CASE NO. 26-1294, 26-3344

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

FERNANDO GOMEZ RUIZ, et al.

Plaintiffs and Appellees,

v.

UNITED STATES IMMIGRATION AND CUSTOMS ENFORCEMENT, et al.

Defendants and Appellants,

v.

CORECIVIC, INC.,

Intervenor and Appellant.

On Appeal From The United States District Court,
Eastern District of California, Case No. 1:26-cv-02546-JLT-CDB,
Hon. Jennifer L. Thurston, Presiding

BRIEF OF AMICUS CURIAE PHYSICIANS FOR HUMAN RIGHTS IN SUPPORT OF PLAINTIFFS-APPELLEES

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I. STATEMENT OF AUTHORITY TO FILE

Amicus Physicians for Human Rights submits this brief without a motion for leave because all parties have consented to its filing.

II. STATEMENT OF INTEREST OF AMICUS CURIAE

Physicians for Human Rights ("PHR")[1] is an international human rights organization with networks of clinicians around the world, including in the U.S., who work to advance human rights and support accountability and justice for survivors of human rights violations. PHR uses its core disciplines—science, medicine, forensics, and public health—to conduct research and medical evaluations, undertake fact-finding investigations, and galvanize thousands of health professionals and allies in the legal sector to end human suffering, save lives, and secure justice and universal human rights for all. PHR is a global leader in forensic documentation of human rights abuses and shared in the Nobel Peace Prize in 1997.

PHR has been documenting health conditions in immigration detention centers across the United States since the 1990s.[2] PHR has published multiple

[1] Pursuant to Federal Rules of Appellate Procedure, Rule 29(a)(4)(E), Amicus PHR affirms that no party's counsel authored this brief in whole or in part and that no person or entity (other than the Amicus, its members, or its counsel) has contributed money intended to fund this brief's preparation or submission.

[2] *See* Minn. Lawyers Int'l Hum. Rts. Comm. & Physicians for Hum. Rts., *Hidden From View: Human Rights Conditions in the Krome Detention Center* (Apr. 1991), https://theadvocatesforhumanrights.org/Res/krome_2.pdf; ACLU, Am. Oversight

reports documenting hazardous conditions in these facilities, including reports on United States Immigration and Customs Enforcement's ("ICE") deviations from its own policies during the COVID-19 pandemic, and on overuse and misuse of solitary confinement in immigration detention.[3] Most recently PHR co-authored a report with Human Rights Watch, entitled *Dying in Detention: Rising Deaths in an Expanding US Immigration Detention System* (2026). This report examined deaths in detention facilities across the U.S., including in the state of California, and found many instances concerning for inadequate and delayed care.[4] PHR's reports

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& Physicians for Hum. Rts., *Deadly Failures: Preventable Deaths in U.S. Immigration Detention* (June 25, 2024), https://phr.org/wp-content/uploads/2024/06/REPORT-ICE-Deadly-Failures-ACLU-PHR-AO-2024.pdf; Physicians for Hum. Rts. & Hum. Rts. Watch, *Dying in Detention* (June 2026), https://phr.org/wp-content/uploads/2026/06/PHR-HRW-Report-US-Deaths-ICE-detention-2026.pdf.

[3] *See* Heartland All. Nat'l Immigrant Just. Ctr. & Physicians for Hum. Rts., *Invisible in Isolation* (Sep. 2012), https://phr.org/wp-content/uploads/2020/11/Invisible-in-Isolation-Sep2012-detention.pdf; Physicians for Hum. Rts., *Praying for Hand Soap and Masks* (Jan. 2021), https://phr.org/wp-content/uploads/2021/01/PHR-Praying-for-Hand-Soap-and-Masks.pdf; Physicians for Hum. Rts., Harv. Immigr. & Refugee Clinical Program & Peeler Immigr. Lab, *"Endless Nightmare": Torture and Inhuman Treatment in Solitary Confinement in U.S. Immigration Detention* (Feb. 6, 2024), https://phr.org/wp-content/uploads/2024/02/PHR-REPORT-ICE-Solitary-Confinement-2024.pdf; Physicians for Hum. Rts., *Cruelty Campaign: Solitary Confinement in U.S. Immigration Detention* (Sep. 17, 2025), https://phr.org/wp-content/uploads/2025/09/PHR-Report-Cruelty-Campaign-ICE-Solitary-Confinement-September-2025.pdf.

[4] Physicians for Hum. Rts. & Hum. Rts. Watch, *Dying in Detention*, *supra* note 2.

have unfortunately revealed a consistent pattern of violations by ICE, even with respect to ICE's own detention standards.[5]

PHR is deeply concerned that inadequate healthcare systems and lack of oversight at the California City Detention Center ("Cal City") put detainees at risk of serious, irreparable harm, including life-threatening illnesses, catastrophic injuries, and even loss of life. As a result of our experience, research, and our review of the information available to us, including the record before this Court and materials made publicly available thereafter, PHR writes to urge this Court to affirm the district court's preliminary injunction order and affirm appointment of a medical monitor.

III. SUMMARY OF ARGUMENT

The Cal City detention facility is subject to the National Detention Standards ("NDS), a less rigorous standard applied to "non-dedicated" ICE facilities. Standards are lower because non-dedicated facilities also house other detainees. Despite this, as both the lower court and the court-appointed external monitor have found – and is discussed in detail below – Cal City has repeatedly fallen short of even these less demanding standards.

[5] Physicians for Hum. Rts., *Cruelty Campaign: Solitary Confinement in U.S. Immigration Detention*, *supra* note 3, at 18.

Areas where Cal City has consistently fallen short include: inadequate staffing; failing to conduct appropriate medical intake screenings; failing to provide timely access to medical specialists; inadequately distributing prescribed medication; and failing to maintain a timely emergency response system. These failures lead to serious adverse medical consequences for both individual detainees and the detained population as a whole.

As a result, the appointed independent medical monitor is indispensable for the safety of the detainee population. This is particularly true given that the federal administration has defunded or dismantled all three DHS oversight offices which should be addressing medical problems in detention facilities. Further, DHS has impeded outside physicians from engaging with the detainee population. Under these circumstances, the preliminary injunction and the appointment of the external monitor are vital to ensure adequate healthcare for Cal City ICE detainees.

IV. ARGUMENT

A. ALTHOUGH SUBJECT TO A LESS DEMANDING ICE DETENTION STANDARD, CAL CITY FALLS SHORT

In evaluating the decision of the Court below, Physicians for Human Rights believes that it is significant that Cal City has been legally required to meet a lower standard than other similar facilities in California – and yet has failed to meet even this lower standard.

Cal City is a private detention facility operated by CoreCivic under a two-year contract with ICE. This contract requires CoreCivic to follow a set of operational standards set by ICE.[6] While other California immigration detention facilities are required to adhere to ICE's Performance Based National Detention Standards 2011 ("PBNDS"), contractually, Cal City is only obligated to comply with the less rigorous National Detention Standards ("NDS").[7] This is because NDS applies to non-dedicated facilities, like Cal City, which are facilities that hold state and local inmates in addition to immigration detainees.[8] In contrast, PBNDS applies to dedicated ICE detention facilities that operate exclusively for ICE's immigration enforcement mission.[9]

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[6] CoreCivic, California City Immigration Processing Center, https://www.corecivic.com/facilities/california-city-immigration-processing-center (last accessed Nov. 3, 2026).

[7] Cal. Dep't of Just., *Immigration Detention in California: A Review of Conditions of Confinement* at 143 (May 2026), https://oag.ca.gov/system/files/media/immigration-detention-2026.pdf; *see also* Decl. of Christopher Chestnut ¶17, Mar. 3, 2026, Dkt. No. 82-1; U.S. Immigr. & Customs Enf't, *70CDCR25D00000010 P00004: California City CDF – California City, CA* at 4 (May 2026) [hereinafter *California City Contract*], https://www.ice.gov/doclib/foia/detFacContracts/70CDCR25D00000010_P00004_CaliforniaCityCDF_CaliforniaCityCA.pdf.

[8] *California City Contract*, *supra* note 7; *see* National Immigration Forum, *Explainer: U.S. Immigration Detention and Custody Standards* at 1 (June 18, 2025), https://forumtogether.org/article/explainer-u-s-immigration-detention-and-custody-standards/ (last accessed Oct. 15, 2026); U.S. Immig. & Customs Enf't, *Detention Management*, https://www.ice.gov/detain/detention-management (last accessed Oct. 15, 2026).

[9] *See* National Immigration Forum, *Explainer: U.S. Immigration Detention and Custody Standards*, *supra* note 8; U.S. Immig. & Customs Enf't, *Detention*

NDS is generally less protective of detainees than PBNDS. This implicates several areas including medical care, solitary confinement, and disability accommodations.[10] For example, while the PBNDS provides detailed provisions and expectations regarding medical and mental health care, the NDS is not as comprehensive.[11] The PBNDS also protects suicidal individuals in ICE custody from being placed in solitary confinement, while the NDS does not.[12] By omitting clear and necessary measures for facilities to follow, the NDS is less protective for detainees.[13]

Despite having only to comply with lower standards, Cal City has consistently failed to meet them. The district court found that Plaintiffs-Appellees

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Management, https://www.ice.gov/detain/detention-management (last accessed Oct. 15, 2026).

[10] Katy Murdza, *ICE Revises Its Standards for Some Detention Facilities* (Dec. 2, 2019), https://www.americanimmigrationcouncil.org/blog/ice-updates-detention-standards/#.X4CiKdBKjIV.

[11] 4.3 Medical Care in NDS 2025 is 15 pages in length. In PBNDS 2011 rev. 2016, it is 41 pages in length; U.S. Immigr. & Customs Enf't, *Performance-Based National Detention Standards 2011* (rev. ed. 2016) [hereinafter *PBNDS* 2011], https://www.ice.gov/doclib/detention-standards/2011/pbnds2011r2016.pdf (last accessed Nov. 3, 2026); U.S. Immigr. & Customs Enf't, *National Detention Standards* (rev. ed. 2025) [hereinafter *NDS* 2025], https://www.ice.gov/doclib/detention-standards/2025/nds2025.pdf (last accessed Nov. 3, 2026).

[12] Murdza, *supra* note 10.

[13] *See Floor or Ceiling: How Two Sets of Standards Result in Divergent Treatment for People in ICE Detention, and a Call for Consistency*, A.B.A. (Mar. 15, 2021), https://www.americanbar.org/groups/public_interest/immigration/generating_justice_blog/floor-or-ceiling-how-two-sets-of-standards-result-in-divergent-treatment/.

("Plaintiffs") had shown Cal City was likely providing inadequate health care for detainees.[14] The court ordered Defendants-Appellants ("Defendants") to ensure detainees were provided with access to a functional health care system and appointed an external medical monitor to verify compliance.[15] In July 2026, the external monitor, Dr. Muthusamy Anandkumar, released the first report on the conditions of healthcare services.[16]

Drawing on its medical expertise, PHR will set out below: (1) Cal City's failure to meet the more permissive NDS; (2) the remedial measures the district court ordered in response; (3) Cal City's ongoing violations of those very measures; and (4) the underlying medical importance of those measures.

1. Cal City does not have adequate staffing to meet detainee healthcare needs.

The NDS require Cal City to "employ sufficient medical staff to perform basic exams and treatments for all detainees."[17] Prior to the district court's order,

[14] Order Granting in Part Pls.' Mots. Prelim. Inj., Feb. 10, 2026, Dkt. No. 72; *see also* Mem. Decision, Mar. 27, 2026, Dkt. No. 111.
[15] Order Granting in Part Pls.' Mots. Prelim. Inj. 1, Dkt. No. 72.
[16] Geeta Sharma, *Monitor Finds ICE Neglected Constitutional Medical Care at CA Detention Center*, VANGUARD NEWS GROUP (July 30, 2026), https://davisvanguard.org/2026/07/ice-detention-center-medical-failures/.
[17] *NDS* 2025, *supra* note 11, at 112; *see also* U.S. Immigr. & Customs Enf't, *National Detention Standards* at 120 (rev. ed. 2026) [hereinafter *NDS* 2026], https://www.ice.gov/doclib/detention-standards/2026/nds2026.pdf (last accessed Nov. 3, 2026).

there was a "crisis-level health care understaffing at Cal City."[18] At one point, Cal City had only one doctor for 942 detainees.[19] This sole doctor was "working five 11-hour days per week . . . overburdened" and forced to triage patients rather than provide necessary medical care.[20]

Considering this, the district court ordered Defendants to ensure "adequate health care staffing" at the facility.[21] Yet months after Defendants were ordered to remedy this healthcare personnel shortage, the court-appointed medical monitor found that staffing shortages continued, "creating a serious risk of delayed clinical care and increasing the likelihood of preventable harm."[22] He also noted that "staff who had not been fully trained were themselves training new staff."[23] According to the monitor, "[g]iven the number of patients and the seriousness of their medical and mental health needs, these substantial gaps contribute to an unsafe environment."[24]

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[18] Cal. Dep't of Just., *Immigration Detention in California*, *supra* note 7, at 143, 165.
[19] *Id.* at 143, 147, 165.
[20] *Id.* at 165.
[21] Order Granting in Part Pls.' Mots. Prelim. Inj. 1, Dkt. No. 72.
[22] Report of External Monitor on Medical Care at California City Detention Facility 12, *Gomez-Ruiz v. U.S. Immigr. & Customs Enf't*, No. 26-cv-02546 (E.D. Cal. July 27, 2026), Dkt. No. 166-2.
[23] *Id.* at 3.
[24] *Id.*

Inadequate staffing means there are not enough personnel to effectively monitor and respond to the medical needs of individuals in detention. In its 2024 analysis of ICE facilities, DHS's Office of Inspector General ("OIG") warned that staffing shortages impacted "timely sick call responses, medication refills, and the level of care detainees received for suicide watch, dental, optometry and chronic care."[25]

In PHR's report *Deadly Failures: Preventable Deaths in U.S. Immigration Detention*, which analyzed 52 deaths in ICE detention between January 1, 2017, and December 31, 2021, 44 percent of the deaths occurred in facilities with "serious staffing issues, including shortages, improper training, or care outside the scope of practice."[26] A separate study of detention centers found that inadequate staffing led to insufficiently trained personnel incorrectly addressing the healthcare needs of detained individuals.[27] In one facility, inadequately trained medical staff

[25] Off. of Inspector Gen., U.S. Dep't of Homeland Sec., *Summary of Unannounced Inspections of ICE Facilities Conducted in Fiscal Years 2020-2023* at 10 (Sep. 24, 2024), https://www.oig.dhs.gov/sites/default/files/assets/2024-09/OIG-24-59-Sep24.pdf.

[26] ACLU, Am. Oversight & Physicians for Hum. Rts., *Deadly Failures: Preventable Deaths in U.S. Immigration Detention*, *supra* note 2, at 10.

[27] Parveen Parmar et al., *Mapping Factors Associated with Deaths in Immigration Detention in the United States, 2011-2018: A Thematic Analysis*, 2 Lancet Reg'l Health Am. at 6 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC9904093/ (noting "[i]nadequate resources, including shortages of appropriate staff and absence of protocols or training appeared to be contributory in some deaths reviewed.").

dispensed medications that deviated from the treatment protocol.[28] Such deviations can result in adverse drug reactions, undermine the effectiveness of prescribed treatment, and worsen underlying health conditions.[29] In another example, staffing vacancies at a facility resulted in undertrained individuals missing critical findings such as when a clinician "dismissed severe chest pain in a woman with known cardiac disease who died days later of a heart attack."[30] Whether lacking recognition of disease or not knowing proper prescribing of medications, all instances of insufficiently trained staff can cause serious injury or even death.

2. Cal City does not conduct appropriate medical intake screenings, health assessments, or ongoing care.

The NDS require detention facilities provide detainees with an initial screening "[a]s soon as possible, but no later than 12 hours after arrival."[31] Facilities must then ensure each detainee receives a comprehensive health assessment, including a physical and mental examination, to be performed within

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[28] *Id.*

[29] *See* UC Davis PSNet Editorial Team, *Medication Errors and Adverse Drug Events*, Patient Safety Network (Dec. 15, 2024), https://psnet.ahrq.gov/primer/medication-errors-and-adverse-drug-events; World Health Org., *Medication Without Harm: Policy Brief* (2023), https://iris.who.int/server/api/core/bitstreams/1eacccb6-838e-4787-bfd9-4bdeb4debfcf/content; Ronda G. Hughes & Mary A. Blegen, *Patient Safety and Quality: An Evidence-Based Handbook for Nurses* ch. 37 (2008), https://www.ncbi.nlm.nih.gov/books/NBK2656/pdf/Bookshelf_NBK2656.pdf.

[30] Parveen, *supra* note 27, at 3.3.1.

[31] *NDS* 2025, *supra* note 11, at 113; *see also NDS* 2026, *supra* note 17, at 120-21.

14 days after arrival.[32] After intake, the NDS mandate the facility ensure continuity of care by providing "comprehensive, routine and preventive health care, as medically indicated."[33]

Cal City failed to uphold each of these standards, repeatedly placing detainees' lives at risk. First, initial screenings were "incomplete" and "haphazard."[34] As documented by Plaintiffs, "[w]hen people arrive at Cal[] City, they are not seen for an initial health care screening in a private setting[.]"[35] Instead, "nurses . . . fail to collect necessary information; . . . fail to consistently continue verified, necessary medications; and in some cases, fail to screen for tuberculosis, despite elevated risk of people being infected with that illness in a detained setting."[36] Second, requisite health assessments were either "not completed within the NDS standard time frames or were dropped altogether."[37] Finally, the continuity of care was either nonexistent or seriously delayed. Despite the district court's order, violations persist at Cal City. In July 2026, the monitor found the intake screening tool was still not "comprehensive," and critical

[32] *NDS* 2025, *supra* note 11, at 113; *see also NDS* 2026, *supra* note 17, at 121.
[33] *NDS* 2025, *supra* note 11, at 112; *see also NDS* 2026, *supra* note 17, at 119.
[34] Mem. Decision 5, Dkt. No. 111.
[35] First Am. Compl. ¶ 127, Dkt. No. 15.
[36] First Am. Compl. ¶ 128, Dkt. No. 15.
[37] Cal. Dep't of Just., *Immigration Detention in California*, *supra* note 7, at 163.

questions often went unanswered.[38] Specifically, the monitor noted transfer documents were not always "acknowledged in the intake screening record," "[e]scalation to a higher level of care did not appear to occur consistently when clinically indicated," and physicians were "not consistently contacted when a patient's condition warranted it."[39] Additionally, the initial appraisal "did not always provide the level of evaluation needed to guide safe and timely treatment."[40] For example, "health concerns identified during intake screening were not always addressed" and "[f]indings noted at intake were [] not always followed up, further evaluated, or included in the treatment plan."[41] Finally, the monitor determined that across several different clinical service areas, such as mental health care and chronic disease management, continuity of medical care was lacking.[42] Lack of continuity of medical care can lead to medical errors, unnecessary visits, avoidable hospitalizations, and suboptimal treatment since providers may lack complete information about the patient.[43]

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[38] Report of External Monitor on Medical Care at California City Detention Facility, *supra* note 22, at 14-16.
[39] *Id.* at 15-16.
[40] *Id.* at 18.
[41] *Id.*
[42] *Id.* at 27-42.
[43] First Am. Compl. ¶¶ 136-37, Dkt. No. 15; Lisa M. Kern et al., *Care Fragmentation, Care Continuity, and Care Coordination – How They Differ and Why It Matters*, 184 JAMA INTERNAL MED. at 1 (2024), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2814486.

Plaintiff Viera Reyes experienced these healthcare failures firsthand. He missed a scheduled biopsy appointment when he was transferred to Cal City.[44] Test results at his previous facility had indicated he likely had prostate cancer.[45] Despite needing urgent medical attention to confirm these results and initiate a treatment course, he did not have an appointment until more than three weeks after his arrival at Cal City.[46]

An example of the importance of a prompt and thorough initial mental health screening is that of Mr. Chaofeng Ge.[47] In July 2025, Mr. Ge was detained by ICE at Moshannon Valley Processing Center ("MVPC") after transfer from another facility.[48] He had an initial health screening but only by a Licensed Practical Nurse who released him to the general population, noting that he had "no current behavioral risks for suicide."[49] Later that day, the transfer summary from his prior facility arrived describing prior suicide attempts and current use of an

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[45] *Id.*
[46] *Id.*
[47] U.S. Immigr. & Customs Enf't, *Detainee Death Report: GE, Chaofeng*, Project Salt Box: FOIA Archive, https://github.com/projectsaltbox/psb-foia/blob/main/ice/FOIA%20Library%20Artifacts/ICE%20Mortality%20Reports/ddrChaofengGe.pdf (last accessed Nov. 3, 2026).
[48] *Id.*
[49] U.S. Immigr. & Customs Enf't, *Mortality Review - Report of Findings: Chaofeng, GE* 2 (Nov. 17, 2025), https://www.ice.gov/doclib/foia/reports/ddrChaofengGe.pdf.

antidepressant.[50] This was reviewed by an advanced practice provider who did not re-screen Mr. Ge or refer him to mental health services.[51] Days later he was found dead, hanging in his cell, by facility staff.[52] Even ICE's own mortality review committee found that "MVPC did not provide Mr. Ge medical care within the safe limits of practice."[53] Mr. Ge's story is just one example of the serious consequences that can occur when detainees are not thoroughly screened.

3. Cal City does not provide timely access to medical specialists.

The NDS mandates every facility must provide both "specialty health care" and "timely responses to medical complaints."[54] The NDS additionally requires that new arrivals with "acute, emergent, or pertinent past or chronic medical conditions . . . shall be sent for evaluation to a qualified, licensed health care practitioner as quickly as possible, but no later than two working days."[55]

The district court found this process woefully insufficient at Cal City. The court noted that out of thirteen orders for specialty care, none had been authorized

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[50] *Id.*
[51] *Id.*
[52] *Id.*; Ted Hesson, *ICE Failed to Monitor Detainee at Risk of Suicide Who Later Killed Himself*, WASHINGTON POST (Oct. 24, 2026), https://www.washingtonpost.com/immigration/2026/10/24/ice-failed-monitor-detainee-with-suicide-risk-who-later-killed-himself/.
[53] *Mortality Review- Report of Findings, Chaofeng Ge*, *supra* note 49.
[54] *NDS* 2025, *supra* note 11, at 112; *see also NDS* 2026, *supra* note 17, at 119.
[55] *NDS* 2025, *supra* note 11, at 113.

other than two individuals who had been specifically referenced in a Motion for a Temporary Restraining Order.[56] The court ordered Defendants to immediately ensure "timely approval and access to medical specialists."[57] Months later, the monitor found issues remained at almost every step of the referral process to medical specialists.[58] There were delays, priority levels were not consistently assigned, and there were breakdowns in communication between specialists and the medical staff at the facility.[59]

Without question, delays in getting detainees to health specialists can cause their conditions to worsen needlessly. A primary care physician is not equipped to handle all the subspecialties of medicine. Therefore, it is crucial that detainees who have serious or complex health issues be referred to a physician who can treat their condition. Such referrals must be made quickly as delays negatively affect health outcomes.[60] For example, a meta-analysis of 34 studies showed that delay in treatment for cancer patients of just four weeks increases the risk of death.[61] For

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[56] Order Granting in Part Pls.' Mots. Prelim. Inj. 6, Dkt. No. 72.
[57] Order Granting in Part Pls.' Mots. Prelim. Inj. 3, Dkt. No. 72.
[58] Report of External Monitor on Medical Care at California City Detention Facility, *supra* note 22, at 22.
[59] *Id.* at 23-24.
[60] Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42 HEALTH SERVS. RSCH. 644 (2007), https://pmc.ncbi.nlm.nih.gov/articles/PMC1955366/.
[61] Timothy P. Hanna et al., *Mortality Due to Cancer Treatment Delay: Systematic Review and Meta-Analysis*, 371 BRIT. MED. J 1 (2020), https://www.bmj.com/content/bmj/371/bmj.m4087.full.pdf.

patients with tumors that require surgery, one study showed a 6-8% increase in the risk of death for every four-week delay.[62]

4. Cal City does not provide timely and responsive emergency services.

The NDS states that if a detainee "requires emergency medical care, the first responding officer will immediately take the necessary steps to contact a health care practitioner."[63] The NDS further mandates medical emergency training in which healthcare staff will be trained to "respond to health-related emergencies within a 4-minute response time."[64] When detention staff do receive the mandatory training, they need to be able to "[recognize] the signs of potential health emergencies and deliver the required response[.]"[65]

The district court found these procedures to be virtually nonexistent at Cal City. Specifically, the district court found even when a detainee was suffering from a life-threatening congenital heart condition that put him at risk of sudden cardiac death, the detainee was only sent to a cardiologist after court intervention.[66] Defendants were ordered to remedy this issue and ensure the delivery of "timely and responsive emergency services."[67] Despite this order, the monitor found

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[62] *Id.* at 4-5.
[63] *NDS* 2025, *supra* note 11, at 116; *see also NDS* 2026, *supra* note 17, at 124.
[64] *NDS* 2025, *supra* note 11, at 116; *see also NDS* 2026, *supra* note 17, at 123.
[65] *NDS* 2025, *supra* note 11, at 116; *see also NDS* 2026, *supra* note 17, at 123-24.
[66] Mem. of Decision 2-3, Dkt. No. 111.
[67] Order Granting in Part Pls.' Mots. Prelim. Inj. 3, Dkt. No. 72.

serious gaps persisted. It was not clear that care was consistently provided when a patient was awaiting hospital transport, nor was it apparent that follow-up assessments continued to ensure the patient remained stable.[68] This is particularly significant, as the monitor noted that Cal City's "considerable distance from the nearest hospital" heightened the risk to detainees, particularly when the staff on hand are not equipped or trained to handle emergency situations.[69]

Gaps in emergency services place detainees' lives at immeasurable risk. Failing to call for help, or calling too late, can have grave consequences. For example, one study examining the survival rate for individuals that go into cardiac arrest found a 67 percent survival rate if an individual immediately receives treatment.[70] Without any treatment, the survival rate drops 5.5 percent per minute.[71]

5. Cal City does not provide timely access to prescribed medications.

The NDS requires facilities that do not have medical staff 24 hours a day to distribute medication in a manner "consistent with state law and/or regulations, by

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[68] Report of External Monitor on Medical Care at California City Detention Facility, *supra* note 22, at 26-27.
[69] *Id.* at 27.
[70] Mary P. Larsen et al., *Predicting Survival From Out-Of-Hospital Cardiac Arrest: A Graphic Model*, 22 ANNALS EMERGENCY MED. 1652 (1993), https://pubmed.ncbi.nlm.nih.gov/8214853/.
[71] *Id.*

detention officers who have received proper training."[72] At a minimum, the facility shall ensure a "seven-day supply of medication."[73] Cal City has consistently failed to adhere to this requirement. Medical records show "shortages of stock medication" at the facility and when medication was available, it was delivered to detainees at odd hours or discontinued without reason or clinical justification.[74]

The district court ordered Defendants to remedy this issue and provide "timely access to prescribed medications."[75] Nevertheless, problems persisted. The medical monitor documented "several serious concerns with the medication process" at Cal City.[76] The monitor noted that patients who arrived at the facility on active medications often did not have these medications continued in a consistent and timely manner. In fact, hundreds of medication requests were rejected, and medications scheduled to be dispensed between 7:00 p.m. and 8:00 p.m. were often not delivered until 1:00 a.m. or 2:00 a.m.[77] If detainees fell asleep before staff arrived with their medication, the default was for them to miss their dose entirely.[78]

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[72] *NDS* 2025, *supra* note 11, at 117; *see also NDS* 2026, *supra* note 17, at 124.
[73] *Id*.
[74] Mem. Decision 4, Dkt. No. 111.
[75] Order Granting in Part Pls.' Mots. Prelim. Inj. 3, Dkt. No. 72.
[76] Report of External Monitor on Medical Care at California City Detention Facility, *supra* note 22, at 44.
[77] *Id.* at 44-45.
[78] *Id.* at 45.

Delays in medication can have severe negative outcomes. For instance, Type 2 diabetes is a common medical condition including in the adult detainee population.[79] Studies have shown that delays in adjusting insulin medication for Type 2 diabetes to meet glycemic targets can lead to serious microvascular complications, including diabetic retinopathy, nephropathy, neuropathy, and diabetic foot ulcers.[80] Failure to appropriately treat Type 2 diabetes causes morbidity and disability.[81] One study even found that individuals older than 65 who had delayed adjustments of their insulin were 62% more likely to have cardiovascular disease-related deaths.[82]

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[79] *See* Decl. of Fernando Gomez Ruiz in Supp. of Pls.' Mot. Prelim. Inj. 3, Dkt. No. 22-8; *see also* First Am. Compl. ¶¶ 5, 140, 147, 202, Dkt. No. 15 (describing multiple detainees with diabetes).

[80] Sharmin Shabnam et al., *Effect of Delay in Treatment Intensification in People with Type 2 Diabetes and Suboptimal Glycaemia After Basal Insulin Initiation: A Real-World Observational Study*, 26 DIABETES, OBESITY & METABOLISM 512, 520 (2023), https://dom-pubs.pericles-prod.literatumonline.com/doi/10.1111/dom.15337.

[81] *See* John Dawi et al., *Diabetic Foot Ulcers: Pathophysiology, Immune Dysregulation, and Emerging Therapeutic Strategies*, 13 BIOMEDICINES 1 (2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12109115/ ("microvascular complications including diabetic retinopathy, nephropathy, neuropathy, and diabetic foot ulcers (DFUs) are some of the leading causes of morbidity and disability in patients with diabetes."); *see also* Shabnam et al., *supra* note 80, at 512 (delayed treatment "increases risks for CVD-related death and macrovascular events.").

[82] Shabnam et al., *supra* note 80, at 520.

6. Cal City does not provide a responsive sick call system.

The NDS states medical personnel must be available at "regularly scheduled times" to respond to requested medical services.[83] The NDS requires detention facilities to ensure that all request slips are "received and triaged by the medical staff within 24 hours of receipt of the request."[84] Despite this, Cal City's sick call system "suffer[ed] from systemic delays and failures" such that urgent medical symptoms went unaddressed for days or even weeks.[85] When care was finally provided, it was "often deficient" with multiple instances of "poor clinical judgment."[86]

Given this, the district court ordered Defendants to ensure Cal City had a responsive "sick call" system.[87] Months later, the monitor found that issues remained within Cal City's sick call system. Requests were missed or delayed for extended periods of time, and detainees were forced to submit multiple requests because they were unsure if their original request had been received.[88]

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[83] *NDS* 2025, *supra* note 11, at 115; *see also NDS* 2026, *supra* note 17, at 123.
[84] *Id.*
[85] Mem. Decision 4, Dkt. No. 111.
[86] *Id.*
[87] Order Granting in Part Pls.' Mots. Prelim. Inj. 3, Dkt. No. 72.
[88] Report of External Monitor on Medical Care at California City Detention Facility, *supra* note 22, at 46.

Additionally, the monitor noted that requests were often not appropriately triaged by severity level.[89]

Failure to respond to complaints in a timely manner allows medical conditions to become more serious and even fatal. An adequate healthcare system ensures detainees' health concerns are addressed promptly, preventing treatable conditions from becoming life-threatening and infectious diseases from spreading.

B. CAL CITY NEEDS A MEDICAL MONITOR BECAUSE ICE'S ALTERNATIVE MONITORING MECHANISMS HAVE BEEN, OR ARE BEING, DISMANTLED

The appointment of a medical monitor to oversee a detention facility is neither an unprecedented nor overreaching remedy. ICE has long relied on independent monitors to ensure that detention facilities provide healthcare consistent with modern medical standards, and courts have on several occasions appointed monitors to oversee immigration detention facilities.[90]

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[89] *Id.* at 48-49.

[90] One prominent example is the continued monitoring of the treatment of unaccompanied minors held in immigration detention facilities as part of the *Flores v. Reno* settlement. *See* Stipulated Settlement Agreement, *Flores v. Reno*, No. 85-cv-04544 (C.D. Cal. Jan. 17, 1997). The original settlement agreement established in 1997 held the broad mandate that children in government custody be housed in "safe and sanitary" conditions. *Id.* at 7. On August 3, 2022, following allegations from plaintiffs' counsel that the conditions in the El Paso and Rio Grande Valley Customs and Border Protection (CBP) facilities amounted to a "public health emergency," the court approved the appointment of independent public health expert Dr. Paul Wise to conduct assessments of child well-being in CBP custody. Thereafter, Wise filed regular reports regarding the status of the CBP facilities. Notice of Filing of Juvenile Care Monitor Report by Dr. Paul H.

In the past, there were several other avenues to ensure detention facilities were providing adequate care, including: (1) the Department of Homeland Security ("DHS") Office of the Immigration Detention Ombudsman, (2) the Office for Civil Rights and Civil Liberties, and (3) the Citizenship and Immigration Services Ombudsman office. These offices functioned alongside, or absent, independent monitors. However, the federal administration has systematically dismantled and defunded these built-in oversight mechanisms within DHS.

Wise, *Flores v. Garland*, No. 85-cv-04544 (C.D. Cal. July 18, 2023), ECF No. 1352. In 2026, the court re-appointed Dr. Wise as medical monitor, expanding his mandate to ICE's Dilley Immigration Processing Center in Dilley, Texas, and any hotels contracted to house detained children. B. Duff-Brown, *Federal Judge Appoints SHP's Paul Wise to Monitor Children in Immigration Detention*, STANFORD HEALTH POLICY NEWS (Sept. 15, 2026) https://healthpolicy.fsi.stanford.edu/news/federal-judge-appoints-shps-paul-wise-monitor-children-immigration-detention. Another example is the appointment of a monitor to the Adelanto ICE Processing Center in California. In a complaint that mirrors the matter before this Court, plaintiffs allege that "detained individuals are routinely denied necessary medical care. . . [and] countless detained individuals have suffered medical issues with limit access to proper care." Complaint for Injunctive and Declaratory Relief, *L.T. v. U.S. Immigr. & Customs Enf't*, No. 26-cv-00322 (C.D. Cal. Jan. 26, 2026), Dkt. No. 1. The District Court for the Central District of California issued a preliminary injunction that called for a "remedial plan to implement comprehensive systems for medical care." Order Granting, in Part, Plaintiffs' Renewed Motion for Preliminary Injunction, *L.T. v. U.S. Immigr. & Customs Enf't*, No. 26-cv-00322 (C.D. Cal. July 16, 2026), Dkt. No. 104. The court also appointed an "independent monitor [who] will observe and report on the systems for medical care [.]" *Id.*

The Office of the Immigration Detention Ombudsman[91] ("OIDO") was established in 2019 to carry out independent and neutral oversight of ICE and Customs and Border Protection ("CBP") facilities and investigate any potential violations of detainees' rights.[92] OIDO was unique in that it placed on-site inspectors and case managers inside detention centers so they could hear complaints directly from detainees and immediately address their grievances.[93] OIDO was set up to be the entity that investigated systemic issues regarding conditions in detention, including any complaints of inadequate medical care or deaths in ICE custody.[94] The Office for Civil Rights and Civil Liberties ("CRCL") was created to receive complaints of civil rights and civil liberties abuses by DHS. CRCL conducts public outreach, so people are aware of the option to file

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[91] Isabela Dias, *Immigrants Are Dying in ICE Detention. A Key Watchdog Office is Now Gone*, MOTHER JONES (May 15, 2026), https://www.motherjones.com/politics/2026/05/how-the-trump-administration-gutted-immigration-detention-oversight/; 6 U.S.C. § 205; Dave Jamieson & Matt Shuham, *Trump Administration Closes Watchdog Office for Immigration Detention Abuses*, HUFFINGTON POST (May 4, 2026), https://www.huffpost.com/entry/immigration-detention-ombudsman-closure_n_69f8facee4b0115dd7bf98e5.

[92] Dias, *supra* note 91; Dep't of Homeland Sec., *A Note from the Acting Ombudsman, David Gerstein* (June 2023), https://www.dhs.gov/sites/default/files/2023-06/OIDO%20Newsletter%20-%20June%202023.pdf.

[93] *Id.*

[94] Physicians for Hum. Rts. & Hum. Rts. Watch, *Dying in Detention*, *supra* note 2, at 62.

complaints and reports to Congress regarding the complaints the office receives.[95] According to a former CRCL staffer interviewed for a joint PHR and Human Rights Watch report, when a detainee death occurred, CRCL staff would review the relevant medical information and records.[96] If CRCL staff had concerns, they had three options: (1) issue informal advice to ICE that addressed the concerns; (2) issue a recommendation memorandum that would be made public; or (3) escalate the case to senior ICE leadership.[97]

The Citizenship and Immigration Services Ombudsman Office ("CIS Ombudsman office") was mandated to assist individuals and employers who are having issues with immigration issues, make recommendations to U.S. Citizenship and Immigration Services based on reports of problems, while also providing Congress with an annual report on the types of harms being experienced along with recommendations for improvements. The CIS Ombudsman Office handled roughly 24,000 requests for assistance via its online portal in 2023.[98]

However, in March 2025, shortly after taking office, the federal administration announced cuts to all three of these offices reportedly to "streamline

[95] *See* 6 U.S.C. § 345.
[96] Physicians for Hum. Rts. & Hum. Rts. Watch, *Dying in Detention*, *supra* note 2, at 62.
[97] *Id.*
[98] Citizenship & Immigr. Servs. Ombudsman, Dep't of Homeland Sec., *Annual Report 2024* (June 28, 2024), https://perma.cc/7TB9-D824.

oversight" and remove "bureaucratic hurdles" to immigration enforcement.[99] In doing so, necessary safeguards, transparency, and accountability in the immigration detention system were set to be eliminated. In response to several organizations who filed a lawsuit in April 2025 challenging this decision, DHS stated that it had not abolished OIDO, CRCL, or the CIS Ombudsman.[100]

Yet all three of these offices have had significant reductions in staffing and in their budgets. In fact, in the 2026 fiscal year budget presented to Congress, DHS reduced positions within OIDO from 86 to zero, CRCL from 135 to 4, and the CIS Ombudsman from 42 to 2.[101] The budget for OIDO was cut entirely, while the budgets for CRCL and CIS Ombudsman were reduced by nearly ninety percent.[102] The proposed executive budget justification explicitly stated "OIDO has been eliminated in its entirety."[103]

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[99] *Trump Administration Closes Three DHS Offices Focused on Civil Rights and Oversight*, Econ. Pol'y Inst. (Apr. 3, 2025), https://www.epi.org/policywatch/trump-administration-closes-three-dhs-offices-focused-on-civil-rights-and-oversight/.

[100] Compl. for Decl. & Inj. Relief, *Robert F. Kennedy Hum. Rts. v. U.S. Dep't of Homeland Sec.*, No. 25-1270 (D.D.C. Apr. 24, 2025), Dkt. No. 1.

[101] Off. of Sec. & Exec. Mgmt., U.S. Dep't of Homeland Sec., *Fiscal Year 2026 Congressional Justification*, at OSEM – O&S – 11, 12 (June 12, 2025), https://www.dhs.gov/sites/default/files/2025-06/25_0613_osem_fy26-congressional-budget-justificatin.pdf.

[102] *Id.*

[103] Off. of Sec. and Exec. Mgmt., *supra* note 101, p. OSEM – O&S – 12; *see also* Mem. Law in Supp. of Pls.' Mot. Summ. J. at 9, 33-34, *Robert F. Kennedy Hum. Rts. v. U.S. Dep't of Homeland Sec.*, No. 25-1270 (D.D.C. Jan. 17, 2026).

A former CRCL staffer noted that when the administration ordered CRCL to stop working on March 21, 2025, the office still had roughly 550 open complaints.[104] The staffer also noted that, as of November 2025, CRCL's compliance team had been reduced from roughly fifty employees to three, and she had no idea what had happened with the outstanding open complaints.[105]

When the White House released its 2027 fiscal year budget proposal, it included plans to reorganize DHS headquarters, which involved the elimination of OIDO, CRCL, and the CIS Ombudsman.[106] In its legal filings, the government claimed OIDO was winding down because the DHS appropriations bill passed by Congress in April 2026 defunded the office.[107] In fact, the appropriations bill did

[104] Physicians for Hum. Rts. & Hum. Rts. Watch, *Dying in Detention*, *supra* note 2, at 63.
[105] *Id.* at 64.
[106] Exec. Off. of President of U.S., Off. of Mgmt. & Budget, *Budget of the U.S. Government*: *Fiscal Year 2027*, at 27 (Apr. 2026), https://www.whitehouse.gov/wp-content/uploads/2026/04/budget_fy2027.pdf (accessed April 28, 2026); *see also* Pls.' Notice of Recent Developments at 1, *Robert F. Kennedy Hum. Rts. v. U.S. Dep't of Homeland Sec.*, No. 25-1270 (D.D.C. Apr. 13, 2026).
[107] Defs.' Notice of Legal Development at 1, *Robert F. Kennedy Hum. Rts. v. U.S. Dep't of Homeland Sec.*, No. 25-1270 (D.D.C. May 12, 2026).

not direct OIDO's closure.[108] OIDO is still a congressionally mandated office that is required to report to Congress.[109]

A former OIDO employee testified at a Senate forum that the impact of firing all OIDO employees was "the elimination of any meaningful oversight . . . the result has been devastating and predictable: dangerous conditions and a rising death toll."[110] She reported that case managers stopped visiting facilities overnight, and complaints went unanswered.[111] Thus the regular oversight regime that would ensure healthcare standards are met has been severely reduced or altogether eliminated. The predictable result is individuals facing life-threatening, avoidable health harms. The former OIDO staffer, who now works at a nonprofit, testified about receiving a call through her triage line from,

> [The] family of a man with diabetes who was not getting his medication in detention. His wife thought he could make it through. He survived worse in his trip to the United States to seek safety. By the end of the

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[108] Homeland Security and Further Additional Continuing Appropriations Act, Pub. L. No. 119-86, 140 Stat. 773 (2026), https://www.congress.gov/119/plaws/publ86/PLAW-119publ86.pdf (accessed June 17, 2026); Dominik Lett, *Here's How the Administration Plans to Spend the Largest Immigration Enforcement Funding Surge in History*, CATO INSTITUTE (Mar. 27, 2026), https://www.cato.org/blog/heres-how-administration-plans-spend-largest-immigration-enforcement-funding-surge-history.

[109] 6 U.S.C. § 205.

[110] Senate Minority Whip Holds Forum on Conditions in ICE Detention Facilities, C-SPAN (July 29, 2026), https://www.c-span.org/program/public-affairs-event/senate-minority-whip-holds-forum-on-conditions-in-ice-detention-facilities/683512.

[111] *Id.*

> week, the man was calling our office begging for help in getting immediate removal. He was sure that he would die if he stayed in detention any longer. OIDO would have been able to get him a medical appointment and have his medications provided. Now, his only option was to give up his rights and leave or risk dying.[112]

It has become increasingly difficult for medical professionals to obtain information about the welfare of detainees. Throughout 2025 and continuing into 2026, doctors and public health officials have struggled to get meaningful access to ICE facilities.[113] Members of Congress have been told they cannot bring "mixed groups," including physicians, to visit facilities.[114] In one ICE detention center, also operated by CoreCivic in California, public health officials were blocked from conducting essential components of a facility inspection, including "review of medical records and confidential interviews with detainees."[115] There, the county

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[112] *Id.*

[113] *See, e.g.*, Lisa Rozner, *Doctors Attempting to See ICE Holding Facility at 26 Federal Plaza Are Rejected*, CBS NEWS (Aug. 18, 2025), https://www.cbsnews.com/newyork/news/26-federal-plaza-detainee-holding-conditions/; Jake Kincaid & Sofía Mejías-Pascoe, *Amid Escalating Medical Concerns, Otay Mesa Detention Center Faces a Question of Oversight*, INEWSOURCE (June 17, 2026), https://inewsource.org/2026/06/17/ice-otay-mesa-trump-congress-oversight/.

[114] Press Release, Chris Van Hollen for Senate, *Van Hollen Joins Ossoff, Colleagues in Launching Inquiry into DHS' Obstruction of Congressional Oversight* (Dec. 1, 2025), https://www.vanhollen.senate.gov/news/press-releases/van-hollen-joins-ossoff-colleagues-in-launching-inquiry-into-dhs-obstruction-of-congressional-oversight.

[115] Salvador Rivera, *San Diego County Health Inspectors Denied Access to Otay Mesa Detention Center*, KTSM (Feb. 20, 2026), https://www.ktsm.com/news/san-diego-county-health-inspectors-denied-access-to-otay-mesa-detention-center/.

brought a lawsuit seeking to compel access to these facilities in compliance with a California state law giving county health officers the right to inspect private immigration detention facilities.[116]

Overall, there has been a seismic shift in ICE's approach to physicians. ICE long maintained a policy of allowing "medical and/or mental health examinations by a practitioner or expert not associated with ICE/DRO."[117] They only required a legal representative of the detained individual submit a written request, and treated that request with a presumption of approval, stating "[o]rdinarily, the Field Office Director shall approve the request for independent examination, as long as it would not present an unreasonable security risk."[118] In accordance with this policy, in late 2024 and early 2025, PHR obtained access to several ICE detention facilities as part of its efforts to document detention conditions and health care practices. PHR physicians conducted site visits at the Krome North Service Processing Center in Miami, the Otay Mesa Detention Center in San Diego, California, and the

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[116] City News Service, County Sues DHS Over Access to Otay Mesa Detention Facility, NBC SAN DIEGO (Mar. 10, 2026), https://www.nbcsandiego.com/news/local/county-sues-dhs-over-access-to-otay-mesa-detention-facility/3992889/; *SB 1132: County Health Officers*, CalMatters: Digital Democracy (Aug. 19, 2024), https://calmatters.digitaldemocracy.org/bills/ca_202320240sb1132.

[117] U.S. Immigr. & Customs Enf't, *ICE/DRO Detention Standard: Medical Care* at 23 (Dec. 2, 2008), https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf.

[118] *Id.*

Northwest ICE Processing Center in Tacoma, Washington.[119] These visits provided PHR with firsthand observations of detention conditions that have informed subsequent monitoring efforts.

PHR has tracked how deaths in immigration detention are rising not merely because of the sheer pace and scale of the expansion of immigration detention but *disproportionately* to it.[120] Detention grew by seventy-seven percent in the first year of the second Trump administration, while the number of annual deaths more than tripled.[121] Moreover, Detainee Death Reports are not being filed in a timely manner, nor are they providing the comprehensive information needed for oversight.[122]

When immigration detention facilities are taking in more detainees than ever, there needs to be increased outside oversight and transparency to ensure that those held by the United States government, and its contractors, are not facing irreparable health harm. Unable to rely on federal government oversight, courts are increasingly relying on trained medical professionals to evaluate whether the government is meeting the requirements for healthcare laid out in their court

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[119] Electronic communication between ICE and PHR-affiliated clinicians organizing visits to detention facilities in 2024 and early 2025.
[120] Physicians for Hum. Rts. & Hum. Rts. Watch, *Dying in Detention*, *supra* note 2, at 20.
[121] *Id.*
[122] *Id.* at 36.

orders. This is precisely what the court has done in this instance. It is particularly important given Plaintiffs have been forced to file two notices of noncompliance with the district court's order in relationship to medical care needs for a detained individual in 2025 and 2026.[123]

It is clear that oversight is more than necessary to ensure adequate medical care in Cal City. Any semblance of the prior oversight regime has been effectively dismantled. Without question, this Court must keep the court-appointed medical monitor in place to ensure that detainees are treated in line with constitutional and medical standards.

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[123] Second Notice of Noncompliance with Court's December 22, 2025 Order Resolving Pls.' Mot. for Temporary Restraining Order, Dkt. No. 80.

V. CONCLUSION

Amicus curiae Physicians for Human Rights respectfully urges this Court to uphold the district court's preliminary injunction mandating Defendants-Appellants provide adequate healthcare and affirm the court's appointment of an independent medical monitor.

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Respectfully submitted,

s/ Raymond P. Boucher

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VI. CERTIFICATE OF COMPLIANCE

I am the attorney for *Amicus Curiae* Physicians for Human Rights.

This brief contains 6985 words, including **0** words manually counted in any visual images, and excluding the items exempted by FRAP 32(f). The brief's type size and typeface comply with FRAP 32(a)(5) and (6).

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Signature *s/ Raymond P. Boucher* **Date** November 6, 2026