

December 14, 2023

Mr. Troy A. Miller
Senior Official Performing the Duties of the Commissioner
U.S. Customs and Border Protection
1300 Pennsylvania Ave., NW
Washington, DC 20229

Dear Mr. Miller:

As you know, Anadith Danay Reyes Álvarez, an eight-year-old girl with sickle cell disease and congenital heart disease, tragically died on May 17, 2023, in U.S. Customs and Border Protection (CBP) custody, following several days of illness.¹ I write to express my concern that failure to provide adequate medical care—which resulted in the avoidable death of Anadith Álvarez—is not an isolated incident.

The medical personnel responsible for Anadith’s care were employees of Loyal Source, a company contracted by CBP to provide medical care to individuals in CBP custody.² Recently a CBP employee whistleblower alleged that CBP has failed to hold Loyal Source accountable for deficient medical care over a period of years.³ The whistleblower’s allegations indicate CBP has not held Loyal Source accountable for unsupported invoicing, severe understaffing, unlicensed and improperly credentialed medical personnel, and privacy breaches.

It is important that the Committee understands CBP’s role in these alleged failures, including chronic understaffing, the roles and responsibilities of CBP personnel involved in overseeing the delivery of medical care, CBP’s Electronic Medical Record (EMR) software platform, and expectations regarding the level of care to be delivered to migrants in CBP custody.

Prior to the recent whistleblower allegations, reports from agency oversight offices raised alarms about CBP’s failure to provide adequate medical care.⁴ CBP’s Office of Professional Responsibility (OPR) found numerous breakdowns in Anadith’s care, including Loyal Source

¹ CBP, Update: Death in Custody of 8-Year-Old in Harlingen, Texas (May 21, 2023),

<https://www.cbp.gov/newsroom/speeches-and-statements/update-death-custody-8-year-old-harlingen-texas> (“CBP May 21, 2023 Statement”)

² Nick Miroff, *Medical provider vying for border contract faces scrutiny after girl’s death*, THE WASHINGTON POST, Nov. 19, 2023, <https://www.washingtonpost.com/immigration/2023/11/19/border-loyal-source-medical-care-migrants/>.

³ Nick Miroff, *Whistleblower alleges failures in medical care at U.S. border facilities*, WASHINGTON POST, Nov. 30, 2023, <https://www.washingtonpost.com/immigration/2023/11/30/border-whistleblower-loyal-source-medical-migrants/>.

⁴ CBP, Update: Death in Custody of 8-Year-Old in Harlingen, Texas (June 1, 2023), <https://www.cbp.gov/newsroom/speeches-and-statements/june-1-2023-update-death-custody-8-year-old-harlingen-texas> (“CBP June 1, 2023 Statement”).

staff’s professed lack of awareness that Anadith had sickle cell disease and a history of congenital heart disease; medical personnel’s failure to consult with on-call physicians, including an on-call pediatrician; and medical personnel’s failure to document multiple medical encounters with Anadith.⁵

As CBP acknowledged in its investigation of the circumstances preceding Anadith’s death, Mabel Álvarez, Anadith’s mother, took necessary steps to alert Loyal Source staff of her daughter’s medical conditions only hours after they were placed in CBP custody.⁶ When Anadith’s health declined, Ms. Álvarez repeatedly requested that Anadith be taken to a hospital.⁷ Medical staff only called an ambulance after Anadith suffered a seizure and was unresponsive.⁸

According to investigations of substandard medical care in CBP facilities, the circumstances that resulted in Anadith’s death are not an aberration, but are indicative of systemic problems with the provision of medical care in CBP facilities and CBP’s broader failure to properly oversee that care. A pediatrician appointed by a federal court to monitor CBP’s compliance with the June 29, 2022 settlement agreement in *Flores v. Garland* issued two reports highlighting serious concerns with medical care of children in CBP facilities.⁹ The second report, issued after Anadith’s death, addressed the “systemic procedures and policies that proved catastrophically inadequate to prevent the deterioration in [Anadith’s] condition and ultimately, her tragic death.”¹⁰ According to the report, “these failures occurred at multiple levels and should not be viewed as rare anomalies but rather as systemic weaknesses that if not remedied, are likely to result in future harm to children in CBP custody.”¹¹

A July 2020 GAO report noted that CBP has not consistently implemented enhanced medical care policies and procedures for those in their custody, including children, at southwest border facilities.¹² A Department of Homeland Security (DHS) Office of Inspector General (OIG) report issued the same year provided an overview of investigations into the deaths of two children in CBP custody and related congressional investigations and hearings about migrant deaths in custody.¹³ A 2022 report issued by the DHS Immigration Detention Ombudsman concluded

⁵ *Id.*

⁶ CBP May 21, 2023 Statement.

⁷ CBP June 1, 2023 Statement.

⁸ *Id.* Anadith’s family alleges both neglect and discrimination contributed to her death. Anadith’s mother has alleged medical staff ignored her pleas and treated her family poorly, in part, because her family is Black. Camilo Montoya-Galvez, *Official concedes 8-year-old who died in U.S. custody could have been saved as devastated family recalls final days* (July 20, 2023), CBS NEWS, <https://www.cbsnews.com/news/anadith-danay-reyes-alvarez-8-year-old-migrant-died-border-patrol-custody-family/>.

⁹ Paul H. Wise, *Juvenile Care Monitor Report 21-40* (Jan. 2023), <https://youthlaw.org/sites/default/files/2023-07/2023.01.30%20-%20Flores%20Juvenile%20Care%20Monitor%20Report.pdf>; Paul H. Wise, *Juvenile Care Monitor Report 32* (July 2023), https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf.

¹⁰ Paul H. Wise, *Juvenile Care Monitor Report 32* (July 2023), https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf.

¹¹ *Id.* at 38.

¹² GAO, *Southwest Border CBP Needs to Increase Oversight of Funds, Medical Care, and Reporting of Deaths* (July 2020), <https://www.gao.gov/assets/gao-20-536.pdf>.

¹³ DHS OIG, *Management Alert – CBP Needs to Award a Medical Services Contract Quickly to Ensure no Gap in Services 6* (Sept. 3, 2020), <https://www.oig.dhs.gov/sites/default/files/assets/Mga/2020/oig-20-70-sep20-mgmtalert.pdf>.

there was a “critical shortage of medical services at CBP facilities” that “could jeopardize the health and safety of noncitizens in CBP custody.”¹⁴

In addition to inadequate medical care, we are concerned about the length of time individuals, including children, are held in CBP custody and how this impacts overall health outcomes. The DHS Office of Inspector General (OIG) recently conducted inspections of CBP detention facilities in the San Diego area and found 56 percent of detainees were held in custody longer than 72 hours, the general limitation on CBP detention.¹⁵ The length of time in custody may exacerbate existing medical care needs, create additional challenges for medical staff attending to the needs of large numbers of migrants, and create dangerous and untenable conditions in CBP facilities that were not designed for long-term detention.

CBP’s Office of the Chief Medical Officer (OCMO) has briefed my staff regarding the challenges in providing medical care to nearly 90 facilities where only five years ago there were virtually no medical care providers. According to OCMO, approximately 1,400 Loyal Source staff provide medical services at these facilities. Despite these challenges, it is the agency’s responsibility to ensure adequate medical care and rigorous oversight of contracted medical staff.

To aid my understanding of the delivery of medical care in CBP facilities, I request the following information and responsive answers no later than January 18, 2024:

1. A list of CBP facilities where Loyal Source is providing medical care, including the number of medical staff assigned to each facility and a description of medical staff’s roles and responsibilities.
2. Documents and communications from January 2020 to the present related to the understaffing of medical personnel in CBP facilities, including internal correspondence alerting Office of Acquisition personnel about understaffing of medical personnel.
3. Documents and communications related to the length of the clearance process for new medical personnel to begin work under the contract with Loyal Source and the impact of any delays pursuant to the clearance process on the delivery of medical care.
4. A copy of the Contractor Performance Assessment Reporting System (CPARS) report drafted for the Period of Performance (POP) of September 30, 2020-September 29, 2021 that lowered Loyal Source ratings from “exceptional” to “unsatisfactory” and “marginal” and recommended Loyal Source not be recommended for future contracts, and the CPARS report for the same POP that upgraded Loyal Source ratings from “unsatisfactory” and “marginal” to “exceptional” and “very good.”

¹⁴ Office of the Immigration Detention Ombudsman (OIDO), Ombudsman Alert: Critical Medical Understaffing on the Border 1 (July 12, 2022), https://www.dhs.gov/sites/default/files/2022-07/OIDO%20Ombudsman%20Alert%20CBP%20Medical%20Contract%20Final_508.pdf.

¹⁵ DHS OIG, Results of Unannounced Inspections of CBP Holding Facilities in the San Diego Area 4 (Nov. 15, 2023), <https://www.oig.dhs.gov/sites/default/files/assets/2023-11/OIG-24-07-Nov23.pdf>.

5. Any CPARS interim or final report submitted for Loyal Source and any Loyal Source response.
6. A copy of the August 10, 2023 Cure Letter that CBP issued to Loyal Source and any other reports or communication indicating contract discrepancies issued to Loyal Source.
7. A copy of the June 8, 2023 memorandum sent by Acting Chief Medical Officer Herbert O. Wolfe to Acting CBP Commissioner Troy Miller recommending medical improvement actions.
8. Documents and communications from January 2022 to present relating to CBP's current EMR software platform and the status of CBP efforts to obtain a new electronic medical record platform, including input from contractors required to use the current software platform.
9. Current guidance governing medical care of migrants in CBP custody, including existing guidelines for seeking medical care outside of a CBP facility. This includes any protocol for assessing the custodial and medical requirements for children at elevated medical risk who are being held in CBP facilities, including what events trigger a consultation with an on-call pediatrician or an evaluation at a local hospital.
10. Plans to hire additional federal employees to oversee the delivery of medical care in CBP facilities in the field and at CBP headquarters and a description of the roles and responsibilities of these employees.

I thank you for your prompt attention to this inquiry.

Sincerely,



Richard J. Durbin
Chair

cc: The Honorable Lindsey O. Graham
Ranking Member, Senate Committee on the Judiciary