her father. We reviewed all audio and video evidence that was available; including 8 DVDs of video footage and recorded radio communications. We also reviewed the detailed medical examiner's report documenting the causes of death. Our investigation did not reveal any evidence of CBP employee malfeasance or misconduct.

INVESTIGATION CONCERNING THE DEATH OF AN 8-YEAR-OLD BOY

An 8-year-old boy and his father were apprehended in El Paso, Texa on December 18, 2018. They were processed at the Paso Dd Norte Station and then transferred to the El Paso Station due to detention space limitations. They remained at the El Paso Station until December 23, 2018, when they were transferred to Alamogordo, New Mexico to complete processing and then transferred to Highway 70 Alamogordo Checkpoint to await family placement.

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

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

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

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

hospital because his son was feeling ill again. A Border Patrol agent drove the child and his father to the Gerald Champion Regional Medical Center again.

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

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

DHS OIG received notice of the child's death from CBP's Office of Professional Responsibility (OPR), on December 25, 2018, and initiated an investigation into the circumstances surrounding the death that same day. Because this was the second death investigation of a child in CBP custody in a short time frame, and because a large number of OIG agents were already assigned to the investigation of the death of the 7-year-old girl, the OIG decided to leverage assistance from CBP OPR with conducting specific parts of the investigation, for example interviews.

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

Upon the conclusion of both investigations, we posted summaries of the investigations on our public website. While we are prohibited by privacy laws from posting full OIG reports of investigation, in an effort to be transparent about OIG's work, we determined in these instances that public summaries were appropriate. We provided both reports to the committee after receiving a written request from the Chairman. We have also provided 2 briefings to committee staff regarding the investigations, and exchanged written correspondence with the committee regarding several outstanding questions.

DHS OFFICE OF INSPECTOR GENERAL'S UNANNOUNCED INSPECTIONS OF CBP FACILITIES

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

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

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

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

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

use microwaves or warming ovens to heat frozen food or prepare other food items, such as instant soup or oatmeal.

OIG's unannounced inspections of CBP holding facilities evaluate compliance with TEDS and determine whether CBP provides reasonable care to detainees, from apprehension to holding. During our unannounced visits to ports of entry and Border Patrol facilities, we focus on elements of the TEDS standards that can be observed and evaluated by OIG inspectors without specialized law enforcement or medical training. These inspections are limited-scope compliance inspections and we report solely on observations of compliance or non-compliance with TEDS on the day and time of the inspectors' visit. As part of our inspections, we also review records and logs and interview a limited number of CBP personnel and, when possible, detainees.

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

We began our fiscal year 2019 unannounced visits of CBP facilities in April 2019. In the summer of 2019, we issued 2 Management Alerts and made 1 recommendation about issues we observed requiring DHS's immediate attention. We issued these interim reports because the conditions we observed posed a serious and imminent threat to the health and safety of both DHS personnel and detainees. These issues included dangerous overcrowding and prolonged detention of children and adults in both the El Paso and Rio Grande Valley sectors.[5]

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

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

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

During fiscal year 2019, CBP experienced a surge in families and UACs crossing the Southwest Border, with these 2 groups representing the majority of all Border Patrol apprehensions. These significant increases contributed to Border Patrol apprehending more than twice the undocumented aliens during fiscal year 2019 than in any of the previous 4 full fiscal years.

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

Despite the crowding, our interviews with detainees and observations of the facilities indicated that Border Patrol ensured detainees had ready access to potable water and toilets. We also observed an Border Patrol stations had food, snacks, juice, and infant formula available for children. All Border Patrol stations we visited also had basic hygiene supplies (e.g., toilet paper, diapers, and baby wipes). However, not all facilities had consistently provided children access to hot meals as required. Additionally, not all facilities we visited had showers or provided showers

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[4] Joint Explanatory Statement, *Consolidated Appropriations Act, 2019* (Pub. L. 116–6).

[5] *Management Alert—DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley* (OIG–19–51), *Management Alert—DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center* (OIG–19–46).

[6] *Capping Report: CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge* (OIG–20–38).

consistently to detainees approaching 72 hours in detention. Border Patrol had arranged temporary shower trailers for some, but not all, facilities. Some facilities without showers on-site provided "dry showers" (i.e., a wet wipe and dry wipe) to detainees.

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

Based on our observations, we recommended in one of our Management Alerts that DHS take immediate steps to alleviate the overcrowding at the El Paso Del Norte Bridge Processing Center.[7] CBP concurred with our recommendation and described its efforts to construct additional soft-sided structures to accommodate more detainees, as well as to open a Centralized Processing Center within 18 months. That recommendation remains resolved and open, meaning that OIG considers CBP's proposed corrective actions responsive to the recommendations.

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

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

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

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

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

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

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

In response to these observations, we made 2 recommendations to CBP. First, we recommended that CBP establish procedures for evaluating compliance with requirements to provide and document phone calls for unaccompanied alien children

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

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

in custody. Second, we recommended that CBP implement consistent guidance on how it handles detainee personal property.

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

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

However, overall, in the facilities we visited, we observed CBP staff members making an effort to care for the detained children. For example, we observed CBP personnel trying to provide the least restrictive setting available for children when possible (e.g., by leaving holding room doors open or cells unlocked), We also observed in most facilities CBP staff had purchased toys or snacks that appealed to children.

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

Provision of Medical Care at Short-Term Facilities Has Limits

Under TEDS standards, CBP agents and officers are also tasked with observing and reporting physical and mental injuries and illnesses for appropriate medical care. In addition, detainees should have access to emergency medical care and necessary medications. Although TEDS standards do not require CBP to have trained on-site medical staff in its holding facilities, in fiscal year 2014, Border Patrol established the Centralized Processing Center in the Rio Grande Valley and staffed it with contracted medical teams led by a nurse practitioner or physician's assistant. The Centralized Processing Center was the first CBP facility with an on-site medical team. Between 2014 and the end of 2018, CBP expanded the Centralized Processing Center's medical contract to provide medical staff and services at 5 additional Border Patrol stations. The contract included the services of an on-site medical team led by a nurse practitioner or physician's assistant, as well as an on-call physician, to provide basic care, refill prescriptions, and determine which detainees required care at a hospital or clinic. All other CBP facilities relied on CBP agents and officers to identify medical issues.

At the time of our inspections, medical coverage varied by facility, but the facilities we visited generally met the TEDS standards for access to medical care even in the crowded conditions.[9] Specifically, upon a detainee's entry into a CBP hold room, detainees were asked about, and visually inspected for, any sign of injury, illness, or physical or mental health concerns, and asked questions about any prescription medications. In addition, although TEDS does not require CBP to maintain on-site medical staff, due to initiatives bv CBP and the DHS Office of the Chief Medical Officer, 10 CBP facilities had on-site medical personnel handling medical assessments and triage. In the remaining facilities, CBP officers and agents, some of whom were emergency medical technicians (EMT), performed assessments in accordance with TEDS standards.

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

Most Border Patrol facilities we visited took steps to try to evaluate and respond to the medical needs of the sizable detainee population resulting from the increase in apprehensions. This included conducting medical screenings of all detainees before entrance into a facility, stocking common over-the-counter medications, and arranging dedicated appointment hours at local clinics. At several facilities we visited with on-site medical personnel, a medical team consisting of 2 to 4 staff questioned detainees about their health and conducted a physical assessment of each detainee before processing detainees for intake into the facility. In facilities without medical staff, CBP officers and Border Patrol agents medically assessed detainees by asking them about their health concerns, injuries, and medications.

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

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

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

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

Ports of Entry Generally Met TEDS Standards

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

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

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

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

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

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

ON-GOING OIG OVERSIGHT

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

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

- *CBP's Holding of Detainees Beyond 72 Hours*.—This evaluation's objective is to determine the causes leading to CBP's inability to comply with the general requirement to hold detainees in its custody for no more than 72 hours.
- *CBP's Processing of Asylum Seekers*.—We are reviewing CBP's handling of asylum seekers at ports of entry. The objective was to determine if CBP OFO was turning away those who present themselves for asylum at the ports of entry.
- *CBP's Use of Fiscal Year 2019 Appropriated Funds for Humanitarian Assistance*.—Our objective is to determine whether CBP has adequately planned for deployment, and is deploying, fiscal year 2019 appropriated funds quickly and effectively to address the humanitarian needs on the Southern Border.
- *CBP's Procedures for Detained Migrants Experiencing Serious Medical Conditions*.—Our objective is to determine whether CBP's policies and procedures safeguard detained migrants experiencing serious medical conditions while in custody.
- *Southern Border Detainee Transportation and Support*.—The objective is to determine how the migrant surge affected CBP staffing and its ability to secure the Southern Border.
- *Implementation of DHS's Streamlined Asylum Review Pilot Programs*.—The objective is to determine how DHS, especially CBP and USCIS, have implemented the Prompt Asylum Claim/Screening Review and Humanitarian Asylum Review Process (HARP) pilot programs.
- *Audit of CBP Border Security Technology and Infrastructure*.—We will assess the effectiveness of CBP's current tools and technologies to support Border Patrol's mission operations for preventing the entry of illegal aliens or inadmissible individuals who may pose threats to National security.
- *CBP Leadership's Knowledge of and Actions to Address Offensive Content Posted on Facebook by CBP Employees*.—The objective is to determine whether complaints were made to CBP leadership regarding the "I'm 10–15" or similar private Facebook group(s) prior to recent media reporting; which senior-level officials knew about the "I'm 10–15" or similar private Facebook group(s) prior to the July 2019 media reporting, when they became aware, and what they knew about the content; and what actions, if any, were taken to evaluate and address potential employee misconduct in the group.
- *U.S. Customs and Border Protection's Use of Canine Teams*.—The objective is to determine to what extent CBP's canine training approach and execution support the Canine Program mission.
- *U.S. Customs and Border Protection's Use of Force Near the San Ysidro, California Port of Entry on November 25, 2018 and January 1, 2019*.—Our objective is to review the circumstances surrounding the incidents and determine whether CBP complied with its use of force of policy.
- *Review of Removal of Separated Alien Families*.—Our work will determine whether ICE removed any parents without first offering them the opportunity to bring their separated children with them.

- *ICE's Use of Segregation in Detention Facilities*.—To determine whether ICE's use of administrative and disciplinary segregation across all authorized detention facilities complies with Departmental detention standards.
- *DHS DNA Collection*.—Our objective is to determine whether DHS law enforcement agencies collect DNA samples from arrested or detained persons as required by the Fingerprint DNA Act of 2005 and subsequent Department of Justice regulations.
- *DHS Management and Oversight of Immigration Hearings in Temporary Courts Along the Southwest Border*.—Our objective is to determine the extent to which DHS provides accurate hearing notices and facilitates immigration hearings at temporary courts in accordance with laws and regulations.
- *U.S. Immigration and Customs Enforcement Efforts to Combat Human Trafficking*.—Our objective is to determine the extent to which ICE identifies and tracks human trafficking crimes to save victims.
- *Review of July 2018 Family Reunifications Issues at Port Isabel Detention Center*.—Our objective is to determine whether children were held in vans for up to 39 hours, why that occurred, and whether ICE has taken steps to prevent it from happening again.
- *Unannounced Inspections of CBP Holding Facilities & ICE Adult Detention Facilities*.—Our objective is to continue conducting unannounced inspections of DHS and contract facilities to monitor DHS compliance with health, safety, and civil rights standards outlined in CBP's National Standards on Transport, Escort, Detention, and Search; and ICE's Performance-Based National Detention Standards.
- *CBP's Searches of Electronic Devices at Ports of Entry*.—Our objective is to determine to what extent CBP conducted searches of electronic devices at U.S. ports of entry in accordance with its standard operating procedures.
- *ICE's Efforts to Prevent and Mitigate the Spread of COVID–19 in its Facilities*.—Our objective is to determine whether ICE Enforcement and Removal Operations effectively managed the pandemic at its detention facilities and adequately safeguarded the health and safety of both detainees in their custody and their staff.
- *Early Experiences with COVID–19 at CBP Facilities*.—Our objective is to determine how CBP (Office of Field Operations and Border Patrol) is managing the COVID–19 pandemic at their facilities, with respect to both detainees in their custody and to their staff.
- *ICE Should Document its Process for Adjudicating Disciplinary Matters Involving Senior Executive Service Employees*.—Our objective was to evaluate U.S. Immigration and Customs Enforcement (ICE) policies and procedures regarding Senior Executive Service (SES) employee discipline after complaints were raised that a former ICE SES official received favorable treatment during disciplinary proceedings.
- *Assessing the Effectiveness of DHS's Joint Task Forces*.—Our objective is to determine whether DHS has effectively managed and coordinated its Joint Task Forces (JTF) resources to accomplish the JTFs' intended mission.
- *CBP's Covert Testing Efforts*.—Our objective is to determine whether CBP's covert tests identify vulnerabilities at ports of entry and borders and whether CBP uses the test results to address identified vulnerabilities and shares lessons learned throughout the component.

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

Chairman THOMPSON. Thank you very much for your testimony. I now recognize our next witness for 5 minutes.

STATEMENT OF REBECCA GAMBLER, DIRECTOR, HOMELAND SECURITY AND JUSTICE, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. GAMBLER. Good afternoon, Chairman Thompson, Ranking Member Rogers, and Members of the committee. I appreciate the opportunity to participate in today's hearing to discuss GAO's work on CBP efforts to provide medical care to those in its custody along the Southwest Border. My remarks are based on a report GAO is releasing today, and a legal decision we issued last month address-

ing issues related to CBP's use of funds for and efforts to provide medical care.

I will be covering 3 areas from the report and legal decision. First, CBP's use and oversight of funds it received for consumables and medical care under the fiscal year 2019 emergency supplemental appropriations. Second, CBP's efforts to enhance medical care. Third, CBP's reporting of deaths in its custody.

First, last summer, the Fiscal Year 2019 Emergency Supplemental Appropriations Act was enacted to provide for humanitarian assistance and security at the Southwest Border. The act required that CBP use certain funds for specific purposes which are referred to as line items. One of the line items in the act was consumables and medical care. We found that CBP obligated some funds in the line item for consumable and medical care goods and services, like food and hygiene products, masks, and gloves.

However, CBP also obligated some of the funds for other purposes like goods and services for its canine program, equipment for facility operations, like printers and speakers, and facility upgrades and services. We found that these obligations violated an appropriation law known as the purpose statute, because CBP obligated funds from the consumables and medical care line items for some goods and services that were not consistent with the purpose of that appropriation. We concluded that CBP should adjust its accounts accordingly.

We identified 2 factors that contributed to CBP's violations: No. 1, insufficient guidance to CBP offices and components before obligations were made and a lack of oversight roles and responsibility for reviewing obligations once made. We recommended that CBP develop and implement additional guidance and establish oversight roles and responsibilities to ensure supplemental funds were obligated consistent with their purposes. CBP concurred with these recommendations.

Second, CBP has taken various steps to enhance medical care and services for individuals in its custody. These steps include increasing its use of contracted medical care providers, issuing new health screening policies, and requesting the CDC assess conditions and make recommendations for the reduction of influenza in CBP facilities among other things.

As a more specific example of CBP's efforts, in 2019, CBP issued interim and updated medical care directives, which, among other things, required health interviews and medical assessments for certain groups. In March 2020, CBP issued implementation plans for these directives.

While these are positive steps, we found that CBP has not consistently implemented its enhanced medical care policies and procedures. For example, we found that some CBP locations were not consistently conducting health interviews and medical assessments as required by the medical directives. CBP also has not documented how it made its decision not to offer influenza vaccines to those in its custody as recommended by the CDC. We recommended that CBP develop and implement oversight mechanisms and document what information it is using to assess whether to offer the influenza vaccine to individuals in custody. CBP concurred with these recommendation.

Finally, CBP is supposed to report information on deaths of individuals in its custody to Congress. We have reviewed CBP's documents and reports for fiscal years 2014 through 2019, and found that 31 individuals died in custody along the Southwest Border during that period. However, CBP only documented 20 deaths in its Congressional reports. We recommended that CBP ensure reliable information on deaths in custody is reported to Congress, and appropriate documentation on such reporting is maintained. CBP concurred with this recommendation.

In closing, while CBP has taken steps to enhance its medical care efforts, our work has identified a number of areas requiring additional attention to ensure that CBP is appropriately using supplemental funds it receives, overseeing medical care efforts, and reliably reporting information on deaths in custody to Congress. Going forward, we will be monitoring CBP's actions to address our recommendations.

This concludes my prepared statement, and I am pleased to answer any questions Members may have.

[The prepared statement of Ms. Gambler follows:]

PREPARED STATEMENT OF REBECCA GAMBLER

WEDNESDAY, JULY 15, 2020

SOUTHWEST BORDER.—CBP SHOULD IMPROVE OVERSIGHT OF FUNDS, MEDICAL CARE, AND REPORTING OF DEATHS

GAO–20–680T

Chairman Thompson, Ranking Member Rogers, and Members of the committee: We are pleased to be here today as you examine issues related to U.S. Customs and Border Protection's (CBP) care and custody of adults and children. Beginning in fall 2018, the Department of Homeland Security's (DHS) CBP experienced a significant increase in the number of individuals apprehended at or between U.S. ports of entry along the Southwest Border, resulting in overcrowding and difficult humanitarian conditions in its facilities.[1] From December 2018 through May 2019, 3 children—ages 7, 8, and 16—died in CBP custody, prompting questions about CBP's medical screening and care of those in its custody. In July 2019, an emergency supplemental appropriations act (2019 Emergency Supplemental) was enacted, providing additional funds to CBP to respond to the significant increase in Southwest Border apprehensions, including approximately $112 million for "consumables and medical care."[2]

CBP is the lead Federal agency charged with, among other things, ensuring the detection and interdiction of persons unlawfully entering or exiting the United States.[3] Within CBP, the U.S. Border Patrol (Border Patrol) apprehends individuals between ports of entry, and CBP's Office of Field Operations (OFO) encounters inadmissible individuals who arrive at ports of entry. Border Patrol and OFO detain individuals at short-term holding facilities to complete processing, which involves collecting information about the apprehended individual, including any potential health concerns. While individuals are held at CBP facilities—either by Border Pa-

[1] See, for example, Department of Homeland Security, Office of Inspector General, *Management Alert—DHS Needs to Address Dangerous Overcrowding and Prolonged Detention of Children and Adults in the Rio Grande Valley* (Redacted), OIG–19–51 (Washington, DC: July 2, 2019); *Management Alert—DHS Needs to Address Dangerous Overcrowding Among Single Adults at El Paso Del Norte Processing Center* (Redacted), OIG–19–46 (Washington, DC: May 30, 2019); and *Acting Secretary McAleenan's Prepared Remarks to the Council on Foreign Relations* (Washington, DC: Sept. 23, 2019).

[2] See Pub. L. No. 116–26, title III, 133 Stat 1018, 1019–1020 (2019). Supplemental appropriations are laws enacted to address needs that arise after annual appropriations have been enacted. In the context of CBP's appropriation, the term "consumable" refers to goods that are exhausted by use, and the phrase "medical care" includes goods and services used to provide assistance related to the diagnosis and treatment of disease or injury and maintaining health. B–331888, June 11, 2020, at 4.

[3] See 6 U.S.C. § 211(c).

trol or by OFO—CBP personnel typically place individuals in a secure holding cell or room while these individuals await transfer of custody to another agency, removal from the country, or release into the United States.[4]

Our remarks are based on our report, released today, entitled *Southwest Border: CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths.*[5] Specifically, we will summarize the report's key findings on: (1) The extent to which CBP obligated and conducted oversight of funds for consumables and medical care; (2) steps CBP took to enhance medical care; (3) the extent to which CBP implemented and oversaw its medical care efforts; and (4) the extent to which CBP has reliable information on, and reported, deaths, serious injuries, and suicide attempts of individuals in custody. For the report, we reviewed CBP documentation, including financial reports; directives, policies, and training related to screening individuals for medical issues; and directives and policy documentation on reporting deaths in custody. We interviewed CBP officials in headquarters and 2 field locations and observed medical efforts in facilities in field locations, selected based on higher volumes of apprehensions. Additional information on our scope and methodology is available in our report.[6] The work on which this statement is based was performed in accordance with generally accepted Government auditing standards.

CBP OBLIGATED SOME CONSUMABLES AND MEDICAL CARE FUNDS FOR OTHER PURPOSES IN VIOLATION OF APPROPRIATIONS LAW

We found that, as of May 2020, CBP had obligated nearly $87 million of the approximately $112 million it received specifically for consumables and medical care in the 2019 Emergency Supplemental.[7] CBP obligated some of these funds for consumable goods and services, like food and hygiene products, as well as medical care goods and services such as defibrillators, masks, and gloves. However, in June 2020, we concluded that CBP violated an appropriations law, known as the purpose statute, when it obligated funds from the 2019 Emergency Supplemental consumables and medical care line item appropriation for some goods and services that were not consistent with the purpose of that line item.[8] Specifically, we found that some of the goods and services did not clearly fall within the ordinary meaning of the terms "consumable" or "medical care," nor did they bear a reasonable and logical relationship to the purpose of the line item. For example, we found that CBP violated the purpose statute when it obligated some of these funds for goods and services for its canine program; equipment for processing individuals apprehended by CBP, like printers and speakers; and various upgrades to computer networks used for border enforcement activities. CBP also obligated the consumables and medical care line item for transportation items. We concluded that obligations for certain transportation-related items that were not primarily used to provide medical services violated the purpose statute.[9]

We identified 2 factors that contributed to CBP's purpose statute violations—insufficient guidance to CBP offices and components before obligations were made and lack of oversight roles and responsibilities for reviewing obligations once made.

- *Insufficient guidance on the purpose of the funds.*—After the 2019 Emergency Supplemental was enacted, CBP did not provide sufficient guidance explaining how offices and components could obligate funds for consumables and medical care and, as a result, some offices and components may not have understood that there were limitations on how they could use those funds. For example, officials from one CBP component stated they believed they could use the consumables and medical care funds for any goods or services they considered to be in the interest of individuals in custody or that would help ensure the efficient processing of individuals.

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[4] CBP policy states that individuals should generally not be held for longer than 72 hours in CBP custody. CBP refers individuals to DHS's U.S. Immigration and Customs Enforcement (ICE) for long-term detention. If CBP apprehends a child that is designated as an unaccompanied alien child, that child is transferred to the custody of the Office of Refugee Resettlement within the Department of Health and Human Services (HHS).

[5] GAO, *Southwest Border: CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths,* GAO–20–536 (Washington, DC: July 14, 2020).

[6] GAO–20–536.

[7] In general, an obligation is a commitment by the Government that creates a legal liability to pay for goods or services it orders or receives.

[8] GAO, *U.S. Customs and Border Protection—Obligations of Amounts Appropriated in the 2019 Emergency Supplemental,* B–331888 (Washington, DC: June 11, 2020). Under the purpose statute, appropriations are to be used only for the purposes for which they are made, except as otherwise provided by law.

[9] B–331888, June 11, 2020, at 5–6.

- *Lack of oversight roles and responsibilities*.—CBP offices and components took some steps to conduct oversight of obligations from the 2019 Emergency Supplemental funds, but we identified gaps in CBP's roles and responsibilities for reviewing obligations to ensure they were consistent with the intended purpose of the funds.[10] For example, officials from CBP's Office of Finance stated that they were not responsible for determining whether obligations were consistent with the purpose of the line item and relied on components to make such determinations. However, of the 5 components that obligated funds from the consumables and medical care line item appropriation, only 1—Border Patrol—reviewed obligations to determine whether they were consistent with the purpose. Further, Border Patrol's review was limited in scope because it did not include all obligations Border Patrol made using this line item. For example, Border Patrol did not request obligation data on goods and services purchased by its canine office.[11]

DHS and CBP officials stated that the agency experienced challenges managing some aspects of the funds from the 2019 Emergency Supplemental due to a lack of experience with these line items and the large increase of apprehensions on the Southwest Border occurring at the time. Specifically, officials from DHS's Office of the General Counsel and CBP's Office of Chief Counsel noted that CBP typically receives an annual lump-sum appropriation, which provides the agency with broader discretion in determining the use of funds as compared to the 2019 Emergency Supplemental, which specified how CBP could use the funds through line items. As such, these officials stated that CBP did not have systems in place to ensure that the funds were obligated consistent with the purpose of the line item. Our report recommended that CBP develop and implement additional guidance for ensuring that funds appropriated for a specific purpose are obligated consistent with their purpose, and establish oversight roles and responsibilities to ensure that such funds are obligated consistent with their purpose. DHS agreed with these recommendations and said it plans to issue additional guidance and outline new oversight roles and responsibilities within its standard operating procedures document.

CBP INCREASED CONTRACTED MEDICAL PROVIDERS, ISSUED NEW SCREENING POLICIES, AND ENGAGED ENTITIES WITH MEDICAL EXPERTISE IN 2019

We found that, throughout 2019, CBP took various steps to enhance medical care and services to individuals apprehended and held at its facilities. These steps included increasing the number of facilities that have on-site contracted medical providers from 6 locations in December 2018 to 42 in December 2019 and issuing new health screening policies. In particular, in January 2019, CBP issued an interim directive which, among other things, required health interviews and medical assessments for certain individuals in its custody.[12] CBP updated this directive in December 2019 and issued corresponding implementation plans in March 2020.

Additionally, CBP engaged with various entities to leverage their expertise and coordinate efforts. Two entities with medical expertise—the Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services (HHS) and the American Academy of Pediatrics (AAP)—also provided recommendations or assistance with the development of training. At the request of DHS, CDC teams visited Border Patrol facilities in December 2018 and January 2019 to assess conditions and make recommendations for the collection of data on, and to reduce the spread of, infectious diseases, particularly respiratory diseases such as influenza. Based on these visits, CDC provided DHS with recommendations to address immediate needs for protection and care related to respiratory infections and to prepare for future influenza seasons.[13] In addition, CBP requested, and the AAP developed, a short training video on recognizing the signs of a child in medical distress. CBP issued the training in late September 2019 as part of a 35-minute training for CBP emergency medical technicians and paramedics.

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[10] While CBP officials stated that individual components had processes in place to review individual obligations before they were made, the agency had not provided guidance regarding the purpose of the individual line items, as noted above.

[11] CBP's canine program is responsible for terrorist detection and apprehension and the detection and seizure of controlled substances and other contraband, among other functions.

[12] A health interview is a standardized medical questionnaire for individuals in CBP custody. A medical assessment is an evaluation of an individual by a health care provider to assess medical status.

[13] These recommendations are summarized in our report. See GAO–20–536.

CBP'S IMPLEMENTATION AND OVERSIGHT OF MEDICAL CARE EFFORTS HAS BEEN INCONSISTENT

While CBP has taken steps to enhance medical care for those in its custody, we found gaps in CBP's implementation and oversight of its efforts. For example, we found the following:

- *Inconsistent implementation of enhanced medical care policies and procedures.*—Through facility visits and analysis of CBP data, we found that some CBP facilities along the Southwest Border were not consistently conducting health interviews and medical assessments, as required by the medical directives. Our review of Border Patrol records from a 1-week period in February 2020 found that 143 of 373 apprehended children under age 18 who were processed at Border Patrol stations without contracted medical providers did not receive a health interview or medical assessment referral at those stations. This included 116 children under age 13, and 27 children ages 13 through 17. When we notified CBP of these issues, CBP officials said that they found that most of the 143 children in question had received a health interview or medical assessment elsewhere, though some children had not. CBP officials indicated they were previously unaware of these issues and had not determined why they occurred.
- CBP did not document how it weighed costs and benefits in deciding not to offer the influenza vaccine. CBP decided not to implement a recommendation from CDC to offer influenza vaccines to individuals in custody but did not document how it arrived at this decision. For example, CBP documentation cited operational, medical, legal, and logistical challenges to vaccinating apprehended individuals for influenza. CBP officials told us that they considered these factors with DHS and that the Department overall decided not to offer the vaccine to apprehended individuals. However, CBP did not document how the agency weighed the costs or potential benefits of offering the influenza vaccine. For example, CBP could not provide documentation on how it determined that costs—such as providing cold storage at CBP facilities to support vaccines, hiring additional medical staff, or maintaining additional medical records related to offering influenza vaccination—would be significant. CDC officials we spoke with stated that they believed these challenges and costs could be addressed.

CBP officials also stated that they believed that offering the influenza vaccine to individuals in custody would provide little benefit to the agency since it is CBP's goal to transfer individuals out of its custody within 72 hours, while the influenza vaccine requires 14 days to take effect. However, CBP officials also stated that they have no control over how long individuals may remain in CBP custody when there is a lack of capacity at ICE facilities. In May and June 2019, the DHS Office of Inspector General found serious overcrowding and prolonged detention in Border Patrol facilities in Texas because CBP could not transfer individuals in custody out of its facilities in a timely manner, as both ICE and HHS were operating at or above capacity.[14] For example, the DHS Office of Inspector General found that some adults were held as long as a month and some children held for 2 weeks.

CBP made its initial decision not to offer vaccines to those in its custody prior to the Coronavirus Disease 2019 (COVID–19) pandemic. Since that time, CDC has noted additional benefits of offering the influenza vaccine. Additionally, since CBP made its initial decision, CBP officials stated that they continue to meet with other DHS officials on public health issues, including how to prevent the spread of influenza in its facilities. Officials told us that they will use this forum to continually reassess whether to offer influenza vaccines to individuals in its custody.

- *CBP does not provide officers and agents with training to identify medical distress in children.*—CBP policies require officers and agents to identify potential medical issues in all individuals, including children, but CBP has not developed and implemented training for agents and officers on identifying medical distress in children. According to AAP representatives, recognizing medical distress in children in a timely fashion is important because children can fall severely ill faster than adults and are less able to communicate about their illness. CBP officers and agents take 2 first aid courses as part of their initial training, but these courses do not include information specifically related to identifying medical distress in children—such as through changes in skin tone or crying patterns.

  CBP and AAP developed a training video on recognizing medical distress in children, which CBP included as part of its training for emergency medical tech-

[14] See OIG–19–46 and OIG–19–51.

nicians and paramedics as noted above.[15] CBP officials told us that the agency has not provided the training video to all officers and agents because they believed it was too technical, though it is available to officers and agents as an optional continuing education course. CBP officials stated that they have considered offering training on recognizing medical distress in children to all officers and agents who may come into contact with children in custody, but have not begun to take steps to develop and implement such training.

Our report recommended that CBP develop and implement oversight mechanisms for its policies and procedures relating to medical care; document what information it uses to assess whether to offer the influenza vaccine to individuals in custody; and develop and implement training on recognizing medical distress in children for all officers and agents who may come in contact with children. DHS agreed with our recommendations and said it plans to clarify performance metrics, targets, and corrective actions; consider how to best document whether to offer the influenza vaccine to individuals in custody; and develop and implement training on recognizing medical distress in children.

CBP HAS TAKEN STEPS TO CLARIFY RESPONSIBILITIES AND PROCEDURES FOR REPORTING DEATHS IN CUSTODY, BUT REPORTING GAPS REMAIN

From fiscal year 2015 through fiscal year 2019, CBP was directed to report deaths of individuals in its custody to Congress.[16] We reported that while CBP has taken steps to revise its policies and procedures for reporting deaths in custody, the agency has not consistently reported deaths to Congress, as directed, or maintained documentation of such reporting. Our review of CBP documentation and reports to Congress showed that 31 individuals died in custody along the Southwest Border from fiscal years 2014 through 2019, and CBP provided documentation that it reported 20 to Congress. Additionally, when CBP reported deaths to Congress, it did not always report them in a timely manner. For example, for fiscal years 2016 through 2019, CBP was directed to report all deaths in custody within 24 hours. However, CBP was unable to substantiate that the agency met the 24-hour requirement for fiscal years 2016 and 2017. Further, in December 2018, CBP reported to Congress the death of a 7-year-old girl who died in Border Patrol custody 4 days after the 24-hour window for notification had passed. Moreover, CBP was directed to provide annual information on deaths in custody for fiscal year 2017 but did not provide this information until March 2019.

CBP officials attributed these reporting issues to a lack of defined responsibilities and procedures. In December 2018—recognizing the need for more consistent and timely reporting—the CBP Commissioner issued a memorandum outlining interim policy and procedures for notifications of a death in CBP custody. However, we found that field personnel have not consistently followed those procedures, which resulted in at least one late notification to Congress, and CBP could not provide documentation that it had notified Congress of an additional 2 deaths that had occurred after the issuance of the memorandum.[17] Officials stated that this may have been due to a lack of awareness about the December 2018 memorandum reporting requirements. Our report recommended that CBP ensure that reliable information on deaths in custody is reported to Congress and that appropriate documentation on such reporting is maintained. DHS agreed with this recommendation and said it is reviewing and updating procedures to ensure deaths in custody are reported to Congress as appropriate.

In summary, CBP has taken some steps to improve its care and custody of adults and children, but the agency needs to increase oversight of the use of funds, medical care, and reporting of deaths. By implementing our report's recommendations, CBP has the opportunity to provide additional guidance and oversight of appropriated funds; develop and implement oversight mechanisms related to medical care policies; document decisions made regarding offering the influenza vaccine; and provide guidance to ensure that deaths in custody are reported to Congress, as directed.

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[15] As of April 2020, CBP could not provide information on how many of its CBP emergency medical technicians and paramedics had taken this training. There are approximately 1,200 emergency medical technicians and paramedics that work on the Southwest Border.

[16] The Congressional reports accompanying annual Department of Homeland Security's appropriations acts for fiscal years 2015 through 2019 direct DHS to report certain information on deaths in custody within specific time frames to the appropriations committees. For more information, see table 4 of our report, GAO–20–536. Additionally, in fiscal year 2014, DHS was directed to provide information on deaths in custody in summary statistics to the appropriations committees. See House Rep. No. 113–91 (2013).

[17] CBP officials stated they may have notified Congress by telephone.

Chairman Thompson, Ranking Member Rogers, and Members of the committee, this concludes our prepared remarks. We would be pleased to respond to any questions that you may have at this time.

Chairman THOMPSON. Thank you for your testimony. I thank all the witnesses for their testimony. I remind each Member that he or she will have 5 minutes to question the panel.

I now recognize myself for questions. To Mr. Cuffari, as you know, we sent a letter to you asking for a number of things, the committee. You sent it back, we reviewed it. After we sent our response back, you revised the public summary. Why didn't the original public summary include any reference to influenza as a cause of death?

Mr. CUFFARI. Mr. Chairman, you are correct. In the interest of privacy, initially we included a high-level summary of information on our public website regarding the deaths of the 2 children. Subsequently at your request, we made an adjustment to that public summary to include a diagnosis of influenza B, and to indicate that our investigation did not reveal Border Patrol were aware of that diagnosis.

I would like to add that this is the very first time that we have done public summaries in this fashion, and we wanted to make sure that we got it right the first time. We thought it was appropriate to basically err on the side of privacy for the children. Now, out of deference to you, sir, we added and made those minor corrections.

Chairman THOMPSON. Well, I thank you. So have you noted on your website, or the summary itself, that the summary has been revised?

Mr. CUFFARI. Yes, sir. We did that the same day. We made the updates and sent those to your staff.

Chairman THOMPSON. Thank you very much. With respect to your review of the initial death, did you have qualified medical professionals on your review team?

Mr. CUFFARI. No, sir. Just to clarify for the committee's consideration, those 2 reviews were actually investigations conducted by our office of investigation of the 2 deaths of the children in custody. We didn't have, at the time, any medical professionals available from for staff. But as I indicated in my opening statement, based on the enhanced funding that you provided this past fiscal year, we are contracting out to have a team of health care professionals augment any of our on-going or projected work in the future, audits, inspections, and investigations.

Chairman THOMPSON. So at the time based on what you just said, and of your review of the deaths, you did not have on staff or contracted any medical personnel?

Mr. CUFFARI. No, sir.

Chairman THOMPSON. Dr. Mitchell, you have heard my question. In your professional opinion, do you think, if you are looking at a death of any kind that a medical personnel would be important to the team?

Dr. MITCHELL. Yes, absolutely. I think that, especially deaths in custody, deaths in custody require fatality reviews. Most fatality review panels need to be multidisciplinary. Therefore, you are going to get the recommendations. So it is going to really depend

upon what you are trying to get out of investigation. But from a fatality review construct, you need to not only have clinicians, like pediatricians if it is a child death, internists if it is an adult death, but also a forensic pathologist or a medical examiner, so they would be able to interpret the findings at autopsies. All of that is going to be required in the future. It is going to be helpful.

Chairman THOMPSON. Thank you very much. Mr. Cuffari, according to your report, Border Patrol agents stated they were in contact via text message when Felipe was transported to the hospital the first time, the morning of December 24. Do you have copies of any of those text messages in your file?

Mr. CUFFARI. To my knowledge, sir, no, we do not.

Chairman THOMPSON. So you put in a report information that you could not document?

Mr. CUFFARI. We documented, sir, the testimony from the Border Patrol agents and their supervisors. All credible testimony.

Chairman THOMPSON. I understand that, but nobody thought to get a copy of the text messages or anything like that?

Mr. CUFFARI. Not to my knowledge.

Chairman THOMPSON. Well, did the inspector general's office pull or review any emails or other electronic messages involving CBP personnel regarding Felipe's care or death?

Mr. CUFFARI. Not to my knowledge, sir.

Chairman THOMPSON. Thank you.

I now recognize the Ranking Member of the full committee for questions.

Mr. ROGERS. Thank you, Mr. Chairman. I think it would be productive if I yield my time to my colleague from Tennessee, Dr. Mark Green.

Chairman THOMPSON. The gentleman from Tennessee is recognized for 5 minutes.

Mr. GREEN of Tennessee. Chairman, Ranking Member, and witnesses, thank you. The hardest part about being a doctor is sometimes you do everything you can for a patient, and they still die. Mr. Chairman, I would like to introduce myself. There are a few things I have never shared, but today it is important I do so.

I graduated in the top third of my med school class, attended the No. 1 emergency medicine residency training program in the Nation. All 3 years in residency, we scored No. 1 in the Nation. Yes, we beat those Harvard doctors too. I deployed all over the world in some of the most remote places in the planet, provided medical care to children of Afghani villagers, and battle-hardened Navy SEALs and delta operators. I have never been sued for malpractice, I have served as medical director of 4 different emergency departments in 3 States ranging from depressed rural to a level 2 trauma center.

I was CEO of a company of emergency physicians, and PAs, and nurse practitioners, that ran 52 emergency departments in 11 States. I have served as both defense and plaintiff expert on tons of med mal cases doing exactly this, forensically assessing care given.

In this case, first by CBP and then medical facilities. Both of these cases are about pediatric sepsis. First, a few facts about ped sepsis, a review of the medical literature on sepsis recounted 4

studies in the United States that found that even when a patient goes to a state-of-the-art emergency department, the mortality rate for sepsis in America was 10.3 percent in one, 8.9 percent in another, 14.4 percent, and 19 percent respectively. Even when these patients present to EDs in the United States, many still die.

Why is this disease process so hard to treat? Well, like Dr. Danaher said in her testimony, children don't look bad until the very end. When I trained EM residents, we called it the pediatric cliff. They look great and then crash in seconds. I appreciate the written testimony of our pathologist who honestly reported that in both cases he felt, "The actions taken by individual U.S. CBP agents seem to be appropriate and timely". I affirm from this that Dr. Mitchell understands that standard of care depends on where you are and the facilities available.

Dr. Danaher's testimony is disconnected from this idea. The reality of rural health care is millions of Americans aren't able to walk into a Harvard quality care. The standard of care at Mass General on a given day will never be comparable to triaging 160 migrants in the dark of the night in Antelope Wells.

Dr. Mitchell's testimony is balanced and professional. It is not political hyperbole, but it does suggest that the Federal Government has the ability to deploy doctors to remote areas of the border, interview migrants about their health, and do a variety of tests which is simply unrealistic.

Dr. Danaher's written testimony is blatantly partisan. She critiques the conditions of CBP facilities going on about lack of toothbrushes and clean water. I know from my own visits, the CBP facilities and the facts in these cases, those allegations are simply false. She also discusses the psychological dynamic of the data of one patient to not share information to agents as if that environment is the law enforcement officer's fault. That dynamic existed because of crossed the border illegally, and then didn't tell agents that Jakelin was sick, even when they repeatedly asked him.

If a patient presents to an ED in the United States and lies about their medical condition, it is not the doctor's fault.

Look, both of your testimonies center around getting more resources. The bottom line, you want more doctors and electronic medical records. Just published yesterday new estimates of doctor shortages in the United States. The United States is short 14,494 doctors. Where in the world are we going to get doctors to put somebody at every single crossing site? This testimony proposes building health care infrastructure for illegal immigrants that would dwarf the health care systems in 77 percent of rural counties in America.

Last year, House Democrats voted to advance an electronic medical record to illegal immigrants within 90 days when veterans in many States still don't have it, and won't have it for 7 years.

Finally, this side of the aisle spent all of last year highlighting how dangerous the journey to our border is for kids. The answer is not to turn CBP stations into Mass General. We have to break the cartels that entice people to come here with children and fix our immigration law loopholes. Until we do that, smugglers will continue to turn a profit over enticing families to come to our border with false promises.

Mr. Chairman, I yield.

Chairman THOMPSON. Thank you very much.

The Chair now recognizes other Members for questions they may wish to ask witnesses. As previously outlined, I will recognize Members in the order of seniority, alternating between Majority and Minority. Members are reminded to unmute themselves when recognized for questioning, and to the extent practical, to leave their cameras on so they are visible to the Chair.

The Chair now recognizes, 5 minutes, the gentlelady from Texas, Ms. Jackson Lee.

Ms. JACKSON LEE. Mr. Chairman, thank you for holding this very important hearing. Thank you to the Members of the—witnesses who are here as well who have provided very important testimony.

All of us were shocked to learn in December 2018 that 2 children died in separate incidents while in the custody of U.S. Border Patrol, which are the first deaths of children in Border Patrol custody in more than a decade. I am going to be very clear that when you lead a Nation, all that happens, whether you like it or not, falls at your feet. I have known Border Patrol agents and visited with them in my State of Texas for decades. I have seen their passion. I have seen them buy baby food and formula.

Where this tragedy falls is clearly at the feet of an administration that is inattentive and does not recognize that we are to comply with the international protocols of human rights and human decency.

Following the deaths of those 2 children in 2018, U.S. Customs and Border Protection, the Border Patrol parent agency, issued an interim directive in January 2019 establishing new medical screening and other procedures. I physically went down to the border and saw the immediate emergency tactics that were used. It was a table and the use of Coast Guard doctors. They all meant well.

Dr. Danaher, thank you for your leadership. My question: As all of this falls at the feet of the President of the United States and the administration and we have to adhere to human rights protocols, can you please elaborate on the differences between pediatric disease processes and adult disease processes so you know that a child may be sick and why understanding the nuances of each is important, especially in these situations?

Dr. Danaher.

Dr. DANAHER. So children are physiologically different from adults. They can compensate in different ways for infection than adults can. As Dr. Green mentioned, when they are sick, they can look well for quite a while before they crash. That is all very true.

So I think it is really, really important for there to be pediatric expertise at the border. That does not necessarily have to mean pediatricians. It means intense training for the EMTs who are already working with the vulnerable people. Currently, EMTs in New Mexico helping children who are apprehended only get about 10 percent of their training dedicated to pediatrics, which only amounts to a few hours.

So it is incredibly important to be able to recognize when children get sick. They definitely look different.

Ms. JACKSON LEE. You understand that Border Patrol agents are not doctors, they are not EMTs, they are not nurses, correct?

Dr. DANAHER. Correct.

Ms. JACKSON LEE. So it would be your view that minimally, a Nation as powerful, as rich as the United States, could recognize the importance of those nuances and have a system in place that would deal with pediatric issues or children who are in life-and-death situations?

Dr. DANAHER. Yes, yes.

Ms. JACKSON LEE. I didn't hear you. I'm sorry.

Dr. DANAHER. Yes, yes.

Ms. JACKSON LEE. Thank you.

To the inspector general, Mr. Cuffari, you did a report there was some suggestion that CBP officers try to engage with the parent. Do you know what language they spoke to Jakelin's father?

Mr. CUFFARI. I believe, ma'am, Jakelin father indicated on his in-processing paperwork that he was fluent in the Spanish language and the Border Patrol agents spoke to him in Spanish.

Ms. JACKSON LEE. My understanding is that he spoke his indigenous language, K'iche'. Did anyone try to speak to him in that language to make sure he understood?

Mr. CUFFARI. Not to my knowledge, ma'am.

Ms. JACKSON LEE. So what elements of change would you recommend, or did you recommend, in light of the 2 deaths of children that had never happened, and it certainly didn't happen with the mass migration during the Obama administration.

Mr. CUFFARI. We actually—as I mentioned in my opening statement, we have 3 on-going projects to look at the matters that you just asked about. These are 3 of 21 that I had in my prepared statement. We will make recommendations based on what our findings are at the time and hold DHS accountable for implementing those recommendations.

Ms. JACKSON LEE. The recommendations that you are looking to is framed around 2 deaths, and as well, no response timely enough to save those lives?

Mr. CUFFARI. We are looking at the circumstances that surrounded the deaths, the medical care, and the access that is capability of being provided by DHS to the children who are in custody, as well as to other adults, et cetera.

Ms. JACKSON LEE. Well, let me just say that we have 3 million-plus COVID–19 deaths in the United States. Obviously there will be major investigations dealing with the responsibility of this administration in—excuse me, 3 million cases, let me correct myself, 3 million-plus cases rising to 140,000 deaths, maybe about 137,000 deaths. Make sure the record is clear, 3 million-plus cases. Many of those cases are obviously in States like Texas, New Mexico, and even Mississippi and others.

So, I would emphasize that your work is extremely important. When the Federal Government fails the Nation, it is important for there to be concise, direct, wide-spread understanding of why, and directions of how that is remedied. The loss of a child is precious. I give my deepest sympathy to the families and, therefore, we must make sure that we correct it.

I thank you, Mr. Chairman. I yield back.

Chairman THOMPSON. Thank you very much. The Chair now recognizes the gentleman from New York, Mr. Katko, for 5 minutes.

Mr. KATKO. Thank you, Mr. Chair. Having lived on the border and prosecuted cases on the border in the mid–1990's, I can tell you back then the border and porousness of the border was a problem and it attracted more and more people, and tragedy often resulted back then. It is still happening today, and it is a terrible thing. It is terrible thing to lose anyone at the border in custody. It is a terrible thing ever to lose them if they are a child. We have to do all we can to make sure of that going forward.

But I will note that it is an incredibly complex issue, much more complex than I think some of the dialog today. I would like to defer to my colleague, Dr. Green, to take the balance of my time. I yield to him.

Chairman THOMPSON. The Chair recognizes the gentleman from Tennessee for the balance of the time.

Mr. KATKO. Thank you Mr. Chairman.

Mr. GREEN of Tennessee. Thank you, Mr. Chairman.

Dr. Mitchell, you mentioned in your testimony that resource hurdles prolonged CBP custody and delayed access to medical care. I agree. The efforts led by House Democrats to defund ICE have had sweeping consequences, mainly impacting CBP facilities such as what happened during December 2018.

ICE family residential centers were at capacity, forcing CBP to hold immigrants much longer than they should. The bureaucracy exacerbated by the border crises preventing those in CBP custody from reaching ICE facilities built for long-term holding and for more thorough medical assessments and access to care.

My question to you is do you support additional funding for ICE capacity and medical staff to ensure that children don't get stuck in CBP custody like they did last year?

Dr. MITCHELL. Yes. I think that any funding that is going to go forward to resolve this issue must go forward to decrease any overcrowding burden. I will leave it up to the House and the politicians to understand where exactly that goes and what agencies get those resources. But I think you and I agree, Dr. Green, that overcrowding conditions is a major concern, particularly when we are talking about infectious disease.

Then as far as the issue of timeliness, and I appreciate you elucidating the fact that I wanted better access to health care there at the border, I agree. I think physicians would be a hard burden, a hard bar to reach. But I believe that there is opportunities, as my colleague Danaher described, is that higher training of the EMT, maybe nurses, nurse practitioners, that are available there to make sure that the burden is not placed on our agents to try to triage these patients.

Mr. GREEN of Tennessee. I really appreciate your comments. I think clearly we, on our side of the aisle, would like to see more funding for ICE. There are a lot of people, especially for those detention facilities, a lot of people on the other side of the aisle want to defund ICE, but I want to follow up one more question, Dr. Mitchell, for you before my time expires.

You indicated in your testimony that you believe Jakelin's death could have been prevented in the initial health assessment questionnaire if it had been performed by a licensed medical provider.

You may not know this, but yesterday DHS—or not DHS but HHS released the doc shortage. Seventy-seven percent of America's rural counties right now are short both doctors and PAs, and by 2032, that is going to be 121,000 short. Where do we get these medical providers? I mean, do we take them from American cities? I am eager to hear your thoughts on that.

Dr. MITCHELL. Again, I think the shortage of medical providers is across the Nation, as you describe. I just don't believe that the recommendation of providing adequate health screening to whoever we come into contact with, it stops being a recommendation because the hurdles and barriers are too big. I think our job is to try to create opportunities where we can meet the goals of saving lives, wherever it exists. So no, not taking away from anyone, but attempt to provide it to everyone.

Mr. GREEN of Tennessee. Yes. We just have to be realistic in our solutions and find solutions that work, and your recommendations were, you know, a licensed medical person. I just—with the shortage we already have, I just don't see how that can happen.

I think my time has expired, Mr. Chairman.

Chairman THOMPSON. Thank you.

The Chair recognizes the gentleman from Louisiana, Mr. Richmond, for 5 minutes.

Mr. RICHMOND. Thank you, Mr. Chairman. As much as I would want to go into the shortage issue and the proverbial Trumpism of pitting communities against each other, and I guess that is what we are doing in terms of access to doctors, I just won't entertain it. I mean, we are the greatest country in the world.

Dr. Mitchell, could you just for me, in laymen's terms, explain what Felipe died of?

Dr. MITCHELL. Yes. So Felipe, he died of—he had a bacterial infection that was superimposed on flu. So everybody knows what bacteria is when I say it. It is a small organism that can cause infection. This particular type of organism that he had, he had flu, and then that flu had a bacterial infection on top of it.

The type of infection he had was so severe that it caused a rapid disease within his lungs, and so he died from, like, a hemorrhagic pneumonia or sepsis, and so that is functionally what he died from.

Mr. RICHMOND. Dr. Danaher, let me ask you, and I think both you and Dr. Green mentioned the uniqueness of treating children and when their symptoms show. Does it require special training to determine how severely ill a child is?

Dr. DANAHER. Yes. I would say it does.

Mr. RICHMOND. Ms. Gambler, in your written statement, it says that the report you are releasing today has found, "CBP does not provide officers and agents with training to identify medical distress in children."

Is that correct?

Dr. DANAHER. Yes. That is our finding.

Mr. RICHMOND. To the Inspector General, in reviewing Felipe's death, did your office examine whether the agents who were responsible for caring for him had received training in identifying medical distress in children? If so, what did your office's review find?

Chairman THOMPSON. You need to unmute yourself.

Still not able to hear you.

Looks like we are——

Mr. CUFFARI. I am sorry, Mr. Chairman. My computer froze. I had to come back into the meeting. I am really sorry.

Mr. RICHMOND. Let me repeat that question, then. In reviewing Felipe's death, did your office examine whether the agents who were responsible for caring for him had received training in identifying medical distress in children? If so, what did your office's review find?

Mr. CUFFARI. My understanding is the Border Patrol is trained in basic first aid, CPR, and trauma care. They also have advanced paramedics in several of their stations. In this case, in the case of Jakelin, there was a paramedic who happened to be at that station. I didn't find any evidence of pediatric training, though.

Mr. RICHMOND. Well, it was also clear that Felipe's father asked for him to be returned to the hospital in a sense of urgency. It took about an hour before they left the station, so it is unclear if the urgent nature of the situation was conveyed to everyone involved in the transportation.

So Dr. Danaher, given those circumstances, are there any questions about CBP's policies and practices for dealing with emergencies that should be reviewed?

Dr. DANAHER. One issue that arose for me in reading the time frame in which he received care is whether anybody is actually entering the cells to examine a child's [inaudible] medical assistance is actually requested. From what I could tell from the records that were available it would appear that we are checking on his cell door. But it is not clear that anybody took a close look at something. If they had, it would be very, very apparent if he was in distress.

Mr. RICHMOND. To the Inspector General, if possible, could you either forward to us or articulate any recommendations or policy revisions you have after reviewing Felipe's death and the file surrounding it?

Mr. CUFFARI. Sir, we have——

Mr. RICHMOND. With that, Mr. Chairman, I yield back.

Chairman THOMPSON. You can answer the question.

Mr. CUFFARI. Thank you, Mr. Chairman.

Sir, as I mentioned, we have on-going projects to look at that exact question, and we will be happy, very happy to provide the committee with our recommendations once we finish those reviews.

Chairman THOMPSON. You said that is the end of December, right?

Mr. CUFFARI. We should have one sometime toward the end of this year for you, sir.

Chairman THOMPSON. Thank you.

The Chair recognizes the gentlelady from Arizona, Mrs. Lesko, for 5 minutes.

Mrs. LESKO. Thank you, Mr. Chairman, and thank you for those testifying.

When I read the accounts of the 2 young children dying, I mean, it is very sad. I am sure all of us can agree that it was sad, and we wish it didn't happen.

But if I heard it right, Dr. Mitchell said both deaths were preventable and blamed the Customs and Border Protection agency, and Dr. Danaher said Customs and Border Protection agency was at fault. After reading the IG's report of what all happened, I really fail to see how you came to that conclusion.

I mean, first of all, you had in the young woman's—or the young girl's account, she entered the United States and was apprehended on December 6 after traveling, I assume, thousands of miles. The CBP asked if anyone was sick because they wanted to get the sick people on the first bus, and they didn't say anything. Then they didn't fill out on the form—they said actually on a filled-out form that they were not sick, that they were healthy. Then the father didn't say anything to the CBP officers that his daughter had been vomiting, and he told the bus driver that his daughter was vomiting but didn't tell CBP.

So then they got off the bus first after they found out from the father, and the EMT gave immediate medical care, and it was only then that the father told the EMT that his daughter had been vomiting and not eating for 2 to 4 days.

So I fail to see how that is the agency's fault. Then they airlifted her to a hospital, and unfortunately, she died.

In the case of the boy, it sounds like the CBP transferred as soon as they knew there was something wrong. The hospital didn't write in there things, that he had influenza B, didn't give medication, the amoxicillin, didn't note that, so to me, that seems more like a hospital error than a CBP error.

So my question to Mr. Cuffari is, Mr. Cuffari, in your investigation, have you determined that either one of these parents, the parents seeking medical care and the child receiving medical care before they were apprehended by CBP, especially the girl who had been sick for 2 to 4 days?

Mr. CUFFARI. It doesn't sound as though that the investigation found that that had been the case. Their first medical treatment was once they came into CBP custody in 2 different instances, one at the Lordsburg station and the other at the facility at the checkpoint.

Mrs. LESKO. Thank you. Mr. Cuffari, do you think the cartel would have given them medical care? I mean, the accounts I have heard about the cartel, they could care less about these people. They just make money off of them.

Mr. CUFFARI. Representative Lesko, that is beyond the scope of my testimony here today.

Mrs. LESKO. Well, you know, it is my opinion that instead of blaming the Customs and Border Protection agency for everything that happens, to me, it was clear that traveling thousands of miles, we should start blaming the cartels, don't you think? People should at least be partly accountable for children's deaths if the parents don't tell the medical people or Customs and Border Protection that their child's even sick. They have been traveling thousands of miles.

I mean, I just think it is unrealistic to expect the Customs and Border Protection to just know that these things are going to happen. To me, it seemed like they went over and beyond trying to help these children.

I have a few seconds left to give to Dr. Green.

Chairman THOMPSON. The Chair recognizes the gentleman from Tennessee for the balance of the time.

Mr. GREEN of Tennessee. Thank you, Mr. Chairman.

A very quick question to Dr. Danaher. Have you done med mal cases, review cases before?

Dr. DANAHER. No.

Mr. GREEN of Tennessee. You obviously reviewed the records here. What stood out to you about the resuscitation in this case, Felipe's resuscitation, when you reviewed that case?

Dr. DANAHER. In terms of when he presented to the hospital the second time?

Mr. GREEN of Tennessee. The second visit when they tried to resuscitate him, was there anything that jumped out to you as a physician on that resuscitation documentation?

Dr. DANAHER. I mean, there were definitely some irregularities in terms of what happened when he reached the hospital, but he arrived already pulseless. They had a really difficult time intubating him. There was a significant amount of blood in the airway which contributed to the multiple failed intubation attempts [inaudible].

Mr. GREEN of Tennessee. If I could just say, answer the question, because I know you have played, you know, guess what I am trying to ask you before as a physician. We do that a lot to one another. But he was incorrectly intubated, and they continued the resuscitation for several minutes with the breathing tube down his esophagus. Clearly, you can't resuscitate a patient, and he is not getting oxygen for several minutes in the resuscitation. That is problematic for saving the child's life.

I yield.

Chairman THOMPSON. The Chair now recognizes the gentleman from New Jersey for 5 minutes, Mr. Payne.

Mr. PAYNE. Thank you, Mr. Chairman. I appreciate the opportunity to be here today. It is very interesting to listen to the gentleman from Tennessee who has stated that he has been on the defense side and the prosecution side of these issues. You know, also, when my other colleagues mentioned that, you know, it is the cartel's fault.

You know, we are all responsible. We are the legislative body of the U.S. Government. We are responsible for making sure that nothing happens to these children. But you see, the administration went down a road to collect these people and lock them up in cages. Then when something happens, oh, well, we didn't have anything to do with it.

No. This is abominable. This is absolutely abominable, what I am listening to. Two children have died. I put my children in that position. All of us need to put our children in a position, and I think we might take—there might be a different tenor to this hearing.

But I only have 5 minutes, so Dr. Mitchell, can you please explain how and why video footage is important to understanding all of the circumstances surrounding a death in custody?

Dr. MITCHELL. Yes. So I was one of the primary authors on the death in custody and how to report, examine, investigate, and report out deaths in custody, put out by the National Association of

Medical Examiners. Part of what that organization calls for is, indeed, any information that is available for deaths in custody which includes any video footage, any medical records. Anything that can give an idea of the time leading up to the death is going to be important to categorizing the final findings at autopsy.

Mr. PAYNE. Thank you.

Inspector General, can you discuss the video footage obtained and reviewed regarding Felipe's death?

Mr. CUFFARI. My understanding, sir, is the video footage was obtained regarding—while Felipe was in custody. Our trained criminal investigators reviewed that footage, and they determined that the footage married the testimony of the Border Patrol agents.

Mr. PAYNE. OK. Is there footage of Felipe leaving the station to travel to the hospital on that evening on which he died?

Mr. CUFFARI. You know, sir, I am going to have to get back to you on that specific question.

Mr. PAYNE. OK. Did you review any aspect of the CBP's collection and retention of the video footage of the individuals in custody as part of the review of Felipe or Jakelin's death?

Mr. CUFFARI. I am not sure I understand the question, sir. We did obtain the video footage concerning the time period in which Felipe was in custody. But to my knowledge, that was—I don't believe they took any other footage outside of that time period.

Mr. PAYNE. OK. So you didn't review the aspects of how it was collected and retained, right?

Mr. CUFFARI. The collection and retention would have been done by our criminal investigators or by CBP OPR agents acting on our behalf in collecting the evidence.

Mr. PAYNE. So there would be in the report some mention of that, correct?

Mr. CUFFARI. To my knowledge, yes, sir.

Mr. PAYNE. Mr. Chairman, how much time do I have? I know I am getting close.

Chairman THOMPSON. The gentleman has 1 minute left.

Mr. PAYNE. Thank you, sir.

Inspector General, how many times did Border Patrol officers conduct wellness checks of Felipe on the day he died after he returned from the hospital the first time and before he left the station for the hospital for the second time? How many times was he checked on?

Mr. CUFFARI. The exact number, I couldn't give you, sir. But from the report of the interview of Felipe's father and consistent with Border Patrol testimony, the father said that the Border Patrol agents checked on he and his son 5 to 6—every—sort of every 5 to 6 minutes while they were back in the facility after their first visit to the hospital and before the [inaudible] second time.

Mr. PAYNE. OK. Thank you, Mr. Chairman.

I yield back. Thank you, sir.

Chairman THOMPSON. Thank you. The gentleman yields back.

The Chair recognizes the gentleman from Louisiana for 5 minutes, Mr. Higgins.

Mr. ROGERS. Mr. Chairman, Mr. Higgins is gone.

Chairman THOMPSON. Thank you. The Chair recognizes the gentleman from Tennessee again for 5 minutes.

Mr. GREEN of Tennessee. Thank you, Mr. Chairman. I just want to say, you know, we are responsible. I can tell you I will never forget the first child that I had to pronounce. The child had been hit by a car, and the image of that mother bringing that child in in her arms is forever burned in my brain.

The loss of these 2 children, it is tragic, but what we are doing here is a forensic examination of the record to find where fault happened. This is designed to find where there is fault, and so it takes an objective setting that aside and looking at the case.

So I want to ask Dr. Danaher again, you know. The records are pretty clear that the father of young Jakelin was asking for medications from his fellow travelers before entering into the United States. In fact, since the antibiotic he had on his hands was Flagyl, not the best for strep infection, they probably didn't get that prescribed by a physician. He knew she was sick, and he failed to disclose it.

You mentioned in your written testimony about the environment of a person answering questions to law enforcement being a barrier for Jakelin's father telling the truth about his daughter being sick, and I want to ask you. Are you suggesting that there is some kind of new standard of care that if a patient lies about their medical condition, the physician or that provider is somehow liable?

Dr. DANAHER. Not at all. What I am saying is that the initial screening that occurred when a large group of migrants arrived at the forward operating base. It was, from what I can gather, one agent yelling to more than 100 people that if anybody was sick, they should come forward. They yelled this in Spanish. The father's native language is K'iche', so we don't know if he heard them. We don't know if he understood them.

On top of that, we are asking people to come forward in front of a large group of people to talk about their medical issues which, as I am sure you appreciate, could be very sensitive for some.

Mr. GREEN of Tennessee. Do you have children yourself?

Dr. DANAHER. I do.

Mr. GREEN of Tennessee. So you can imagine having a sick child and not wanting them to know about it? I mean, I don't understand that dynamic——

Dr. DANAHER. I am not certain that——

Mr. GREEN of Tennessee [continuing]. I have taken care a lot of pediatric patients in the ER, and those parents are afraid. They come in, and they want to tell you. Why would he—I don't understand why a father who cares about a child would specifically lie when asked. They asked in Spanish and he responded in Spanish, so he clearly understood Spanish.

Dr. DANAHER. So I think that there is a difference between being able to speak a little bit of Spanish versus to share sensitive or nuanced medical information in Spanish.

On top of that, the questions on the health interview form are very non-specific. There is one question about any type of illness, and the rest are about things that wouldn't be particularly relevant to Jakelin's case. So this all hinges on whether the father understood that one question.

Mr. GREEN of Tennessee. I don't agree—I don't disagree with you that a form review could make that form better. I just—I can't

make CBP responsible for a guy who says his children are OK when asked if they are medically ill.

Let's flip to Felipe's case and I only have a little bit of time so I am going to get right to it. You made some very, I think, appropriate comments in your written testimony about his first visit when he went in. I mean, it was horrible when I looked at it, but I want you to tell the committee what you thought about his care when he was first brought to the hospital there at GCRMC and whether you think they should have let that patient go home.

Dr. DANAHER. No. They absolutely should not have let him go home. I agree with you that the care that he received was very concerning during his first presentation. His vital signs were significantly abnormal. His heart rate was persistently evaluated even when he did not have a fever. His oxygen level went as low as 91 percent at one point.

It is not clear that anybody noted that fact. The physician who saw him later acknowledged during a CMS review that he had not reassessed Felipe before the child left the facility.

Mr. GREEN of Tennessee. Yes. I didn't see any assessments for hydration status, you know, tears or moist mucus membranes. I mean, all things would be standard of care. This is an American physician at an American emergency department, and they let this kid go home.

My question is, is you know, would a normal law enforcement officer question a physician like that? Is he trained enough to question the physician?

Dr. DANAHER. Well, what is interesting in this case is it appears that the law enforcement officer did. He actually advocated for Felipe to receive more care before they left and continued to express concern after they left which says to me that they could recognize that he was quite sick.

Mr. GREEN of Tennessee. Yes. They definitely recognized that the care given was pretty shoddy. I mean, I think he had to ask to have the temperature taken.

So thank you.

I yield, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from New York for 5 minutes, Miss Rice.

Miss RICE. Thank you, Mr. Chairman, and I would just first like to thank the Inspector General for being here today. I only wish that you had been available when we did a hearing on these 2 terrible deaths back in January, and you would not come to that hearing, so I am glad that you are here today.

I think it is—would it be fair to say, Mr. Inspector General, that in the course of reviewing Felipe's death, you clearly don't come to a conclusion that the CBP did anything negligent or inappropriate? Would that be correct?

Mr. CUFFARI. That is correct, Miss Rice.

Miss RICE. So would you say it is fair to say that the Border Patrol agents were not properly trained to be able to comply with the TEDS standards for responding to a medical emergency involving a detainee with difficulty breathing, would you say?

Mr. CUFFARI. I would say that based on the training that the Border Patrol was provided and had at the time that they complied with the standards upon which they were being judged.

Miss RICE. So let me just read specifically from the TEDS standards addressing medical emergencies. It states, "emergency medical services will be called immediately in the event of a medical emergency; for example, heart attack, difficulty breathing, and the call will be documented in the appropriate electronic system of record. Officers, agents must notify the shift supervisor of all medical emergencies as soon as possible after contacting emergency services."

Now, according to your review of Felipe's death at approximately 5 p.m. on the day he died, Felipe was observed to have difficulty breathing and complained about pain in his stomach. An agent reported that he asked Felipe and his father if they wanted to go to the hospital and both declined. Do you think that that was appropriate behavior?

Mr. CUFFARI. At the time, it appeared to be appropriate. It was within the scope of our investigation, and that is what we determined.

Miss RICE. So what do you mean, at the time? Do you have any information now that would lead you to come to any different conclusion?

Mr. CUFFARI. Ma'am, that is why we are doing the additional reviews and evaluations that I briefly mentioned at the beginning. We are going to be looking at those issues.

Miss RICE. Dr. Danaher and Dr. Mitchell, are there issues of informed consent that could come into play in situations in which CBP personnel are asking parents and children in detention if they want to go to the hospital, particularly if they have already been to the hospital on that same day?

Dr. DANAHER. Would you like me to respond first?

Miss RICE. Sure.

Dr. DANAHER. Yes. So I think there are multiple issues here. One is that once a child is in custody, the parent is not really in a position to be advocating for their child to go back to the hospital. The child is in the custody of the Government.

On top of that, we have to remember that when immigrants are in detention, they are—they may perceive themselves as being at the whims of the Border Patrol agents, and they may not want to make themselves a nuisance.

Because we have to remember 6 months prior to this, Border Patrol was separating parents from their children, and there is real reason for people to be afraid of what might happen if—with these agents. I am not suggesting that agents did anything to separate this family at all. I am just saying that the dynamic of being in detention makes it very challenging for parents to advocate for medical care for their children.

Miss RICE. Let me just say I think that everyone on this hearing would agree that there were mistakes that were made at the hospital. Clearly, he should not have been released the first time. There is no question. I don't know if there is an investigation into the treatment, the medical treatment he got at that hospital or not, but there should be for sure. But any attempt to blame the parent

in this situation—Felipe, when he came into custody, was a perfectly healthy child. He got sick while he was in custody.

So CBP had it within their discretion to actually not keep Felipe and his father in custody for those 6 days between the time that they were apprehended and when he died. They could have paroled him. That was well within the discretion of authorities, the Government, at that time.

Let me just also say that, you know, I was happy to hear Dr. Green talk about how important it is to invest in our health care system. No better time than now for us to discuss this, especially as we are dealing with the pandemic.

We are seeing the disparate way that our health care system works for people of color and people in certain socioeconomic backgrounds.

So I am glad to hear Dr. Green talk about how important it is to invest in this, but I think we all have to agree that children present at the border, and our primary responsibility to them is to keep them healthy and not have them die in our custody, and so we have to make the system work better.

I am not blaming these CBP officers because they are not medically-trained personnel, but then that means that we need to have medically-trained personnel at the border.

My colleague, Ms. Underwood, given her background and her repeated trips to the border before this whole pandemic happened, was calling for just that, a more comprehensive health check for every single child who comes into the custody of CBP or ICE.

So I just want to thank all of the witnesses for coming today, and I yield back, Mr. Chairman. Thank you.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from Texas, Mr. Crenshaw.

Mr. CRENSHAW. Thank you, Mr. Chairman. Thank you for holing this hearing.

My first question is for Ms. Gambler from GAO. I just want to clarify something. The line items on medical care you mentioned, those are from the emergency supplemental, correct?

Ms. GAMBLER. Yes, sir.

Mr. CRENSHAW. That all occurred after the deaths in question, correct?

Ms. GAMBLER. The emergency supplemental was enacted last summer, July 2019.

Mr. CRENSHAW. Right. But the spending occurred——

Ms. GAMBLER. The spending occurred then after enactment, so yes, sir.

Mr. CRENSHAW. It was not in the same time frame, so I just want to highlight for the records the GAO's findings don't have a cause-and-effect relationship the child custody does in question.

Mr. Cuffari, and just to confirm, there are 2 completed IG investigations, one continuing, on-going, correct?

Mr. CUFFARI. Concerning deaths in custody, sir?

Mr. CRENSHAW. Yes.

Mr. CUFFARI. Yes. That is correct.

Mr. CRENSHAW. Of the 2 completed investigations, the IG determined that all CBP employees who were involved did everything

possible to ensure both children received medical treatment, and there was no misconduct or malfeasance, correct?

Mr. CUFFARI. That is correct, sir.

Mr. CRENSHAW. From your testimony, it sounds like the main issue here is overcrowding, correct?

Mr. CUFFARI. It was an issue, actually, that we raised during our unannounced site inspections of CBP facilities in 2019. We issued what is called a major management alert to DHS headquarters, and they implemented procedures to alleviate the overcrowding. I am told that they will complete that by the end of this year.

Mr. CRENSHAW. Thank you. I mean, it raises the issue we have long raised which is the reason is there is overcrowding is many of our policies encourage people to illegally cross the border. There is multiple factors.

The reason I bring all this up, it raises the question of the purpose of the hearing. If there is any evidence of malicious intent by CBP, I think this hearing would certainly be warranted, but there is not. This hearing appears to be designed, at worst, to drive a false narrative that implies malicious behavior by CBP.

At best, we are seeking to falsely imply that these tragic deaths could have been prevented by better action by CBP officers even though the children's parents brought them across our border in extremely poor health.

Furthermore, these false narratives, they lack context, falsely assuming that the purpose of border stations is to provide hospital-level child care. Of course, the truth is, the purpose of CBP is, in fact, customs and border protection.

When I went to the Rio Grande Valley sector late last year, there was a humanitarian crisis unfolding. In January 2019, there were more than 58,000 apprehensions. In February, that climbed to more than 76,000. Total border numbers spiked to 144,000 in May.

Let's also keep in mind these were not typical single male economic migrants. They were mainly family units, more than 473,000 in fiscal year 2019, and unaccompanied minors, more than 76,000 in 2019. As migrants are handled differently and completely overwhelmed our border control processing centers.

When this crisis unfolded in early 2019, we were sounding the alarm. It was ignored. The crisis was "manufactured." We didn't vote on an emergency supplemental appropriation until late June. By that time, there had been more than 750,000 apprehensions or inadmissibilities along the Southwest Border.

So again, why are we holding this now? I have to wonder is it because demonizing law enforcement is popular right now? Border Patrol agents haven't been targeted enough lately? Let's be clear. Each of those children who lost their life is absolutely tragic. It is also shameful to try and put the blame on our CBP officers and Border Patrol agents.

I think we could engage in some intellectual honesty and highlight the fact that in the past 18 months, almost 475,000 agent hours have been spent transporting migrants to hospitals and staying on hospital watch with sick migrants. We know those who make the trek from the Northern Triangle do not make it here in the best condition.

We can highlight the fact that more than 8,000 migrants in distress whether rescued from the Rio Grande River or found in need of medical need due to dehydration, injury, or pregnancy complications, have been rescued by Border Patrol. Approximately 200 of those were directly attributed to CBP air and marine operations assistance.

We could also mention the Border Patrol search trauma and rescue teams which was created in 1998 to respond to injured Border Patrol agents in remote locations. Now their main mission is actually rescuing migrants in distress, we could discuss the number of children and women saved from human trafficking by CBP.

We could talk about CPB being on the front line and keeping drugs and other contraband out of our country. Unfortunately, though, the positions and priorities appear clear.

So when we hold this hearing, I want to take the opportunity to let our CBP officers and Border Patrol agents know that we appreciate your service. We appreciate what you are doing under the most difficult of circumstances, and we do have your back.

Thank you. I yield back. Thank you, Mr. Chairman.

Chairman THOMPSON. The Chair recognizes the gentlelady from Michigan, Ms. Slotkin, for 5 minutes.

Ms. SLOTKIN. Thank you very much, Chairman. So I would like to pivot to talk about something that actually Mr. Crenshaw raised which was the special appropriation, the emergency appropriation that we passed last summer. You know, in particular, I am interested in the $112 million that we appropriated to provide for detainee medical care and necessity fees.

So we passed this $4.5 billion supplemental. I voted for it. I think many folks sitting here watching voted for it. I wrote to the Acting Secretary about this just to make sure we understood how that $112 million was being spent. We got a response back that about 8 months later from CBP, just in March.

So Ms. Gambler, can you help us understand and elaborate on GAO's findings regarding CBP's use of these $112 million specifically, please?

Ms. GAMBLER. Certainly, Congresswoman. We found through our legal decision and audit work that CBP did obligate funds from the consumables and medical care line item for some goods and services that fell within the definition or the meaning of consumables and medical care.

So that included things like hygiene products, clothing, gloves, masks. But we also found that CBP obligated funds from that line item for goods and services that did not fall within the definition or the meaning of that line item, the primary purpose of that line item, and that included things like goods and services for CBP's canine programs, computer network upgrades, facilities services and upgrades.

We concluded that CBP violated the purpose statute under appropriations law, and we concluded that CBP should make adjustments to its accounts accordingly.

Ms. SLOTKIN. How much do you believe of the $112 million was misspent on things that were not intended?

Ms. GAMBLER. At the time of our work for the legal decision, Congresswoman, CBP had not completed its review of the obligations it made under that line item.

After we provided a copy of our draft report to CBP, they reported to us that they completed that review, and they identified $13 million that they planned to adjust among accounts from last year's emergency supplemental, and at least $3.9 million that they planned to move from the consumables and medical care line item to CBP's regular appropriations.

I would just note that given the time frames for our review, we have not reviewed that information that CBP reported.

Ms. SLOTKIN. OK. I mean, I guess I would hope that we all, everyone on the committee cares about how the money that Congress appropriates is spent, and that was certainly concerning.

Mr. Cuffari, can you give us your assessment of this $112 million? Are you formally doing an IG review of the expenditure of this money?

Mr. CUFFARI. Yes, Madam Congresswoman. We have an open audit that is going to look at the CBP's use of fiscal year 2019 appropriation funds for humanitarian assistance. We are going to check with our colleagues and cousins at the GAO and make sure that we get all information that is available. There will——

Ms. SLOTKIN. What is the time line of your review? When do you expect to be complete?

Mr. CUFFARI. We just opened that few weeks ago, ma'am.

Ms. SLOTKIN. So a couple months?

Mr. CUFFARI. I can't give you a definitive time line, but we are going to do it as quickly as possible.

Ms. SLOTKIN. OK. I just think it is important, and I would love to hear your commitment to come back and talk to us about that. It is just one of those things. It is like our primarily responsibility as an oversight committee to make sure we know how that money is spent. I literally have no sort-of piece of this, you know, special knowledge of it.

I just think we all are saying from various, you know, angles that we want, you know, this issue to be resourced well to the best of our ability to support CBP so that they can do what they need to do on detainee health.

So can you commit, Mr. Cuffari, to coming back and testifying in front of us about this issue?

Mr. CUFFARI. You have my continued commitment to be responsive Congresswoman.

Ms. SLOTKIN. Great. Thanks so much.

I yield back, Mr. Chairman.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from Pennsylvania, Mr. Joyce, for 5 minutes.

Mr. JOYCE. I want to thank all of the witnesses for appearing today. I want to thank you, Mr. Chairman, for making the committee room available for this hearing today.

I would like to yield my time today to my distinguished colleague from Tennessee, Dr. Mark Green.

Chairman THOMPSON. The Chair recognizes the gentleman from Tennessee for the balance of the time.

Mr. GREEN of Tennessee. Thank you, Mr. Chairman. I want to first thank Congresswoman Slotkin for her questioning. I echo everything she said and agree with her 100 percent and look forward to hearing back from the Department on those misspent funds. That really is one of our primary concerns.

I also want to appreciate the fact that Congresswoman Rice recognized and reiterated the need for America to address this physician shortage. We have significant physician shortages now, and it is only going to get worse in the coming years.

My point in bringing it all up is that we had testimony from witnesses who said you needed licensed professionals. My conclusion from all this is that we can't take those people where Americans aren't even getting care and put them on the border. What we really need to do is give advanced training to our CBP personnel and make sure they are better trained to do those kinds of assessments because I just don't think it is feasible to put licensed medical personnel down there.

I also want to say that I agree with Dr. Danaher that the pediatric cuff, the pulse ox would have been helpful at those border facilities. But as an emergency physician, I can tell you that when Jakelin was posturing, it would not have made a difference in this case, and to say so would be—is a little bit misleading.

Also, as a doctor, you know, I have provided care from Ziway, Ethiopia, to the Himalayas, and a good field medic doesn't need a BP cuff to get a decent pressure off of where you take the pulses.

Dr. Mitchell, I wanted to ask you. What areas of the hospital—what areas of hospital care and care of a patient do you recognize as the highest risk for medical errors?

Dr. MITCHELL. Oh. Well, in my experience, I have seen medical errors in the surgical suite. I have seen medical errors in the ICU. I have seen medical errors upon presentation. We talked about the poor intubation of one of our patients.

So, you know, where medications are prescribed and infused, you can see medical errors. So there are several places within the system where you can see them.

Mr. GREEN of Tennessee. Well, JCAHO has done some pretty extensive research in this. Obviously, the Joint Commission on Hospital Organizations, they are the folks that accredit our hospitals for those who aren't medical providers in the room. They have done a lot of research on this, and those transitions of care are fraught with risk.

When one provider hands a patient off to another provider, going from the emergency department to the ICU, a shift change is an incredibly high-risk time. The gentleman from Louisiana mentioned that hiccup time when one of the officers was going off shift with Felipe, particularly, and another came on, gassed his car up, got there a few minutes late.

But when he got there, if you will recall from the testimony, tell us what that officer did and how he responded when he discovered the severity of the situation with Felipe?

Dr. MITCHELL. Well, I think the Border Patrol agents acted swiftly to engage the patient and try to get the patient to care, and that was evident throughout the record that I reviewed.

Mr. GREEN of Tennessee. Do you think there was anything else they could have done?

Dr. MITCHELL. No. No. I think the agents are acting—you know, particularly in Felipe's case and quite frankly, in Jakelin's case, these agents when they became aware, they moved to make sure that those individual patients got to care.

So, you know, they I don't think they probably are as equipped to recognize the things that they needed to recognize. So we talk about that training. We talk about making sure that we have adequate personnel that is doing that work and not putting it on agents whose job it is to protect in a different way the border. But, yes, I think the actions were swift and accurate.

Mr. GREEN of Tennessee. Thank you, Mr. Chairman. I think my time is up.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentleman from California, Mr. Correa, for 5 minutes.

Mr. CORREA. Thank you, Mr. Chairman, for holding this most important hearing. Can you hear me?

Chairman THOMPSON. Yes, sir.

Mr. CORREA. Yes. I want to thank the witnesses as well.

I would like to direct my questions to Dr. Danaher and Dr. Mitchell, the topic, CBP Directives on Medical Care for our Children.

In January 2019, following the deaths of 2 children in CBP custody in December 2018, CBP expanded the use of contract medical personnel. It is a good step forward. CBP also issued a directive setting forth interim enhanced medical efforts to mitigate risks to and improve care for individuals in CBP custody along the Southwest Border.

The interim directive required the Border Patrol to conduct a health review and medical assessment of all migrants under the age of 18. December 2019, CBP issued a final medical directive, and that final directive appears to be weaker than the interim directive. For example, it only required medical assessment of children under 12 rather than children under 18.

Dr. Danaher, if I may ask you a question. Have you had a chance to review the interim and final medical directives?

Dr. DANAHER. Yes, I have.

Mr. CORREA. Do you see other deficiencies in the final medical directive?

Dr. DANAHER. Yes. There are actually a number of issues that I find quite concerning.

Mr. CORREA. Please elaborate.

Dr. DANAHER. Sure. One is the time frame. The initial directive, as I recall, is supposed to be stated that these health interviews should occur upon initial processing whereas the final directive does not state when the health interview needs to occur.

It also narrows the scope of what is considered a basic medical screening so that it no longer specifies that vital signs must be collected. As we have already discussed in Felipe's case, vital signs could have made all the difference if somebody had been paying attention.

As you mentioned, it only mandates medical screenings for children under 12 or those with identified medical issues, and it includes a caveat. This is subject to availability of resources and operational requirements.

We have to remember that 2 of the children who died in the time frame that we are discussing were 16, and so it is unclear to me why we are reducing this cut-off to the age of 12.

It also seems to reduce the qualifications required for performing medical screenings, saying that they will be conducted by health care providers where available, and it does say that basic acute medical care referral and follow-up can occur on-site which on the surface is good. We want there to be medical services on-site, but we want to make sure that that does not mean children won't have access to pediatricians when they need them.

Mr. CORREA. Earlier this year, the American Academy of Pediatrics submitted a statement for the record to this committee which it stated that the final 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."

Dr. Danaher, would you agree with that assessment?

Dr. DANAHER. Yes, I do.

Mr. CORREA. What changes should be made to the directive, the final directive, to ensure that the adequate medical assessments are conducted on all children?

Dr. DANAHER. So as these cases that we are discussing illustrate, it is extremely important for health interviews to occur in a timely fashion on apprehension, and they need to be performed by somebody who has at least some basic medical training. That could be an EMT. It does not have to mean moving physicians to the border for this purpose.

We also need to make sure that these health interviews ask directed questions so that patients understand what they are being asked about, and we need to make sure that medical screening is offered across the board. We don't want to be missing children just because we are saying that the onus is on the parents to speak up when they notice something is wrong. Once these children are in custody, they are the responsibility of CBP, and we need to make sure they are all healthy.

Mr. CORREA. Thank you.

Mr. Chairman, how much time do I have?

Chairman THOMPSON. The gentleman has 40 seconds.

Mr. CORREA. Dr. Mitchell, do you have anything else to add to this topic of the final medical directive and its deficiencies?

Dr. MITCHELL. No. I think it illustrates that there is a need for a level of training and a level of expertise when dealing with these patients, particularly children under the age of 18.

I think that if we are talking about systems and developing better access to systems, then we would put those resources in place to ensure that our children are being initially screened by individuals that have the proper level of training to ensure that we have better outcomes.

Mr. CORREA. Thank you very much.

Mr. Chair, time being over, I yield.

Thank you very much.

Chairman THOMPSON. Thank you very much.

The Chair recognizes the gentlelady from New Mexico, Ms. Torres Small, for 5 minutes.

Ms. TORRES SMALL. Thank you, Mr. Chair. Thank you for holding this important hearing, and I am glad that we are all here to reckon with these challenges together because it is crucial that we make sure that people in our custody are safe. I want to begin by offering my condolences to the families of Jakelin Caal Maquin and Felipe Gomez-Alonso and other migrant children who have died in U.S. custody.

Since the deaths of Jakelin and Felipe, both of which occur in the district I serve, I have called on DHS and the Inspector General numerous times to comprehensively investigate what happened and specifically what holes in DHS policies need to be filled to make sure we aren't putting our Border Patrol agents in situations where they don't have what they need to keep kids safe in their custody and to stop more migrant deaths from dying in our custody.

This shouldn't be a blame game. This should be looking forward and to the future about how we can solve this together.

I also want to note that these children's deaths occurred in the district I serve, and I agree that we must also take action to expand health care for rural Americans.

I invite all of my colleagues to co-sponsor the Resident Physician Shortage Reduction Act, legislation Mr. Katko and I have championed, to train and keep more rural health care providers.

As well the Training the Next Generation of Primary Care Doctors Act, the Conrad State 30, and Physician Access Reauthorization Act, the Keep Physicians Serving Patients Act, the Maternal Health Quality Improvement Act, the Promoting Access to Diabetic Shoes Act, the Nurse Act, the National Nurse Act, the Immediate Relief for Rural Facilities and Providers Act, the Healthcare Workforce Resilience Act, the Medicare Accelerated and Advance Payments and Improvements Act.

The Save our Rural Healthcare Providers Act, the Border Health Security Act, and the Rural Maternal and Obstetric Modernization of Services Act, all of legislation I have co-sponsored or sponsored to help improve health care for rural Americans.

Inspector General, in your testimony, you noted several new issues which your office is working on. In your testimony to Mr. Crenshaw, you stated you have one on-going investigation of a death in CBP custody. Is your office reviewing any other deaths in CBP custody?

Mr. CUFFARI. So good to see you again, ma'am. Thank you for the question. I believe that is the only additional death in custody investigation that we currently have open.

Ms. TORRES SMALL. Thank you, sir. I appreciate it.

In your testimony today, you also noted to Miss Rice that you did not have a single medical professional on your staff during the investigations into Jakelin and Felipe's deaths.

Will you have—will your on-going investigation into the other death be conducted in the same manner, or will any changes be made in how you review that death?

Mr. CUFFARI. Based on the increased funding, as I mentioned, that the House and Senate gave us this year, we were able to seek outside medical contracts. I am happy to report that within a few weeks, the contracts should be awarded, and I anticipate probably by the end of next month, those individual health care providers will be able to augment our inspectors and investigators and our auditors.

Ms. TORRES SMALL. Thank you. How specifically will the ongoing investigation and the use of medical personnel differ from the investigations into Jakelin and Felipe's deaths?

Mr. CUFFARI. They won't at this moment because the investigation is at the very end of its cycle. We are waiting——

Ms. TORRES SMALL. So you will not supplement that investigation with medical information and expertise?

Mr. CUFFARI. No. We will deal with supplemental review of scoping of the entire Border Patrol's handling of medical health care providers and services to in-custody children.

Ms. TORRES SMALL. In the last minute, in your testimony, you indicated your office is working on a review of "CBP's use of Fiscal Year 2019 appropriated funds for humanitarian assistance."

What exactly will you be reviewing in that work, and will you be looking more closely at the misspending that GAO has already identified and that Congresswoman Slotkin discussed in her questions?

Mr. CUFFARI. Certainly, and let me just clarify my last response. In this particular case, we have engaged the services of an outside medical examiner in the very last instance, so we will have someone from outside looking at the medical review and the autopsy.

So to your current question, what we are going to be doing is looking at the report that the GAO has done regarding the expanding on that, looking at whether CBP has adequately planned for in the deployment of appropriated funds to quickly and effectively address the humanitarian needs at the border.

Ms. TORRES SMALL. Thank you. I yield the remainder of my time.

Chairman THOMPSON. Thank you very much. Mr. Inspector General, how long have you had the money at GPN to obligate for contracts and services [inaudible] personnel? How long have you had this money?

Mr. CUFFARI. I believe, sir, the appropriations came in January, and we were funded in February or March of this year.

Chairman THOMPSON. So you have had the money about 6 months?

Mr. CUFFARI. Yes, sir.

Chairman THOMPSON. Thank you.

The Chair recognizes the gentlelady from Illinois, Ms. Underwood, 5 minutes.

Ms. UNDERWOOD. Well, thank you, Mr. Chairman. Let me be blunt. This administration's treatment of migrant children have been appalling. Three years ago, the Department of Homeland Security implemented a policy of separating families at the border. As a nurse and public health expert, I am familiar with the data showing that family separation causes trauma that can do both immediate and long-term damage to children's health. But it doesn't

take a nursing degree to understand that. We all know it is inhumane, immoral, and just plain wrong.

Today, we are trying to get to the bottom of deaths of just 2 of the migrant children who have died in Federal custody under this administration. Felipe and Jakelin are among the 6 children who died, either during or shortly after their time in CBP detention on this administration's watch, after a decade with zero deaths.

Mr. Cuffari, the time line included in your office's report regarding Felipe's death states that during his first hospital visit on the morning of December 24, 2018, he was diagnosed with influenza B. However, the written discharge instructions included with the medical records from his first hospital visit appear to have been for the treatment of "an upper respiratory infection pediatric" without specifying an influenza diagnosis.

Did your office conduct interviews with any other medical personnel who provided care to Felipe?

Mr. CUFFARI. No, ma'am. That was outside the scope of our investigation.

Ms. UNDERWOOD. Did you conduct a forensic analysis of Felipe's medical records to fully understand what the Border Patrol agents were told about the influenza diagnosis and why?

Mr. CUFFARI. We didn't conduct a forensic analysis. We conducted a review of the medical records that we obtained from the hospital, and noted in the discharge paper for Felipe, there was no indication on there that Felipe had tested positive for influenza.

Ms. UNDERWOOD. Dr. Danaher, in June, the inspector general's office issued a report entitled "CBP's Struggle to Provide Adequate Detention Conditions During 2019 Migrant Surge." This report stated, "Crowded conditions presented health challenges for on-site medical staff in some facilities, including containing the spread of contagious illnesses." Felipe had been in custody for 6 days when he died, which is 3 days longer than allowed. Do you believe it is possible that Felipe contracted influenza while in CBP custody?

Dr. DANAHER. I believe I can state with certainty that he did. Because the longest incubation period for influenza is 4 days, [inaudible] manifest itself.

Ms. UNDERWOOD. Thank you.

Ms. Gambler, last fall, I joined my colleagues in writing to the Centers for Disease Control and Prevention to request information about their recommendation that CBP should vaccinate all migrants over the age of 6 months at the earliest feasible time. I am certainly disappointed that nobody from CBP is here today to answer questions about why they have not implemented the CDC recommendation. Ms. Gambler, did your office examine CBP's decision to not implement the CDC's full recommendation? If so, what did you find?

Ms. GAMBLER. Yes. Thank you for the question. We—through our work, we did identify that CBP has not fully documented the reasons for its decision not to offer the influenza vaccine to those in its custody. CBP identified to us a number of challenges to offering those vaccines, including things like providing cold storage, and the need for increased contracted medical care provider. But they didn't document how they considered, or weighed those costs, or considered those costs versus the benefits that could come from of-

fering influenza vaccine. So, our recommendation was really geared toward CBP more fully documenting the reasons why they decided not to offer the vaccine——

Ms. UNDERWOOD. Right.

Ms. GAMBLER [continuing]. Including how they consider costs and benefits so that as they continue to have conversations about public health issues going forward, they can have a record and good documentation of the decisions they are making.

Ms. UNDERWOOD. Thank you. Ms. Gambler, I understand from your written statement that CBP claimed that offering flu vaccines to people in their custody would, "provide little benefit to the agency," because their goal is to transfer people out of their custody quickly. However, as we saw with Felipe's case, CBP doesn't always transfer people quickly. Isn't that right?

Ms. GAMBLER. That is right. There are reports, and I think the inspector general has reported this as well, that individuals can be in CBP's custody for longer than the amount of time that CBP is hoping to detain them for that short period of time.

Ms. UNDERWOOD. Ultimately, from a medical standpoint, we know that there are consequence of CBP's failure to implement the CDC's recommendation for vaccinations. Given the on-going coronavirus pandemic, we know that individuals who might come into custody would be at increased risk as well.

Thank you so much, Mr. Chairman. Thank you to our panel of witnesses. I yield back.

Chairman THOMPSON. Thank you very much. The Chair now recognizes the gentleman from Missouri, Mr. Cleaver, for 5 minutes.

Mr. CLEAVER. Thank you, Mr. Chairman.

Mr. Inspector General, I don't want you to please take this as some kind of an insult, but in Washington, candor is sometimes silenced, leaving only power as the source of sound. I don't think there is any reason for me to question any of your integrity, and please understand that is not just a statement I am making. I am asking—that is kind-of the issue anyway. But my issue is, do you feel comfortable? Am I still being heard? Hello? OK.

Mr. CUFFARI. Repeat your question. I am sorry.

Mr. CLEAVER. My question is, based on everything that you have seen and heard, I mean, we have a number of IGs who have been fired, relieved of duty. So my question is, do you feel comfortable in being as candid as possible without fear that you would be silenced if you were to say something that was not in harmony with the powers that is all around all of us?

Mr. CUFFARI. I take your question, sir. I commit to you that if I ever felt any pressure to change my opinion for whatever reason, I would come to the Chair, and the Ranking Member of this committee, and other oversight bodies, both in the House and in the Senate.

As you know, I have more than 40 years of honorable service as a U.S. Air Force officer. I served every President from Jimmy Carter to the current, President Trump. I stand committed to speaking truth to powers.

Mr. CLEAVER. There has never been anything that you have said or done that would cause me to believe otherwise. I am just raising a question because of things that I am seeing has happened in

Washington, things that have happened in Washington that are, at least, appear to be unsavory. So thank you.

You are familiar with the fact that one of the agents who had taken care of Felipe had to pay for some of the over-the-counter medication——

Mr. CUFFARI. Yes, sir.

Mr. CLEAVER [continuing]. Out of his own pocket. Can you explain what that might have—what might have precipitated the fact that someone would have to go in their own pocket and pay for some medicine for some poor kid that obviously appeared to be sick?

Mr. CUFFARI. It appeared that the prescription for amoxicillin at the hospital that was issued was covered under their health care services, but the over-the-counter medication, which was for acetaminophen, I believe, or ibuprofen, perhaps—I stand corrected—was not covered. It was an over-the-counter medicine.

Mr. CLEAVER. Well, my assumption, Mr. IG, is that the agent that we found out, that the agent had actually used his or her own money because they were reimbursed. Is that how this came to our consciousness?

Mr. CUFFARI. Actually, I don't know, sir, if he was reimbursed. He did pay for it up front. I don't know whether he asked for reimbursement on that.

Mr. CLEAVER. I was just curious about how we found out about it. Perhaps he mentioned it to someone, which is not unusual for people who are committed and dedicated. My sister is a principal of elementary school here in Kansas City. I am always telling her she is going to be retire broke because she is buying pencils, and colors, and all that out of her paycheck. So I just think that is something that, you know, the agent should be praised for. He or she is probably not the only one.

Mr. CUFFARI. I feel your pain, sir. My wife is a former high school principal as well.

Mr. CLEAVER. Well, you are not going to have any retirement money, because I have seen that out all my adult life with my sister.

Dr. Danaher, do you have anything that you would recommend to us to make corrections that this would not happen again? What would you recommend to us? Do we need to put some policies in place? Do we need to do anything that would assure us and the American people of this is not going to happen anymore? Or are we certainly going to reduce the likelihood that it would happen again?

Dr. DANAHER. So I appreciate the question. I think it is extremely important, as I mentioned before, for health care screening to be occurring as soon as possible after we encounter children, and that needs to mean that we have people with at least basic medical training out in remote areas, like the place where Jakelin was apprehended. If she had to wait several hours before she could receive medical attention, that several hour period may mean life and death. Having people at the border who can at least recognize when children are sick and begin the process of getting into medical care quickly is extremely important.

I think also having the better protocols in place to screen and triage migrants when illness is identified, to make sure they have

access to the appropriate medical care preferably on-site if possible, but [inaudible] that they also have access to prescriptions on-site. Of course, as Dr. Mitchell mentioned, we need to reduce overcrowding and all of the other conditions that are promoting infections.

Mr. CLEAVER. Doctor, thank you very much. I really think that triage issue should be further developed. I wouldn't mind getting a memo on this.

Thank you, Mr. Chairman. I yield back the balance of my time.

Chairman THOMPSON. Well, if you give the staff, Mr. Cleaver, we will gladly make that request.

Mr. CLEAVER. Thank you. I will do that. Thank you, sir.

Chairman THOMPSON. The Chair recognizes the gentleman from Texas, Mr. Green, for 5 minutes.

Mr. GREEN of Texas. Thank you, Mr. Chairman. I thank the Ranking Member as well. I thank the witnesses for appearing.

Let me start, if I may, with the IG. Sir, how many times did you visit the border pursuant to this investigation?

Mr. CUFFARI. Sir, just so you know, set the record straight, I was confirmed by the full Senate at the very end of July of last year. Within 2 months, I went to the border to look at El Paso and the Tucson sectors. The investigations that the committee is holding a hearing regarded events that happened 7, 8 months before even my confirmation. This would have been in December, 2018.

Mr. GREEN of Texas. While you were there, did you pursue any actions to further your insight into what happened to these children?

Mr. CUFFARI. Not to the children in particular, because these were events that had already occurred. I was looking at overarching conditions at the El Paso and the Tucson sectors.

Mr. GREEN of Texas. You actually visited, I take it, the facilities where these children were detained?

Mr. CUFFARI. Not these particular facilities—except I stand corrected. We went to the El Paso del Norte Port of Entry in El Paso, Texas. Yes.

Mr. GREEN of Texas. When you were at that port of entry, did you notice it was somewhat akin to a large facility that allowed vehicles to flow through? Did you notice that, the place where the children entered the facility?

Mr. CUFFARI. I don't believe so, sir. No. Again, this is October 2019.

Mr. GREEN of Texas. I understand. The facility is still the same, I assume.

Mr. CUFFARI. [Inaudible] deconstructed whatever they had as temporary facilities.

Mr. GREEN of Texas. There is a facility there that is probably still standing. This is what I would consider a main facility. But in any event, did you notice how the children were cared for immediately upon entering the country in terms of how they are housed, and whether they are given blankets, whether they are kept warm? Did you notice?

Mr. CUFFARI. Yes, sir. I noticed that the El Paso Border Patrol station where they had soft-sided—not soft-sided tents, but they had large structures that were constructed out of some material.

The families were kept together in open bay sort-of barracks. They had medical attention. They had hot meals. They had toys that were actually, in some cases, the Border Patrol agents were bringing them in for the children. They had access——

Mr. GREEN of Texas. Do you think that the facilities are adequate for the time of year when it is cold and don't have blankets? Do you think that this was adequate?

Mr. CUFFARI. From what I observed at the time on that particular day, it was about a 2-hour visit, they appeared to be adequate. However, I want to add and just emphasize that we are doing on-going work to take a look at CBP's holding of the detainees beyond the 72 hours. And migrants experiencing serious medical conditions.

Mr. GREEN of Texas. Well, isn't it true that they have upgraded since you were there, and they have better blankets and other materials for the children?

Mr. CUFFARI. That is quite possible, sir. But I am sure our inspections and evaluations will identify that in real time.

Mr. GREEN of Texas. Let's move to the current circumstance. Do you believe now that we are prepared at the border to receive children who are sick and appropriately care for them?

Mr. CUFFARI. I actually don't know. My intent is to have these 20 different audits and inspections answer that question.

Mr. GREEN of Texas. Let's just talk for a moment. One of the physicians has been adequately questioned about his medical thoughts, and in a sense, is somewhat challenged about his opinions. So let me just ask you a couple of questions. Is it true that there has been some question with reference to your Ph.D.?

Mr. CUFFARI. That is correct.

Mr. GREEN of Texas. Is it true that you have signed documents indicating that you have a Ph.D., but not that it was in management and some question about it being in management versus philosophy?

Mr. CUFFARI. There was a posting on our official website. When it came to our knowledge that there was a typographical error indicating that I had a Ph.D. in philosophy, not a Ph.D. in management, which is what I do have. We made the typographical correction. I also noted, I will add, there were one or two commas that we recently noticed that we needed to correct as well.

Mr. GREEN of Texas. Did you ever visit the University where you received your Ph.D.?

Mr. CUFFARI. I did on 2 occasions, sir.

Mr. GREEN of Texas. Is it true that there is currently a Subway and a 7-Eleven store in that facility?

Mr. CUFFARI. I have no idea. I attended the University from 1998 through 2002, when I was awarded my degree.

Mr. GREEN of Texas. Is it true that there is some concern as to whether or not this was a mill process for presenting Ph.D.s?

Mr. CUFFARI. To my knowledge, I did all the appropriate work. I paid for the schooling out of my money. I worked for the Department of Justice inspector general at the time. I did this through online learning and I was awarded the degree that I earned.

Mr. GREEN of Texas. I am going to yield back, Mr. Chairman. Thank you.

Chairman THOMPSON. The gentleman yields back. The Chair recognize the gentlewoman from Nevada, Ms. Titus, for 5 minutes.

Ms. TITUS. Thank you, Mr. Chairman. I would like to go back to that capping report that was mentioned earlier that was issued last month by the Inspector General's office. That report summarizes the results of the office's unannounced inspections at 14 Border Patrol stations, and 7 points of entry between April and June 2019. Is that right Mr. Inspector General?

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

Ms. TITUS. As part of these inspections, you reviewed the migrants' access to medical care. However, the capping report states, "Because our office does not have medical expertise, we did not evaluate the quality of medical care CBP provided detainees."

So Mr. Cuffari, when your teams were visiting these Border Patrol facilities, what kind of field work did you do to assess compliance for the TEDS standards? Did they just simply observe what was happening while they were there and do spot checks, or did they also do some type of systematic review of records?

Mr. CUFFARI. Just for the record, ma'am, the time of those unannounced inspections in 2019, we did not have a medical health care provider services contract. Due to our increased funding that you have provided, we have contract for such augmentation.

The unannounced inspections normally are between 1 to 3 days in length at a particular facility. They follow procedures. They are looking at events that are occurring in their presence at that particular point in time. They document that information. If they find that there are abnormalities or issues of misconduct, they report them immediately. In one instance last summer, we issued a major management alert to the Department highlighting a condition that our inspectors saw.

Ms. TITUS. So absent anybody with the medical expertise previously, and without evaluating medical care, can you really confidently assess compliance with the TEDS standards, including that requirement for appropriate care?

Mr. CUFFARI. We follow the Council for Inspector General for Integrity and Efficiency Standards. Our auditors and inspectors are greeted. We have peer reviews. In fact, we are going through a peer review in our inspections and in our audit divisions actually this summer. We base our evaluations on what we observe at the time that we are in facilities.

Ms. TITUS. Well, the results of the inspections section states, "Most Border Patrol facilities took steps to try and evaluate and respond to the medical needs of the sizable detainee population. This included conducting medical screenings of all detainees before entrance into a facility." When it says it was "all detainees," does that mean literally every single detainee received a screening, as you would think that is what "all" means. If so, how were your teams able to assess whether every single person was screened, particularly in the crowding that occurred in some of those facilities?

Mr. CUFFARI. I take the word "all" to mean "all." I am assuming that our inspectors saw and documented what they saw, which would be all the individuals at that particular point were getting medical evaluations.

Ms. TITUS. Well, it seems to me that there are a lot of kind-of assumptions, and we can think, and we can trust, and we believe they did in the report. A lot of these kinds of terms being thrown around.

I would like to ask the 2 doctors if they see anything about the assertions that is concerning you. What concerns do you have if you have had a chance to review that capping report? Could you lay that out for us, so we might be able to improve on that in the future?

Dr. DANAHER. Yes. So the capping report, as you mentioned, seems to acknowledge that there is medical care occurring at some of these facilities. But as you stated, it is very difficult to assess from the report what the quality, or even the extent of that medical care is.

I was also troubled to see that it appears that medical screenings are occurring in large groups of migrants, no privacy. It makes me question whether any exams are actually accompanying these screenings, or if it is just somebody asking questions.

I was also a little bit troubled that there was basically just a photograph of a number of shelves of medications, and there was an assumption that those were the right medications needed onsite for the detainees. Without a physician reviewing that, it is very difficult to know if having those medications there is adequate to meet detainees' needs.

Ms. TITUS. It seems it is difficult to assess any of this without a medical expert there, just some officer going in and taking a look around.

Dr. Mitchell, do you have anything to add?

Dr. MITCHELL. Yes. I think that was the point I was going to make, Representative. I think that having, you know, a medical officer that is engaged in the care that is happening at the border, a responsible oversight in medicine, but also, the review of anything that comes out of this particular set of circumstances is extremely important.

You know, detention centers, once people are in them, they really do become, you know, small hospitals. I mean, in general, most people are going to be sick in these detention centers, or jails, or prisons within this country. So it is so important to have sustainable medical professionals that are overseeing the care that is happening, whether it is triage or original assessment, but overseeing the triage that is happening amongst these individuals. So I would just add that to what we are discussing.

Ms. TITUS. Thank you very much. I yield back, Mr. Chairman.

Chairman THOMPSON. Thank the very much. The Chair recognizes the gentlelady from California, Ms. Barragán, for 5 minutes.

Ms. BARRAGÁN. Thank you, Mr. Chairman, for convening this critically important hearing. I serve as the second vice chair of the Congressional Hispanic Caucus. Last year, my Congressional Hispanic Caucus colleagues and I toured the Alamogordo Border Patrol station on highway 70 CBP checkpoint in New Mexico. I saw first-hand the cell where Felipe Alonso-Gomez, an 8-year-old boy from Guatemala, spent his last hours, and tragically died on Christmas eve. I witnessed the awful condition he was held in. There were no showers. It was an open bathroom where everybody

could see you. It was complete concrete. There was no nutritious foods for people, especially for kids that may be sick. There was a lack of medical supplies.

There was only a first aid kit and a small EMT bag, but no trained medical personnel. CBP's lack of immediate and meaningful care for asylum seekers are putting migrant children's lives in jeopardy. We even spoke to the officers there who says they are not trained to take care of those who are ill. It was unbelievable to me to see the condition in which a child who was sick would be sent to to wait, where there is no blankets, where there is nothing padded, a complete jail cell.

Dr. Danaher and Dr. Mitchell, I know we have talked about this already today, but I think it is very important. Could you please, again, explain the challenges associated with recognizing medical distress in children, particularly young children who may not be able to talk or where there may be language barriers?

Dr. DANAHER. Yes. So it can be extremely difficult to get a clear medical history from a young child, on top of that, from a parent who is in distress about their child's well-being. Children look different than adults when they get sick. They have much more physiological reserve, meaning they can compensate better for longer when they are sick.

But it also means that when they run out of their metabolic reserves, they crash very fast. We run into this all the time in pediatrics where kids come in having looked OK, and then they decompensate very quickly. If action is not taken quickly to help them, then the outcomes can be really terrible, as we saw in this case.

Ms. BARRAGÁN. Thank you. Dr. Mitchell.

Dr. MITCHELL. Yes. Again, I would defer to Dr. Danaher. The reality of it is, is that it is a matter of time leads. So, when we put trained individuals and not rely on the agents that are not trained to do this work, but put trained individuals in position to get people to care or recognize distress earlier, then we have the potential to save lives. So, you know, that is all I would add.

Ms. BARRAGÁN. Thank you. Ms. Gambler, you indicated in your testimony that CBP has not trained its personnel on recognizing medical distress in children. Is that right?

Ms. GAMBLER. Yes. That was one of our findings. In fact, we made a recommend decision to CBP that she should develop and implement such training for all officers and agents who could come in contact with children in custody.

Ms. BARRAGÁN. I believe in your testimony you said that CBP and the American Academy of Pediatrics have, and I quote, obviously will give the quote here: "developed a training video on recognizing medical distress in children, which CBP included as part of its training for emergency medical technicians and paramedics." Is that right?

Ms. GAMBLER. Yes. That was part of our report.

Ms. BARRAGÁN. Ms. Gambler, do you know how many CBP personnel are trained as EMTs and paramedics?

Ms. GAMBLER. We do have that information in the report and we would be happy to follow up and provide that particular number after the hearing.

Ms. BARRAGÁN. OK. I can tell you that when I went to the CBP station there to ask CBP about Felipe in particular, they basically said they had one person available for 3 different stations, and they had to rotate him through. So there was just no way to have anybody there for any extended period of time. There was just a shortage.

Ms. Gambler, has the video on recognizing medical distress in children been shown to all CBP personnel, not just those who are EMTs and paramedics?

Ms. GAMBLER. CBP told us that that video is available as optional training to all officers and agents, but that that training video is primarily geared toward officers and agents who are trained emergency medical technicians. That was one of reasons for our recommendation that CBP needed to develop and implement training for children in medical distress to be provided to all officers and agents who could come in contact with children in custody.

Ms. BARRAGÁN. Well, thank you for recognizing that, because it is completely unacceptable that not everybody would be trained to recognize the distress symptoms amongst children. So thank you for doing that. Hopefully, we will have better treatment of our migrants at the border.

With that, Mr. Chairman, I yield back.

Chairman THOMPSON. Thank you very much. Let me thank the witnesses for their valuable testimony and the Members for their questions. As you can tell, if you are not an expert, you will get tested before this committee. I thank all of you for actually presenting very well and you responded accordingly.

Before adjourning I would ask unanimous consent to submit 2 statements for the record. The first is Mr. Morgan's letter responding to the committee's invitation to testify at this hearing.* The second is former Acting Secretary McAleenan's June 2019 letter to Members of Congress seeking emergency appropriations to the care for migrant children.

Without objection, so admitted.

[The information follows:]

June 12, 2019.

DEAR MEMBER OF CONGRESS: We continue to experience a humanitarian and security crisis at the southern border of the United States, and the situation becomes more dire each day. On May 1, 2019, the Administration requested $4.5 billion in emergency appropriations for the Department of Health and Human Services (HHS), the Department of Homeland Security (DHS), the Department of Defense, and the Department of Justice to address the immediate humanitarian crisis at our southern border. We write today to ask that you appropriate this funding as soon as possible.

We cannot stress enough the urgency of immediate passage of emergency supplemental funding. This funding will provide resources that our Departments need to respond to the current crisis, enable us to protect the life and safety of unaccompanied alien children (UAC), and help us to continue providing the full range of services to the children in our custody.

While Congress has been considering the request, the average daily number of UAC in U.S. Customs and Border Protection (CBP) custody has grown from nearly 870 on May 1 to more than 2,300 today. This is because the number of arriving children greatly exceeds existing HHS capacity. As of June 10, 1,900 processed UAC were in CBP custody awaiting placement in HHS care. However, HHS had fewer than 700 open beds in which to place them. HHS has significantly increased the

*The information has been submitted in a previous portion of this document.

rates at which we are discharging children to sponsors, but UAC are waiting too long in CBP facilities that are not designed to care for children.

This is a direct result of the unprecedented number of arriving children. As of June 10, DHS has referred over 52,000 UAC to HHS this fiscal year (FY), an increase of over 60 percent from fiscal year 2018. Preliminary information shows nearly 10,000 referrals in May—one of the highest monthly totals in the history of the program. If these numbers continue, this fiscal year HHS will care for the largest number of UAC in the program's history. HHS continues to operate near capacity, despite placing UAC with sponsors at historically high rates. HHS is working diligently to expand its bed capacity to ensure that it can keep pace, and based on the anticipated growth, HHS expects its need for additional bed capacity to continue.

On May 17, the Administration notified Congress of an anticipated deficiency in HHS's Office of Refugee Resettlement's (ORR) UAC program, as required by law. Absent an emergency appropriation, HHS anticipates running out of funding as soon as this month. The Anti-Deficiency Act, which is a criminal statute, requires HHS to take actions to minimize the deficiency and only to fund operations that are essential for the safety of human life and protection of property—similar to those activities allowed during a government shutdown. In the last few weeks, because of rapidly depleting funds caused by the border surge, ORR was required by law to scale back or discontinue awards, and had to instruct grantees that new awards cannot be used for UAC activities that are not directly necessary for the protection of life and property, including education services, legal services, and recreation. This was done solely to ensure full compliance with the Anti-Deficiency Act and stretch existing funds as far as possible for the life and safety of children.

ORR would not have had to take these actions to preserve essential operations if requested supplemental funding had been provided. If Congress acts quickly to provide the requested supplemental funding to address the border surge, ORR will be able to restore these services. Until such funding is provided, ORR will only be able to pay for essential services to protect life and safety.

It is unprecedented for a critical child welfare program to run out of funding, and ORR is in close contact with grantees about expected impacts. Once the UAC program is entirely out of funding, grantees will have to care for children with no Federal reimbursement until an emergency appropriation is enacted. It is unclear if grantees would be operationally able to continue caring for UAC, as many are small nonprofit organizations. This funding lapse could also negatively impact grantees' willingness to care for UAC over the longer term and ORR's immediate ability to add new child care facilities to address the overflow of children in DHS border facilities that were not designed for children. Our valued Federal employees in ORR who care for children and place them with sponsors would be required to work without pay.

It is not only the UAC program that will be impacted. On May 16, HHS notified Congress that the Anti-Deficiency Act requires HHS to reallocate up to $167 million from Refugee Support Services (RSS), Victims of Trafficking, and Survivors of Torture to the UAC program if activities do not meet the criteria in 31 U.S.C. § 1515(b)(1)(B). Last week, HHS informed the State refugee coordinators and refugee resettlement grantees in 49 States and the District of Columbia that ORR was withholding third quarter funding for those programs. The RSS program addresses barriers to employment for refugees such as: Social adjustment, interpretation and translation, day care for children, and citizenship and naturalization. Again, this was not a decision that ORR wanted to make, or took lightly. HHS's hand was forced by the current funding situation and the law. HHS must ensure that it is fully compliant with the Anti-Deficiency Act and that HHS stretch its existing funds as far as possible to protect the life and safety of children who are presently, or should be, in HHS care.

While the primary concern of both of our Departments is the safety of children in our care, DHS faces changing dynamics at the border that continue to stress its ability to respond. For example:

- More groups are illegally entering the United States, and they are getting larger.
  - On May 29, U.S. Border Patrol (USBP) agents apprehended over 1,000 migrants illegally crossing from Mexico as one group, overtaxing border operations. Over 400 migrants were apprehended within 5 minutes only 2 weeks before.
- The number of migrants has escalated, with more vulnerable populations arriving.
  - In May 2019, an average of more than 4,650 people daily illegally crossed into the United States or arrived at ports of entry without proper documentation. In May 2017, the daily average was under 650 illegal crossings per day.

- May 2019 experienced more than 144,000 total enforcements on the southern border, a 32 percent increase over the previous month and the highest monthly total since March 2006. This follows 2 months exceeding 100,000—sustained levels not seen in over 12 years.
- As of June 10, 2019, more than 17,000 people are in CBP custody, including over 2,500 UAC.
- The USBP apprehended nearly 85,000 individuals in family units in May 2019 along the Southwest border. An additional 4,100 individuals in a family unit were deemed inadmissible at Southwest border ports of entry. The vast majority of these individuals have been released into the country due to a lack of space and authority to detain them. By comparison, in all of fiscal year 2012, USBP apprehended just over 11,000 individuals in a family unit.

- Border Patrol agents are spending more than 50 percent of their time caring for families and children, providing medical assistance, driving buses, and acting as food service workers instead of performing law enforcement duties.
- Border Patrol agents are making on average 70 trips to hospitals every day to urgently get care to these individuals, further diminishing their ability to perform their official duties.
- The Centralized Processing Center in McAllen, Texas, and other CBP facilities have experienced outbreaks of flu which has required standing up separate quarantine facilities to reduce the risk of further exposing children and other vulnerable populations to infectious disease. While agents are providing the best care possible, these groups need more appropriate care, and they need it now.

If DHS does not receive additional funding, it will be forced to take drastic measures in August that will impact other critical programs that support DHS missions throughout the country. All DHS components, including the Transportation Security Administration, the Federal Emergency Management Agency, the Cybersecurity and Infrastructure Security Agency, the Coast Guard, and portions of CBP supporting legal trade and travel will be required to redirect manpower and funding to support measures to address the crisis.

In addition to the supplemental, it is clear that we need bipartisan legislation to address the causes of this crisis. We urge Congress to take swift action to provide the necessary funding to address the severe humanitarian and operational impacts of this crisis and to enact reforms to the root causes of these problems so that they do not persist into the future.

Thank you for your most immediate attention to this matter. A copy of this response will also be sent to your State's executive leadership.

Sincerely,

ALEX M. AZAR, II,
Secretary, U.S. Department of Health & Human Services.

KEVIN MCALEENAN,
Acting Secretary, U.S. Department of Homeland Security.

Chairman THOMPSON. The Members of the committee may have additional questions for the witnesses and we ask that you respond expeditiously in writing to those questions. Without objection, the committee record shall be kept open for 10 days. Hearing no further business, the committee stands adjourned.

[Whereupon, at 2:35 p.m., the committee was adjourned.]

APPENDIX

QUESTIONS FROM CONGRESSMAN EMMANUEL CLEAVER FOR FIONA S. DANAHER

Question 1. Dr. Danaher, what recommendations would you make to Custom and Border Protection's (CBP's) protocols so that in the future, children do not die in Federal custody?

Question 2. What policies or staffing changes should CBP or Congress put in place to dramatically reduce the likelihood of the child deaths discussed at the hearing today happening ever again?

Answer. Thank you for the opportunity to provide additional written testimony.

The current COVID–19 epidemic and the upcoming influenza season pose unprecedented risks for the health of children in CBP custody. Recent reports of children detained in hotels by subcontractors who may not have child welfare training, outside of standard CBP and ICE/ORR facilities and protocols, with the goal of rapid expulsion, raise additional questions about how carefully the well-being of children in immigration custody is being monitored.[1]

As previously described by the American Academy of Pediatrics (AAP)[2] and the Centers for Disease Control and Prevention (CDC),[3] CBP can take multiple steps to protect the health and safety of children in its custody throughout the process of apprehension, processing, and detention.

In the field

- Prior to apprehension, migrants have often traversed difficult terrain and endured harsh conditions that place them at increased risk for illness. As such, teams of CBP agents working in remote areas should include EMTs with enhanced pediatric training, such as that already offered by the American Academy of Pediatrics. Agents should carry basic supplies like oral rehydration, food, and first aid kits in case they encounter migrants in distress.
- When large groups of migrants are apprehended, they should be temporarily divided into smaller groups of no more than 10 individuals, and each group should be addressed directly by a Border Patrol agent to advise them of the option to request urgent medical attention and/or language interpretation. Assessing need for language interpretation should be performed using a standardized, validated tool. This will help to ensure that all detainees hear and understand the presented information.
- Agents should have access to telephonic interpretation in case a migrant needs to express an urgent medical issue. Agents should also receive training in basic medical Spanish.
- Migrants identified as needing urgent medical attention should be triaged directly to the nearest health care facility, rather than first awaiting completion of processing at a Border Patrol station. In cases of acute illness in a remote area, an ambulance should be requested to meet CBP en route to the hospital.

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[1] Rose, J. and Penaloza, M. *Shadow Immigration System: Migrant Children Detained In Hotels By Private Contractors.* NPR. *https://www.npr.org/2020/08/20/904027735/shadow-immigration-system-migrant-children-detained-in-hotels-by-private-contrac.* Published August 20, 2020. Accessed August 20, 2020.

[2] Testimony for the Record on Behalf of the American Academy of Pediatrics Before the U.S. House of Representatives Committee on Homeland Security, Subcommittee on Border Security, Facilitation, & Operations. Assessing the Adequacy of DHS Efforts to Prevent Child Deaths in Custody. *https://downloads.aap.org/DOFA/Jan%202020%20Hearing%20Statement%20for%20the%20Record%20%20AAP.pdf.* Published January 14, 2020. Accessed July 11, 2020.

[3] Letter from Director of the Centers for Disease Control and Prevention Dr. Robert Redfield to the Honorable Rosa DeLauro at 10–11. *https://www.warren.senate.gov/imo/media/doc/CDC%20Response%20%20migrant%20vaccination.pdf.* Published November 7, 2019. Accessed July 6, 2020.

- Migrants who volunteer nonacute medical concerns (as determined by a CBP EMT) should have their vital signs checked and receive priority transportation to the nearest Border Patrol station for additional assessment.

Health interviews

- Health interviews should be conducted by appropriately-trained CBP personnel as soon as possible after apprehension, in the field if possible. This will not only help to ensure timely attention to urgent medical issues, but will also facilitate safe cohorting and transportation of any migrants with potentially contagious illnesses.
- At a minimum, health interviews should be performed upon initial processing for all detainees under age 18, with particular emphasis placed on ensuring timely interviews for pregnant detainees and those who volunteer a medical concern upon apprehension. If health interviews cannot be completed upon initial processing, they should occur no later than 24 hours after apprehension to ensure that any health issues requiring prompt attention are addressed.
- Health interviews should be conducted individually and out of earshot of other migrants whenever possible, to prevent privacy concerns from hindering disclosure of relevant health information.
- All health interviews should be conducted using a standardized form, developed in consultation with pediatric medical experts. Health screening forms should be updated to include at a minimum:
  - Comprehensive review of potentially concerning symptoms (e.g., fever, chills, night sweats, cough, sore throat, congestion/runny nose, difficulty breathing, nausea/vomiting, diarrhea, abdominal pain, headaches, dizziness, chest pain, palpitations, joint or muscle pain, rashes, wounds/injuries);
  - Chronic medical conditions;
  - Current medications (either taking or meant to be taking, prescribed or over the counter);
  - Allergies;
  - Pregnancy status;
  - History of tuberculosis and whether it has been treated;
  - Whether the detainee had access to adequate food and water in the several days prior to apprehension.
- To protect confidentiality, questions about particularly sensitive information like sexually transmitted infections and HIV status should not be included in the initial health screening and should only be asked later in a private setting by a trained medical provider.

Medical screenings

- Health interviews will not identify all children in need of medical attention, so medical screenings should occur as soon as possible and no more than 48 hours after apprehension.
- All children under age 18 should receive medical screenings, including review of any positive responses on the health interview, a full set of vital signs, and a basic physical exam. The medical screening should be conducted with as much privacy as possible.
- Medical screenings should be performed by an appropriately credentialed clinician, which as per the initial standards set forth in CBP's Interim Enhanced Medical Efforts Directive could include CBP contracted medical professionals or Federal, State, or Local credentialed health care providers. CBP EMS personnel should only be utilized to conduct medical screenings in exigent circumstances and under the direct supervision of a clinician with appropriate expertise.

Detention facilities

- Basic detention standards must be met to minimize detainees' vulnerability to illness. For example, CBP facilities should be clean and maintained at comfortable temperatures. Detainees should be provided with nutritionally-balanced meals and ample access to clean drinking water. They must have adequate space to lie down and conditions in which they can comfortably do so; lights should be dimmed overnight to facilitate adequate sleep. Detainees should be provided with timely access to shower facilities and basic hygiene products (e.g., soap, toothbrushes, sanitary napkins, diapers).
- As the AAP has stated, detention is never healthy for a child.[2] However, if children are to be detained during processing, CBP should work with State and local child welfare agencies to ensure appropriate conditions and training of staff caring for children.
- Young detainees should be preferentially located in CBP facilities within proximity to medical centers with pediatric expertise, in case emergencies arise.

- Children who are sick or medically fragile should not be detained in CBP facilities, which cannot provide conditions conducive to safe monitoring and recuperation.

Disease prevention

- CBP must implement CDC's recommendations for the prevention of influenza and COVID–19 in its facilities.[3]
- Social distancing protocols should be developed. Technological and administrative barriers that unnecessarily prolong detention in CBP facilities should be eliminated to minimize the health risks posed by overcrowding.
- Detainees should have unfettered access to sinks with soap and hand sanitizer (although hand sanitizer must be kept out of reach of young children who might mistakenly ingest it).
- CBP staff should be required to utilize appropriate personal protective equipment (PPE), including face masks, when in proximity to detainees. PPE should also be supplied to detainees and replaced at regular intervals. All staff and detainees should receive instruction on how to use PPE correctly.
- High touch surfaces should be cleaned frequently, and adequate ventilation should be ensured.
- Influenza vaccine should be mandated for all CBP employees who interact with detainees. Influenza vaccine should be offered to all detainees at the time of their medical screening.
- Repeated transfers of detainees between facilities should be avoided to minimize risk of disease spread.

On-going disease surveillance

- CBP must institute comprehensive screening and triage protocols to promptly identify developing signs of illness among detainees.
- Specific screening protocols for symptoms of Multisystem Inflammatory Syndrome in Children (MIS–C) must be developed in consultation with pediatric experts, as this dangerous complication of COVID–19 is unique to the pediatric population and can present subtly at first.
- Detainees identified as sick must be safely isolated in a setting appropriate for convalescence, with close monitoring by trained personnel, while awaiting prompt testing and treatment.
- CBP should work with local public health departments and the CDC to develop an approach to monitoring for and reporting disease outbreaks within its facilities.

Obtaining medical care

- CBP should increase the number of pediatricians it employs to oversee care of young detainees.
- All forward operating bases and Border Patrol stations should be stocked with basic pediatric medical equipment and staff trained in its use. Medical equipment and medications at all CBP facilities should be centrally located and regularly inventoried. CBP facilities should stock oxygen and adult and pediatric doses of basic medications that EMTs or on-site clinicians might routinely administer to treat common medical problems and emergencies. Agents and detainees should never have to pay out of pocket for necessary medications. Detainees' medications should not be confiscated without supplying adequate replacements under the guidance of an appropriately credentialed clinician.
- If a detainee requests medical attention, an on-site clinician (if available) or an agent with EMT training should promptly triage and assess the detainee. Triage should include a full set of vital signs and a basic physical exam.
- If an agent observes a child exhibiting signs of illness, the child should by default be brought for medical attention, rather than relying on a parent to advocate for medical care.
- Children with identified medical issues should be treated by a provider with pediatric expertise whenever possible, even if that means transporting them to a health care facility off-site.
- Paperwork should be streamlined and digitized so that health interviews and transfers to medical facilities are not needlessly delayed by challenges in locating or completing documents.
- Interpretation in medical settings must always be performed by certified medical interpreters to reduce the risk of medical errors. It is never appropriate for a medical facility to utilize a CBP agent for interpretation. All consents and medical paperwork must be provided in parents' native language to ensure comprehension.

- Any detainees suspected of having influenza should receive antiviral therapy like oseltamivir as soon as possible and no more than 48 hours after symptom onset. Antiviral chemoprophylaxis should be offered to vulnerable detainees who may have been exposed to influenza index cases.
- Independent oversight of the quality of medical care provided to detainees must occur regularly. This should include medical record review as well as unannounced site visits. Pediatricians must be included as part of the oversight team to ensure that issues unique to the care of young patients are addressed.

CONCLUSION

An unprecedented number of children have died in CBP custody over the past several years. The current public health crisis posed by the COVID–19 epidemic only underscores the urgent need to minimize time in detention, improve detention conditions, and facilitate access to medical care so as to protect the well-being of migrant children in custody of the U.S. Government.

QUESTIONS FROM CONGRESSMAN EMMANUEL CLEAVER FOR JOSEPH V. CUFFARI

Question 1a. Inspector general, your office issued a "Capping Report" in June entitled "CBP Struggled to Provide Adequate Detention Conditions During 2019 Migrant Surge." The report includes pictures of, "Stocked over-the-counter medications and medical supplies" observed in May and June 2019 in each of the El Paso Del Norte, Texas, and Donna, Texas facilities. Inspector General, are there any standards regarding the over-the-counter medications that Border Patrol facilities should have on hand?

Question 1b. If so, what are they, and did the facilities your teams visited meet these standards?

Answer. CBP's October 2015 National Standards on Transport, Escort, Detention, and Search (TEDS) do not require that over-the-counter medications be kept on hand in Border Patrol facilities and we are not aware of any other Border Patrol standards with this requirement. We reported on the stocking of over-the-counter medications as an example of an economy of scale employed by Border Patrol to better manage the increase in apprehensions in 2019. It was more efficient for facilities to stock over-the-counter medications on-site, rather than making a pharmacy run each time a clinic, hospital, or on-site medical staff prescribed an over-the-counter medication. Not every facility we visited had over-the-counter medications in stock.

Question 2a. Are there any standards regarding the administration of over-the-counter medicines?

Question 2b. If so, what are they and did the facilities your teams visited meet these standards?

Answer. TEDS standards do not provide specific guidance with respect to the administration of over-the-counter medicines. With respect to medication generally, TEDS standard 4.10 states:

"Medication: Except for assistance with lifesaving emergency medical care which they feel comfortable rendering and are trained to render, officers/agents will not administer medical techniques, medications, or preparations unless they are qualified emergency medical technicians or paramedics rendering care. Medication prescribed in the United States, validated by a medical professional if not U.S.-prescribed, or in the detainee's possession during general processing in a properly identified container with the specific dosage indicated, must be self-administered under the supervision of an officer/agent. If a detainee is unable to self-administer their medications due to age or disability, officers/agents may assist the detainee. All detainee refusals of prescribed medication or medical assistance must be noted in the appropriate electronic system(s) of record.

"Non U.S.-Prescribed Medication: Any detainee, not in general processing, with non U.S.-prescribed medication, should have the medication validated by a medical professional, or should be taken in a timely manner to a medical practitioner to obtain an equivalent U.S. prescription. Exceptions to this requirement may only be made by a supervisor in collaboration with a medical professional and based on expected duration of detention and/or elective nature of the medication. If such an exception is made, it must be recorded in the appropriate electronic system(s) of record."

TEDS standard 7.5 states:

"All medications will generally be maintained with the detainee's personal property unless other conditions warrant, such as the medication needing to be regularly administered due to need, and/or needing to be properly stored as the prescription requires."

TEDS standard 2.10 states:

"When transferring a detainee, officers/agents must ensure that all appropriate documentation accompanies the detainee including all appropriate medical records and medication as required by the operational office's policies and procedures."

Using these standards as criteria, OIG inspectors conducted interviews with on-site medical staff and CBP staff to determine whether processes existed for administering emergency medications, enabling detainees to self-administer prescriptions, validating or replacing foreign prescriptions, storing prescriptions that required refrigeration, and transferring medical records and prescriptions with detainees. We also observed if there were detainee prescriptions on-site, whether appropriate storage existed, and if times for administering medications were tracked in data systems or on white boards.

From our interviews with CBP staff, medical staff, and a limited number of detainees, at the time of our visits, we did not identify instances in which CBP staff did not comply with TEDS standards for medications, including both prescription medications and over-the-counter medications that were prescribed for detainees. Ten of the CBP facilities we visited had on-site medical personnel who either had the necessary qualifications to prescribe medications, including over-the-counter medications, or could consult with an on-call doctor. In addition, if a detainee was prescribed a medication, including an over-the-counter medication, during a visit to a clinic or hospital, it was appropriate for CBP staff to supervise self-administration of the medication. Our conclusions were limited to what we observed at the time of our site visits and information obtained from detainees, on-site medical staff, and CBP staff.