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The Forgotten Frontier? Healthcare for Transgender Detainees in Immigration and Customs Enforcement Detention

DANA O’DAY-SENIOR

INTRODUCTION

In 2007, a postoperative transgender individual contacted a prisoner advocacy organization. The individual was in Immigration and Customs Enforcement (ICE) detention awaiting resolution of the individual’s asylum case. ICE detention officials had confiscated the individual’s prescription hormones, a standard part of the individual’s healthcare regimen since long before the individual’s detention, which was necessary for maintaining the individual’s health and transition between genders. Repeated requests to ICE’s medical staff for more hormones had been refused, and the individual wanted to know what to do to get the hormone therapy restored.

This posed a very perplexing problem even for organizations and firms routinely involved in transgender rights, prisoner rights, and asylum law. Frustratingly for the individual client, no one had a quick or easy answer. Initial research showed that, unlike the Federal Bureau of Prisons (BOP) or the California Department of Corrections and Rehabilitation (CDCR) which have established regulations concerning

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1. The introductory story is based on a real case in which the Author had involvement; however, details have been changed to protect the confidentiality and anonymity of the individual involved.


3. CAL. DEP’T CORR. & REHAB., OPERATIONS MANUAL § 91020.26 (1995) [hereinafter CDCR, OPERATIONS MANUAL]; DIV. OF CORR. HEALTH CARE SERVS., CAL. DEP’T CORR. & REHAB., TRANSGENDER MEDICAL CARE POLICY 4.2.1-3 (2007) [hereinafter CDCR, TRANSGENDER MEDICAL CARE POLICY]; see also Union-Tribune News Serv., Ex-Prisoner Awarded $80,000, SAN DIEGO UNION-TRIB., Sept. 1, 2000, at A-3 (leading to, along with the surrounding litigation, the CDCR to expand their offered transgender healthcare beyond the strict limitations stated in the CDCR Operations Manual); Corr.

[453]
How Gender Identity Disorder (GID)¹ will be treated, ICE regulations had no such policy. It appeared that medical treatment decisions were largely discretionary, and had the potential to vary from detention center to detention center.² In the absence of a regulation or policy to cite when arguing for proper transgender healthcare procedures, the individual was left in an uncertain position, stuck in ICE detention for an indeterminate amount of time, with no clear course of action to restore hormone therapy and avoid the degenerative health effects caused by hormone deprivation. Advocates working on the case were also frustrated because, at the time, there were no practitioner’s guides or articles suggesting a course of action to help the client. This story is but one demonstration of the veritable legal black hole in which transgender persons in ICE detention now find themselves, and also served as the inspiration for this Note.

For transgender individuals either in or subject to the laws of the United States, there is a constant, ongoing battle for legal recognition, discrimination protection, and rights. Recent legal scholarship has focused on such diverse topics as rape of transgender and transsexual prisoners,⁶ the current state of gender documentation law in the United States and the challenges it poses,⁷ litigation of Eighth Amendment

Med. Consultation Network, U.C.S.F., Plata Overview, http://familymedicine.medschool.ucsf.edu/cmcn/html/about/bckgrnd.html (last visited Dec. 15, 2008). The ongoing Plata healthcare litigation in the California prison system has led to the establishment of the Correctional Medicine Consultation Network, which is part of the Department of Family and Community Medicine at the University of California, San Francisco, which further facilitates transgender prisoners’ access to hormones and other transgender-related health care in California’s state prisons. Id.


5. See INS, U.S. DEP’T OF JUSTICE, INS DET. STANDARD, MEDICAL CARE 1-2 (2000) [hereinafter INS, MEDICAL CARE], available at http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf. The policy was very recently updated as will be discussed later in this Note; however, this was the version of the policy in effect when the individual described was in detention.

6. See generally Katrina C. Rose, When Is an Attempted Rape Not an Attempted Rape? When the Victim Is a Transsexual, 9 AM. U. J. GENDER SOC. POL’Y & L. 505 (2001) (detailing the problems faced by transgender prisoners surrounding sexual assault and rape and the jurisprudential responses to lawsuits brought by such prisoners).

7. See generally Jason Allen, A Quest for Acceptance: The REAL ID Act and the Need for Comprehensive Gender Recognition Legislation in the United States, 14 MICH. J. GENDER & L. 169 (2008) (comparing the United Kingdom’s recently-passed Gender Recognition Act to current state and federal laws and policies surrounding gender documentation and legal gender change in the United States, and recommending a law similar to the Gender Recognition Act as being needed in light of the REAL ID Act); Dean Spade, Documenting Gender: Incoherence and Rulemaking, 59 HASTINGS L.J. 731 (2008) (providing an overview of the current documentation procedures for all areas of life in the United States from Department of Motor Vehicle regulations, to Social Security Administration regulations, to prison systems’ gender classifications, etc., and how those differ from state to state, and explaining the impact of such haphazard and ad hoc regulations on transgender persons’ lives).
deliberate indifference claims for transgender prisoners, catalogue of problems faced by transgender prisoners, and recommendations for improving or solving the human rights abuses faced by transgender prisoners. As evidenced by the trend in recent scholarship, this battle for legal recognition and protection is perhaps most starkly evident in the context of prisoners, where diminished civil rights and privacy expectations combine with increased dependence on the state and state actors for all aspects of daily life, from housing, to personal safety, to medical treatment.

The rights of transgender prisoners are currently being litigated across the country, especially in the contexts of housing and medical care. However, within this subset of the transgender population and its battle for rights lies an oft-ignored and more legally complex question of rights: that of transgender detainees in Immigration and Customs Enforcement (ICE) detention facilities.

This Note will examine the current reality of transgender detainees in ICE detention with a specific focus on the right to hormone treatment, and the legal and policy obstacles related thereto. As the law stands now, transgender rights is an emerging subject of national debate. The rights of transgender prisoners are being litigated actively in both state and federal courts, while the administrative agencies that run state and federal prisons are busy setting their own administrative policies on the same subject, with varying results. The Supreme Court has been silent on this issue so far.

However, “detainees” falling under ICE’s jurisdiction seem to fall into a legal black hole, not usually subject to the local, state, or federal regulations, and not clearly falling within the jurisdiction of any one

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8. See generally Nikko Harada, Trans-Literacy Within Eighth Amendment Jurisprudence: De/Fusing Gender and Sex, 36 N.M. L. Rev. 627 (2006) (examining the different standards applied to Eighth Amendment claims and the ways in which confusion between sex and gender lead to problems for transgender litigants and their claims).

9. See generally Alexander L. Lee, Gendered Crime & Punishment: Strategies to Protect Transgender, Gender Variant and Intersex People in America's Prisons, GIC TIP J., Summer 2004, at 1 (detailing the different problems faced by transgender prisoners forced into the gender binary of most prison systems).


existing federal court decision." ICE detainees' access to appropriate medical care (including transgender detainees' access to hormones) is complicated by the categorization of ICE detention facilities within the overarching structure of the administrative state, and the discrepancies in structure and policy among ICE detention facilities. ICE detainees include vastly dissimilar groups of people, such as permanent U.S. residents facing deportation after criminal convictions, potential asylees awaiting adjudication of their claims, nonresident aliens awaiting deportation for a variety of reasons, and illegal immigrants—groups that are not necessarily mutually exclusive, but to whom the United States Constitution applies in greatly varying degrees, or who have very different legal rights, statuses, or claims. ICE detention facilities are part of the Department of Homeland Security, and are therefore not subject to policies or court decisions affecting either the BOP or state prisons or jails. Furthermore, there are actually three different types of ICE detention facilities—those directly run by ICE, those administered by private contractors, and those in annexed wings of county jails. As a result, state actors, policies, and procedures can vary drastically depending on the type of ICE facility in which a particular detainee is housed.

This Note will focus on the specific question of medical care rights for transgender persons in ICE detention, and will recommend a more explicit ICE policy that specifically mentions health care procedures and standards for transgender detainees. In Part I, I will briefly explain gender identity in the context of its medicalization, and how that applies in the prison or detention context. In Part II, I will give an overview of a selection of existing federal and state prison system policies for transgender medical care, followed by a brief discussion of the strengths and weaknesses of those policies. Part III will begin with an explanation of ICE’s purpose, existing policies, and the problems posed by those policies. In Part IV, I will conclude with a discussion of the current remedies available for transgender detainees. Finally, in Part V, I will recommend how ICE’s policies can and should be improved to allow for

12. As I explain later on, some ICE detainees are actually housed in annexed portions of county jails or state prisons through Intergovernmental Service Agreements and are therefore subject to the policies of whatever jail or prison in which they are housed. See infra note 16 and accompanying text.
more universal, equal, and medically consistent treatment of transgender detainees, and suggest areas for further research.

I. GENDER IDENTITY AND MEDICALIZATION: A BRIEF OVERVIEW

Why is healthcare for transgender detainees so important? The answer is largely tied up in the importance of gender in our social structure and the way in which treatment and therapy for transgender people has been medicalized. As one court recognized, “[g]ender is an overwhelming feature of a human being’s life.” While most individuals have gender identities that match their anatomical and genetic sex, “[f]or those who do not grow comfortably into their assigned genders . . . the gender binary [of male and female] can be suffocating or dangerous.”

Transgender individuals are those falling between male and female, some wishing to transition physically and anatomically to the sex “opposite” their birth sex, others just wishing to happily exist somewhere in the middle. Transgender persons’ access to healthcare for effecting harmony between their psychological gender and their physical sex is usually controlled by the diagnosis of GID. The DSM-IV defines four criteria for diagnosing GID: (1) the patient has “[a] strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)”; (2) the patient experiences “[p]ersistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex,” again with several different recognized manifestations; (3) “[t]he disturbance is not concurrent with a physical intersex condition”; and (4) “[t]he disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.” In 2008, the American Medical Association officially stated that GID “is a serious medical condition,” that, “if left untreated, can result in clinically significant psychological distress, dysfunction, debilitating depression and, for some people without access to appropriate medical care and treatment, suicidality and death.”

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17. See generally Dean Spade, Resisting Medicine, Re/Modeling Gender, 18 BERKELEY WOMEN’S L.J. 15 (2003) (discussing the medicalization of transgender people and the pros, cons, and tensions created by tying transgender status to the medical diagnosis of Gender Identity Disorder).


19. Allen, supra note 7, at 173.


21. For a full explanation of the term “transgender” and its many forms and implications, see Lee, supra note 9, at 13 n.14.

22. AM. PSYCHIATRIC ASS’N, supra note 4, at 537–83.

23. Id.

24. AM. MED. ASS’N HOUSE OF DELEGATES, RESOLUTION NO. 122(A-08), REMOVING FINANCIAL
In addition to the focus on medical diagnosis, healthcare for transgender people is governed by a number of medical standards, most prominently the Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, published by the World Professional Association for Transgender Health, Inc. (WPATH). However, the most common treatment sought by transgender persons is hormone replacement therapy (providing male hormones to a female-to-male transgender person or providing female hormones to a male-to-female transgender person) in order to provide desired results in acquired secondary sex characteristics and to help the person's physical body to more closely match their psychological gender. Access to continuing hormone treatment is one of the most frequent problems experienced by transgender prisoners and it is a huge problem for ICE detainees, as it was for the individual mentioned in the introduction of this Note, since there is no policy on transgender healthcare or hormone access in ICE detention facilities. Because of this commonality of treatment need and denial of access, I have chosen to focus on this issue for the scope of this Note. “The forced discontinuation from hormone treatment is felt to be a very invasive loss of sovereignty over one's own body, and can be extremely psychologically damaging.”

II. TRANSGENDER PEOPLE AND HEALTHCARE POLICIES IN FEDERAL AND STATE PRISON SYSTEMS

When interacting with prisons, jails, detention centers, and other similar institutions, transgender people typically face problems in two distinct areas: housing (which is outside the scope of this Note) and

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25. See generally The Harry Benjamin Int'l Gender Dysphoria Ass'n, Standards of Care for Gender Identity Disorders (6th ed. 2001). Although the association has formally changed its name since the sixth edition was published, this is still the most recent edition of the association's Standards of Care. These standards are often criticized as being too focused on sexual reassignment surgery as the goal for all transgender individuals. See, e.g., Allen, supra note 7, at 174. Criticism aside, the WPATH Standards of Care are recognized by the American Medical Association, and are considered to be medically necessary treatment. Removing Financial Barriers, supra note 24.

26. Spade, supra note 7, at 754-55. For those who seek medical treatment, the most common medical treatment is not surgery but masculinizing or feminizing hormone therapy, which is an effective step for enhancing feminine or masculine secondary sex characteristics (e.g., voice, facial hair, breast tissue, muscle mass). Id. For surviving daily life—work, school, street interactions—these external markers of gender are far more important than genital status, which is usually only known to one's closest intimates. Id.

27. Lee, supra note 9, at 9 ("[Transgender] people are also frequently denied access to hormones and other gender-related medical treatment that they were receiving before imprisonment.").

28. See generally INS, Medical Care, supra note 5 (transgender healthcare or detainees not mentioned).

29. Lee, supra note 9, at 15-16 n.120.
healthcare.\textsuperscript{30} Since medical diagnosis and treatment is necessary for transgender individuals to legally maintain their level of transition\textsuperscript{31} within the prison or detention center setting, having clear policies that ensure or allow for access to transgender specific medical care (especially hormone replacement therapy), is vitally important. Without a policy, transgender prisoners or detainees arguing to have their hormone treatment continued or restored are left essentially at the whim of individual institutions, administrators, and doctors. This in turn can lead to unequal protection and disparate treatment of similarly situated prisoners as well as negative health effects from the discontinuance of hormone treatment. This Part will look at the existing federal prison policy, as well as policies in a few exemplar states, and compare and contrast them with the existing ICE policy.

A. \textbf{FEDERAL BUREAU OF PRISONS POLICY}

The BOP has a clearly defined policy for transgender inmate healthcare.\textsuperscript{32} All inmates will be maintained at the same level of transition as they were before entering federal custody. The Federal Bureau of Prison's Program Statement on Patient Care states:

Inmates who have undergone treatment for gender identity disorder will be maintained only at the level of change which existed when they were incarcerated in the Bureau. Such inmates will receive thorough medical and mental health evaluations, including the review of all available outside records.

The Medical Director will be consulted prior to continuing or implementing such treatment.

The Medical Director must approve, in writing, hormone use for the maintenance of secondary sexual characteristics in writing.\textsuperscript{33}

Under this policy, an individual who is receiving hormones upon entering the prison system will be able to continue receiving hormones in order to "maintain . . . the level of change which existed when they were incarcerated."\textsuperscript{34} If a prisoner's request for treatment is denied, he or she has a clear policy to cite and fall back on when making requests and filing grievances. While the policy does have some limitations for transgender prisoners in the custody of the BOP, and while it doesn't provide

\begin{itemize}
\item \textsuperscript{30}See \textit{id.} at 4.
\item \textsuperscript{31}In order to legally obtain hormones, transgender people must get a doctor's prescription. Of course, many transgender people run into problems with private health insurance companies' denials of "transgender" medical care, or resort to illicit hormones due to inability to pay for medical treatment or harassment when interacting with medical staff. For a more detailed overview of some of these problems, see Transgender Law Center, Recommendations for Transgender Health Care, http://www.transgenderlaw.org/resources/tlchealth.htm (last visited Dec. 15, 2008).
\item \textsuperscript{32}FED. BUREAU OF PRISONS, supra note 2, at 43.
\item \textsuperscript{33}Id.
\item \textsuperscript{34}Id.
\end{itemize}
transgender-related medical care for those transgender persons without
an official GID diagnosis, with untreated GID, or wishing to continue
progressing their transition at the time they enter federal custody, the
policy does provide a baseline standard for all transgender persons who
have received medical treatment prior to entering federal custody. Therefore, if an individual is on hormone replacement therapy when
entering Bureau custody, that individual has the right to continue
hormone therapy while imprisoned, and has clear grievance procedures
for pursuing violations of this regulation. Because this policy is Bureau-
wide, it applies to all prisoners at all prisons and facilities under the
control of the BOP, and provides clear standards for prison officials as
well.

Additionally, the BOP has standardized grievance forms and
procedures for all prisoners to use. The policy, procedures, and forms
are the same for all institutions governed by the Bureau of Prisons.
Therefore, any prisoner who believes he or she has wrongly been denied
access to hormone replacement therapy or any other transgender related
medical treatment has a policy that universally applies to all institutions
and explicitly states the level of medical care the government is required
to provide. As a result, no matter where prisoners are located, they
should have the same access and opportunities to receive hormone
treatment and other health care, as well as the same procedures and
considerations for appealing unfavorable decisions.

B. CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
POLICY AND STATE PRISON POLICIES IN GENERAL

California has fairly clear regulations, policy changes affected by a
2000 settlement, and a Correctional Medical Consultation Network that
together provide fairly clear access to health care for transgender prisoners and, more importantly, clear procedures for the CDCR to follow that specifically address transgender individuals. The CDCR's

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35. For example, if a transgender individual has not taken medical steps (such as hormone treatment or surgeries) to initiate a transition, the policy does not afford him or her any treatments since its focus is on maintaining the level of transition. FED. BUREAU OF PRISONS, supra note 2.
38. FED. BUREAU OF PRISONS, supra note 36, at 6.
40. Union-Tribune News Serv., supra note 3.
Department Operations Manual indicates that transgender individuals suffering from "gender dysphoria" will be referred to specific institutions for evaluation by medical personnel (looking at many criteria including past use of sex hormones) and will receive psychological referrals in certain circumstances. Additionally, the operations manual specifically states that:

If discontinuation of hormones is considered, medical staff shall assess the risk for negative consequences of such discontinuation. The length of prison sentence may be an important consideration. For a male inmate who is going to spend many years incarcerated, it may be realistic to consider the medical consequences of discontinuance.43

While this only explicitly provides for hormone treatment at certain facilities, the Division of Correctional Health Care Services policy goes further in explaining when hormone replacement therapy will be provided to prisoners. This policy states specifically that all transgender prisoners will be provided with hormone therapy according to guidelines established by the division and in accord with "community standards." The policy goes further, providing that "[t]ransgender patients entering the CDCR who either document or attest to current or recent hormone treatment will continue receiving treatment in accordance with ... guidelines," and transgender prisoners entering the CDCR not already receiving hormones who ask for them will receive an evaluation within ninety days and can be started on hormone therapy as a result of the evaluation.45 Additionally, the CDCR has very clear grievance procedures that allow for regular review of medical decisions, the opportunity to appeal unfavorable decisions, and consistency in decision making across all institutions.46 This provides clear opportunities for exhaustion of administrative remedies as required by the Prison Litigation Reform Act ("PLRA") and California state law.47 It is very important that the Correctional Health Services policy mentions "community standards," since this provides a strong argument that CDCR physicians should follow the WPATH guidelines, which have been recognized by the American Medical Association.48

42. CDCR, Operations Manual, supra note 3.
43. Id.
44. CDCR, Transgender Medical Care Policy, supra note 3, at 4.26.1.
45. Id. at 4.26.1–2.
49. See sources cited supra note 25 and accompanying text.
In addition to California's policy, seven states have explicit, written policies about transgender people in their corrections systems. All seven policies state that they provide hormones to transgender prisoners. Six of them explicitly state, however, that hormone therapy will be provided to only prisoners who were already receiving such care before incarceration and can prove as much. However, one court has found that denial of hormone treatment and other transgender care to transgender persons simply because they did not have a diagnosis or prescription preimprisonment was unreasonable and impermissible.

Eighth Amendment litigation surrounding denial of hormone treatment and other transgender healthcare continues across the country with sometimes mixed results. However, prisoner litigation did lead to the expansion of hormone and transgender health care access in California and to the creation of a specific policy for prisoners with GID in Idaho. So, while litigation itself may not always be successful, many states have responded to the need for consistent decisions by establishing policies that specifically address transgender individuals. The policies don't solve all problems, however; notably, transgender detainees may still face discrimination and difficulty accessing the hormones or other treatment to which they are entitled.

However, such policies do at least provide a clear standard that prisoners can use to litigate their right to access care.

### III. ICE's Role and Current Policy

#### A. A Brief Statement of Statutory and Constitutional Authority Governing the Department of Homeland Security and ICE

United States Immigration and Customs Enforcement is one of many executive agencies created under The Homeland Security Act of

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50. Spade, supra note 7, at 789 (footnotes omitted) (referencing, among others, the explicit policies of Alabama, Colorado, Idaho, Illinois, Michigan, and Minnesota).
52. See, e.g., Phillips v. Mich. Dep't of Corr., 731 F. Supp. 792, 793-94 (W.D. Mich. 1990). This is but one of many such cases. For a more comprehensive view of the situation in state prisons across the country, the documentary Cruel and Unusual provides a stark picture of the legal landscape and realities for prisoners in areas that do not have policies. CRUEL AND UNUSUAL (Reid Productions, LLC 2006). For more information, see Cruel & Unusual, www.cruelandunusualfilm.com (last visited Dec. 15, 2008).
55. Spade, supra, note 7, at 789 ("Even in states where court decisions or written policies require hormone treatment to be provided, advocates report that many prisoners are denied treatment or given low doses or inconsistent treatment, as is typical with prison medical care in general.").
2002.\textsuperscript{57} The Office of Detention and Removal Operations (DRO) operates numerous immigration detention facilities of various types across the United States.\textsuperscript{58} Unlike traditional "prisoners," however, ICE detainees often are not convicted of any crimes and may be in detention for any number of purposes. A sampling of ICE detainees includes asylum applicants, illegal or undocumented aliens awaiting removal, and convicted felons with deportable felonies.\textsuperscript{59} As a recent DRO assessment report states:

The Detention and Removal Program is the only program in government that removes aliens with final orders of removal. Aliens are identified and apprehended by other programs such as Immigration Investigations, the Border Patrol, and Immigration Inspections. Aliens may also be identified by state and local law enforcement jurisdictions. However, DRO is the only entity to manage their cases through immigration proceedings and then execute final orders of removal that are issued by an immigration judge. DRO utilizes other entities to assist in their detention responsibilities, including the Federal Bureau of Prisons (BOP), and the United States Marshal Service (USMS). DRO's approach to case management must be multi-pronged to address a diverse population of aliens. This includes detaining some aliens, releasing others with certain conditions, and placing others in alternative settings such as female facilities, family shelter care, halfway houses, or under electronic monitoring. Those held in detention have requirements that differ from traditional incarceration. ICE detainees are held for purely administrative processing. The standards of their confinement require that they have what is needed to understand their rights and participate fully in the immigration process. Unlike criminal cases, they do not have the right to an attorney provided at government expense. Consequently, they must have access to legal materials, communication with consular officials, and pro bono or hired counsel, where appropriate.\textsuperscript{60}

As noted in the DRO's report, ICE detainees do not have the right to a government-appointed attorney, a fact which can make obtaining necessary healthcare all the more difficult for any detainee, including transgender detainees seeking to continue hormone replacement therapy.

There were nearly 300,000 people in ICE detention in 2006.\textsuperscript{61} Since its reorganization under the Department of Homeland Security,

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\textsuperscript{58} ICE, Immigration Detention Facilities, \textit{supra} note 15.
\textsuperscript{60} \textit{Id.} § 1.3.
\end{flushleft}
Immigration and Customs Enforcement Detention and Removal Operations has had significant problems with both physical and mental health care. In response to these problems and the numerous lawsuits that have resulted from them, the Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law of the Committee on the Judiciary of the United States House of Representatives held hearings to discuss these problems, the reasons therefore, and possible solutions.\(^6^a\) In her opening statements, the Chairwoman of the committee explained the heart of the problem with healthcare in ICE detention:

The DIHS Medical Dental Detainee Coverage Services Packet specifically states that medical care in ICE detention facilities is to be provided primarily for emergency care. Care for, and I quote, "accidental or traumatic injuries incurred while in the custody and acute illnesses is not required but simply reviewed for appropriate care. Care for other illnesses, including pre-existing illnesses that are serious but not life threatening, is also not automatic but simply reviewable for appropriate care."\(^5^3\)

Furthermore, these reviews are conducted in Washington, D.C. by nurses, not physicians, who are away from the patients and simply reviewing paperwork submitted by other health care professionals recommending such care.

With this policy, it is no wonder there are reports of unsafe and inhumane medical treatment in ICE custody. This policy fails to recognize a fundamental principle of medical care in detention. The patient is detained and there is no other option but care authorized by ICE. Yet the policy only ensures emergency care and considers other care even in serious cases on a case-by-case basis.\(^6^3\)

In response to this congressional scrutiny and media attention of various sorts, including a series of articles in the Washington Post, ICE and DRO updated their Operations Manual to include "Performance Based National Detention Standards."\(^6^4\)

B. ICE'S CURRENT POLICIES ON DETAINEE HEALTH CARE

Until September 12, 2008, when ICE and DRO updated their Operations Manual, ICE was still using the old Immigration and Naturalization Service (INS) Detention Standards, including the

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\(^{6^2}\) See generally id. (examining whether or not immigration detention facilities' healthcare programs were adequate and being properly administrated).

\(^{6^3}\) Id. at 2.

\(^{6^4}\) See, e.g., ICE, U.S. DEP'T OF HOMELAND SEC., OPERATIONS MANUAL ICE PERFORMANCE BASED NATIONAL DETENTION STANDARDS (2008), available at http://www.ice.gov/partners/dro/PBNDS/index.htm; Dana Priest & Amy Goldstein, System of Neglect, WASH. POST, May 11, 2008, at A1 (providing an overview of the types of medical neglect suffered in ICE facilities and reporting that over the past five years, eighty-three people had died either during or shortly after leaving ICE custody).
standards for medical care and grievance procedures, both of which were published in September of 2000 (before ICE or the Department of Homeland Security existed). The new ICE/DRO Detention Standard on medical care begins with a broad statement of policy and scope:

This Detention Standard ensures that detainees have access to emergent, urgent, or non-emergent medical, dental, and mental health care that are within the scope of services provided by the DIHS [Division of Immigration Health Services], so that their health care needs are met in a timely and efficient manner.

This statement is somewhat more specific than the policy statement of the former standard, which read, “[a]ll detainees shall have access to medical services that promote detainee health and general well-being,” and many of the changes in specificity are likely due to the criticisms and problems illuminated in recent congressional hearings and investigative journalism. On the whole, the policy applies to all Service Processing Centers (SPCs), which are ICE-run detention facilities; Contract Detention Facilities (CDFs), which are detention facilities operated by independent contractors; and Intergovernmental Service Agreement (IGSA) facilities. The new medical care policy encourages more uniformity than the 2000 policy, which provided that some portions were only “guidelines” for IGSA facilities. However, the uniformity is not perfect, as certain portions of the 2008 policy only apply to SPCs and CDFs, with the caveat that “IGSAs must conform to these procedures or adopt, adapt or establish alternatives, provided they meet or exceed the intent represented by these procedures.” As a result, detainees within ICE’s jurisdiction do not necessarily all fall under the same policy.

Under the INS Detention Standard that existed until September 2008, healthcare requirements and procedures were very vague and discretionary. The INS Detention Standard on medical care set forth a

67. INS, MEDICAL CARE, supra note 5, at 1; see also Detention and Removal Hearing, supra note 61, at 1–2; Amy Goldstein & Dana Priest, In Custody, In Pain, WASH. POST, May 12, 2008, at A1.
68. ICE, supra note 66, at 1. A SPC is defined as “[a] detention facility the primary operator and controlling party of which is ICE”; a CDF is defined as “[a] facility that provides detention services under a competitively bid contract awarded by the ICE”; and an IGSA facility is any facility that has entered into an “Intergovernmental Service Agreement” with ICE to provide “clothing, medical care, food and drink, security and other services specified in the ICE/DRO Detention standards.” ICE, U.S. DEP’T OF HOMELAND SEC., ICE/DRO DETENTION STANDARD: DEFINITIONS 2, 5, 7 (2008) [hereinafter ICE/DRO DEFINITIONS], available at http://www.ice.gov/doclib/PBNDS/pdf/definitions.pdf.
69. INS, MEDICAL CARE, supra note 5, at 1.
70. ICE, supra note 66, at 1.
71. Id.
series of broad topics including medical facilities, medical personnel, medical screening of new arrivals, dental treatment, sick call, emergency medical treatment, medication, HIV/AIDS, informed consent, and many others about which individual detention facilities had to make their own policies, providing a loosely defined administrative floor. The new 2008 Standard is much more specific. For example, the new Standard includes more detailed sections on tuberculosis and HIV prevention and protocols, and includes a list of expected medical care outcomes. The Standard also includes explicit guarantees that medical personnel who actually have contact with detainees will make decisions, stating, for example, that "[i]n no event should clinical decisions be made by non-clinicians." These changes clearly address many of the criticisms raised in the 2007 congressional hearings, but they do little to address the concerns or problems that transgender detainees are likely to face. Neither the new Standard nor the old INS Standard make any mention of transgender individuals, GID, hormone therapy, or any other medical care issues of particular concern to transgender persons.

While none of the new Standard's sections specifically address GID or hormone therapy for transgender people, some of the "expected outcomes" suggest support for providing transgender people with access to hormone therapy and other appropriate healthcare. For example, Outcome Fifteen states that "[d]etainees with chronic conditions will receive care and treatment for conditions where non-treatment would result in negative outcomes or permanent disability as determined by the clinical medical authority." If GID were deemed to be a "chronic condition" under this outcome, and the "clinical medical authority" determined that not treating an individual's GID would result in negative outcomes (a finding strongly supported by medical standards of care for treating transgender individuals), then it would follow that a transgender individual would be able to access appropriate hormone replacement therapy, mental health care, etc., while in ICE detention. Similarly, Outcome Twenty states that "[d]etainees with suspected or known mental health concerns will be referred as needed for evaluation, diagnosis, treatment, and stabilization," and Outcome Twenty-Seven

72. INS, Medical Care, supra note 5, at 1-9.
73. ICE, supra note 66, at 1-3, 6-8.
74. Id. at 4.
75. Compare id. (creating a vague framework for SPCs and CDFs to use to develop their own healthcare policies, but lacking any specific mention of transgender detainees and their healthcare needs), with INS, Medical Care, supra note 5 (establishing clear expectations and more detailed healthcare policies and procedures for all SPCs and CDFs, but still lacking any specific mention of transgender detainees and their healthcare needs or how such needs are to be addressed).
76. ICE, supra note 66, at 2.
77. See discussion supra Part I.
states that “[p]rescriptions and medications will be ordered, dispensed, and administered in a timely and sufficient manner as prescribed by a health care professional.” These expected outcomes suggest that if transgender individuals make their mental health needs known to detention staff, they should be able access mental health care, and if a doctor prescribes hormones, they should be available in a timely fashion. Furthermore, under the “expected practices” section of the new Standard, “specialty health care” is included as one of the types of care each facility is expected to provide. This might include transition-related healthcare, or it might not. “Specialty health care” is not defined in the Medical Care Statement nor in the Definitions Statement. The ICE/DRO Standard is brand new, and only just beginning to be implemented, so there is no indication so far how ICE as a whole or the individual SPCs, CDFs, and IGSA facilities will interpret these “expected outcomes.”

While the policy on the whole is more explicit and specific than its predecessor, the new Standard still leaves implementation decisions and specific practices up to the individual situation. Without transgender-specific policies in the Standard to support these interpretations, there is great potential for generalized and inconsistent interpretation by policy makers at individual ICE detention facilities. This in turn opens the door to detainee litigation and grievances—a potentially disastrous legal combination for detainees and administrators alike.

C. ICE’S CURRENT POLICIES ON DETAINEE GRIEVANCES

Similar to ICE’s medical care policy for detainees, ICE detainee grievance procedures fell under the old INS Detention Standard of detainee grievance procedures (also published in September of 2000) until the new updated Detention Standard was published in September 2008. Like the medical care standards, the grievance procedures apply to all three types of detention facilities, but contain certain policies that apply only to SPCs and CDFs and serve as a comparative floor for the policies of IGSA. Again, this means that depending on the specific

78. ICE, supra note 66, at 2.
79. Id. at 4.
80. See id.; ICE/DRO DEFINITIONS, supra note 68.
81. Compare INS GRIEVANCE PROCEDURES, supra note 65 (requiring facilities to institute their own mechanisms for detainee grievances, with basic requirements that such grievance procedures must include oral and formal written options, emergency grievance procedures, and an option for appeal, but leaving the deadlines and specifics of the procedures up to the discretion of each facility), with ICE, U.S. DEP’T OF HOMELAND SEC., ICE/DRO DETENTION STANDARD: GRIEVANCE SYSTEM (2008) available at http://www.ice.gov/doclib/PBNDS/pdf/grievance_system.pdf (establishing much stricter requirements with clear expected outcomes, definite timelines, and concrete instructions, and a clear chain of appeal for detainees, as well as procedures for all staff at SPCs and CDFs to follow).
82. See ICE, supra note 81, at 1; ICE, supra note 66, at 1.
facility in which a particular detainee is housed, the grievance procedures he or she must follow may vary.

The new standards set forth are more explicit than their very vague and discretionary predecessors. The new 2008 Standard expects that detainees will be informed of their right to file grievances. The Standard also specifies several different levels of grievances and appeal that apply to all three types of facilities including an informal oral level, a formal written level, and an appeal to the Facility Administrator or Designee. The Standard also establishes a policy for "emergency" grievances that applies to all facilities (with more specific policies for SPCs and CDFs), which states: "Each facility shall implement written procedures for identifying and handling a time-sensitive emergency grievance that involves an immediate threat to a detainee's health, safety or welfare."

It is possible that certain transgender individuals seeking hormone therapy or mental health services might fall under this emergency standard, but without more specifics or guidelines, the implementation of this policy across facilities could yield drastically varying results. The new Standard also includes an intermediate level of appeal to the Grievance Officer or Detainee Grievance Committee that applies to SPCs and CDFs.

There are specific procedures laid out for handling of grievances (especially at SPCs and CDFs), and on the whole the process is much less discretionary than under the old 2000 Standard. Yet still there are no

83. Compare ICE, supra note 81 (providing clear, specific instructions to detainees and staff for what each facility's grievance procedures must include, what the timelines must be, and hierarchy of appeals will be), with INS GRIEVANCE PROCEDURES, supra note 65 (allowing each individual facility to come up with their own grievance procedures, while providing only vague instructions for what those procedures should be or how they should be implemented). For example, the old 2000 INS Standard's policies read:

Every facility will develop and implement standard operating procedures (SOP) that address detainee grievances. Among other things, each SOP must establish a reasonable time limit for: (i) processing, investigating, and responding to grievances; (ii) convening a grievance committee to review formal complaints; and (iii) providing written responses to detainees who filed formal grievances, including the basis for the decision. The SOP must also prescribe procedures applicable to emergency grievances. All grievances will receive supervisory review, and include guarantees against reprisal.

Id. at 1. The INS standard did provide additional guidance to facilities about the types of grievances they must allow, and made additional requirements about record keeping and prohibitions on retaliation. Id. at 2–8. However, these requirements were much less rigorous and specific than those discussed in notes 84–87 infra and accompanying text.

84. ICE, supra note 81, at 1.
85. Id. at 3–7.
86. Id. at 4.
87. Id. at 6.
88. Compare id. at 1–9 (requiring, for example, all facilities to provide two specific avenues of appeal for all detainees in SROs and CDFs along with definitive time limits on staff response to such grievances and detailing instructions for staff handling, labeling, and filing of all such appeals), with INS GRIEVANCE PROCEDURES, supra note 65, at 1–6 (providing, for example, only four paragraphs of explanation about what a detention facility's appeals process might look like, with very limited
standardized forms, nor is there any uniform appeal authority that covers all facilities (the facility administrator is the highest level of appeal for each institution), which could lead to different interpretations of the policy and other Standards. 88 Since individual detention facilities still have some leeway to come up with the specifics of their policies, an individual detainee who transfers through several facilities could still potentially have to learn a different procedure in each facility, placing a similar challenge on family members or attorneys helping that individual.

It is certainly a big improvement to have more standardization in the grievance process itself, but even standardized grievance procedures will not make up for the underlying uncertainty and vagueness of the health care policies. 90 It is also unclear whether transgender healthcare needs might fall under the umbrella of emergency grievances, and decisions on such matters could also vary in a broad sense from institution to institution. 91 This variation could lead to disparate treatment for transgender detainees at different points in the process of seeking medical care. Some institutions might approve hormones, while others might not. An individual might be transferred from one facility to another and have his or her hormones discontinued for no reason other than a difference in policy at the latter institution. Furthermore, when trying to appeal decisions concerning hormone treatment denial or discontinuance, the lack of a clear policy affirming access to hormones could lead to the random denial of many individuals grievances simply because the decision is left within the discretion of the medical director. This in turn might allow for decisions based on anti-transgender animus instead of sound medical discretion. The situation can be further compounded by potential disparities in the actual grievance procedures from one facility to the next. Two similarly situated transgender detainees could experience vastly different results (and in some cases procedures to follow) based simply on the facility at which they were detained at any given time.

88. See ICE, supra note 81.
90. See ICE, supra note 66; discussion supra Part III.B.
91. ICE, supra note 81, at 4. The Grievance System does not define what situations or types of situations might qualify as an emergency grievance. "Each facility shall implement written procedures for identifying and handling a time-sensitive emergency grievance that involves an immediate threat to a detainee's health, safety or welfare." Id. Since each facility is responsible for establishing its own procedures for identifying emergency grievances, there is no guarantee that similarly situated detainees will receive the same outcome among the different facilities.
D. WHERE THE PROBLEMS LIE: HOW TRANSGENDER INMATES ARE FALLING THROUGH THE CRACKS IN ICE DETENTION

Individuals in ICE detention are detained for many different reasons, and may have different rights. Transgender individuals may find themselves in immigration detention for any number of reasons.

Many transgender people come to the United States to escape persecution and, upon arriving or later on, seek asylum on the basis of membership in a particular social group.97 While not everyone seeking asylum winds up in ICE detention, federal statute requires the Department of Homeland Security to detain asylum seekers who lack valid travel documents.98 As one author explains, “[t]hese ‘defensive’ asylum seekers typically remain in detention while waiting for credible fear interviews and final adjudication of their claims through an adversarial process,” a lengthy proceeding which may lead to “several months to several years” spent in detention.99

Transgender individuals may also wind up in ICE detention after serving a prison term for a deportable offence. As one attorney reports:

TGI [(transgender, gender variant, and intersex)] people are at risk for incarceration because they are often poor, homeless, immigrants, and of color. They are also particularly at risk as a group because of strong anti-TGI discrimination in employment, housing, and education, which forces many TGI people—especially low-income transgender women of color who are additionally discriminated against as poor women of color—to turn to illegal economies like sex work and the drug trade to survive.100

Thus, many transgender people are imprisoned, many of whom are immigrants, and many of whom wind up in ICE detention after leaving prison. Once in ICE detention, these individuals may still have asylum or withholding-of-removal claims, which may take months or years to complete.

As mentioned in Part III, section B, there are three different types of ICE detention facilities: SPCs, CDFs, and IGSA facilities.101 Regulations and requirements for detainee health care and grievance processes can differ depending on the type of facility and from facility to

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94. Id.

95. Lee, supra note 9, at 5.

96. See INS, MEDICAL CARE, supra note 5, at 1-9; supra note 68 and accompanying text.
facility. Furthermore, since ICE policies and procedures for health care do not address GID or transgender individuals, and grievance procedures carry the possibility of variation among facilities, it is difficult for detainees and the attorneys representing them to predict outcomes or pursue consistent strategies. The question of what transgender-related healthcare is available to any given detainee depends on where they are detained and how that institution interprets the new medical care Standard. This may vary broadly among facilities, even those in the same legal jurisdiction. The procedures detainees and their attorneys must use to appeal denials of care vary in the same dimensions.

Since each facility is responsible for its own policies, it can be very difficult for detainees or those assisting them to determine what the procedures are. Procedures for individual detention facilities are not published in ICE materials readily available to the general public (including attorneys), so interested and affected parties must make inquiries directly to the detention facility in question. However, under newly instituted policies, individual detainees are supposed to receive a copy of the policies for their specific facility.

The combination of these factors can lead to arbitrary and inconsistent results, detainee and attorney frustration and confusion, and lack of clarity for detention administrators and healthcare providers. This is not only frustrating and potentially dangerous for detainees, but inefficient and precarious for ICE itself. As prisoners in other types of facilities across the United States adjudicate Eighth Amendment and other claims for better access to hormones and other transgender healthcare needs, the potential for litigation of ICE’s policies with regard to transgender detainees increases.

Without a standardized, articulated, consistent procedure, detainees have different recognized rights and options depending on the geographical location and type of their particular detention center. Since there are no defined procedures or standards of care specifically addressing the healthcare needs of transgender individuals (definitely not of the highly detailed type outlined by the CDCR), the likelihood for arbitrary or inconsistent application as well as problems with PLRA exhaustion will likely arise.

97. See discussion supra Parts III.B–C.
98. See id.
101. See sources cited supra note 3 and accompanying text.
IV. LEGAL REMEDIES AND AVENUES PRESENTLY OPEN TO ICE DETAINES

Detainees currently in ICE detention have been litigating Eighth Amendment cruel and unusual punishment claims under similar standards to those tried by federal and state prisoners. To succeed, however, a detainee will have to fulfill the relevant Eighth Amendment tests as outlined in *Gammett v. Idaho Department of Corrections*. In order to prevail on Eighth Amendment claims concerning prison medical treatment, prisoners must usually show that prison officials' "acts or omissions [were] sufficiently harmful to evidence deliberate indifference to serious medical needs." As laid out in *Farmer v. Brenan*, the first case in which the United States Supreme Court held that housing and medical treatment concerns could potentially amount to an Eighth Amendment *Bivens* claim for transgender prisoners, "deliberate indifference" occurs when prison officials are aware of and disregard a serious medical condition or when officials are "aware of facts from which the inference could be drawn that a substantial risk of harm exists," and then disregard such facts. *GID* has been found to be a "serious medical condition" by courts on several occasions. Additionally, the United States District Court for the Central District of California recently found that ICE officials did not have immunity from a *Bivens* action based on Eighth Amendment violations.

However, the PLRA places many restrictions on prisoner litigants, including the requirement of complete exhaustion of administrative remedies prior to filing a lawsuit in federal court. The PLRA applies to all prisoner litigation including Eighth Amendment claims. The

103. U.S. CONST. amend. VIII.
105. See 2007 WL 2166896, at *12.
107. See *Bivens v. Six Unknown Named Agents of Fed. Bureau of Narcotics*, 403 U.S. 388, 389 (1971). Bivens is the first case recognizing a cause of action for violations of constitutional rights made by individuals acting under the color of federal law. Id. *Bivens* claims and lawsuits under the Federal Tort Claim Act are the two options for legal remedies for prisoners whose constitutional rights have been violated while in federal custody; the two types of lawsuits approximate the function that § 1983 has for violations of constitutional rights by state actors. See 42 U.S.C. §§ 233(a), 1983, 2671-2680 (2006); 403 U.S. at 389. For a further discussion of these two remedies and how they apply to ICE detainees' healthcare-related Eighth Amendment claims, see generally *Castaneda v. United States*, 546 F.3d 682 (9th Cir. 2008).
108. 511 U.S. at 837–38.
112. See id.
complete exhaustion requirement, when viewed in conjunction with ICE’s vague to variable standards (especially in terms of emergency grievances) and potential disparities in the levels of review provided could pose a problem for ICE detainees. Since different facilities might have different procedures or different interpretations of the same procedure, it might not be easily ascertainable that a detainee had exhausted his or her administrative remedies. There is also the possibility that inconsistency in rulings would apply due to the vast diversity in jurisdictions and facilities involved. Detainees also can argue under the existing medical care policy, perhaps by using the emergency healthcare provisions to argue for access to hormones and other transgender healthcare needs, and by utilizing the existing grievance procedures to appeal negative decisions, but they may continue to face unclear or discretionary decisions that leave them with no option but to seek judicial intervention.

In addition to the seriousness of transgender detainees’ concerns about hormone treatment and healthcare access, ICE is currently embroiled in a number of Eighth Amendment claims for other types of healthcare needs. These include claims by prisoners suffering from bipolar disorder, a man who died of a heart attack after complaining of chest pains, and a cancer patient whose care was ignored for so long that the result was a terminal diagnosis and penile amputation. These instances were most likely very influential in leading ICE to update its medical care policies in general. But while these more specific, less discretionary policies may be helpful to transgender individuals in ICE detention and may be interpreted in ways that encourage more consistent access to hormone replacement therapy and other treatments, they are no substitute for specific transgender healthcare provisions or policies in terms of providing consistent care to all similarly situated individuals, simplifying the grievance process for transgender detainees, and reducing the likelihood of Eighth Amendment–based lawsuits.

V. CONCLUSIONS AND RECOMMENDATIONS FOR POLICY CHANGE AND ADDITIONAL RESEARCH

For the many reasons articulated in this Note, a comprehensive and explicit healthcare policy that specifically mentions transgender health care is needed in ICE detention facilities. Ideally, such a policy would
clearly and specifically address criteria for access to hormone replacement therapy and other common transgender health care needs, and follow the guidelines recommended by the National Lawyers Guild and the San Francisco Commission on Human Rights. 119

The California Department of Corrections and Rehabilitation, Division of Correctional Health Care Services' policy, while not perfect, would provide a good starting point. 120 This policy allows for individualized determinations for access to hormone therapy and other treatments regardless of whether an individual was receiving such treatments prior to being detained, references community standards in setting the standard of care, and applies to all institutions in the CDCR's control. 121 Implementing such a policy at ICE would benefit transgender individuals by ensuring equal and consistent treatment across different facilities, providing clear grounds on which to base any grievances, allowing for humane and individualized evaluations of transgender persons' medical needs, and avoiding further compounding physical and mental healthcare costs as might happen if hormone therapy access was based on an individual's predetention transition status.

At the bare minimum, ICE should have a policy declaring that transgender individuals will be maintained at the same level of transition as when they entered ICE custody, and specifically mentioning hormone replacement therapy (similar to the Federal Bureau of Prison's current policy). 122 However, even such a minimal policy may continue to expose ICE to litigation from transgender individuals denied treatment in detention due to their lack of prior treatment history.

Without these policies in place, transgender detainees will continue to suffer uncertainty, medical neglect, unequal or arbitrary access to treatment, disparate treatment from detention facility to detention facility, and the detrimental and potentially life-endangering results of untreated GID. 123 Not only will transgender detainees suffer, but ICE will continue to leave themselves open to costly and potentially embarrassing

120. CDCR, Transgender Medical Care Policy, supra note 3, at 4.26.1–2.
121. Id.
122. Fed. Bureau of Prisons, supra note 2. While not ideal, since it does not clearly address hormones as a separate issue or discuss what happens with prisoners who have been obtaining "street" hormones without a prescription or otherwise lack a GID diagnosis, this policy does, at the very least, in theory, prevent the removal of hormones, mental health therapy, and other important healthcare measures from persons already accustomed to them. If such a policy as this were in place at all ICE detention centers, the individual mentioned in the introduction, for example, would have been able to continue receiving prescribed hormone therapy, and would not have suffered any deleterious health effects associated with hormone deprivation.
Eighth Amendment claims of cruel and unusual punishment, such as they continue to face for various other types of healthcare denials. In addition, to help improve consistency and clarity for both detainees and ICE officials, emergency grievance procedures should be more explicit and less open to interpretation than their current form.

In addition to these recommendations and consequences, additional legal research is sorely needed. Since the individuals in ICE detention have a variety of immigration statuses, claims, and possibly even varying constitutional rights (depending on immigration status), a thorough examination of the intersection between immigration law and policy and the rights of transgender detainees is needed. There may also be questions of administrative and constitutional law that will need to be examined. For example, would transgender detainees in CDFs face additional hurdles in enforcing their rights via lawsuit since the personnel operating the detention facility are not, strictly speaking, government actors? As this subject area is more fully explored, the rights and options for transgender detainees, as well as the avenues of advocacy for such detainees, will become clearer.

124. See, e.g., Castaneda v. United States, 538 F. Supp. 2d 1279, 1281-85, aff'd, 546 F.3d 682 (9th Cir. 2008) (describing repeated denial of medical care for a detainee who was eventually diagnosed with penile cancer and died not long after being released from ICE detention); Detention and Removal Hearing, supra note 61 (testimony of Tom Jawetz, Immigration Det. Staff Att'y, ACLU National Prison Project) (detailing, among others, the case of Victoria Arellano, an HIV-positive transgender detainee who died in ICE detention after her HIV medications were discontinued by ICE officials); ACLU, supra note 100.

125. ICE, supra note 81, at 4.