



**One Hundred Sixteenth Congress
Committee on Homeland Security
U.S. House of Representatives
Washington, DC 20515**

March 26, 2020

The Honorable Joseph V. Cuffari
Inspector General
Department of Homeland Security
MAIL STOP 0305
245 Murray Lane, S.W.
Washington, D.C. 20528-0305

Dear Inspector General Cuffari:

I write today to express my deep concerns about the two reports issued by the Office of Inspector General (OIG) on the deaths of two children in the custody of Customs and Border Protection (CBP)—a 7-year-old and an 8-year-old. While the Border Patrol agents who cared for both children exhibited great concern for their well-being, the job of the OIG after such deaths is to conduct a thorough review of all of the facts and circumstances surrounding the deaths and to determine whether agency policy should be revised in any way to help ensure that such deaths do not happen again. The reports of investigation produced by the OIG did not fulfill either responsibility.

Of particular concern is the report issued by the OIG on the death of the 8-year-old child, which failed to examine the most important questions about the child's death. It also failed to include any review of whether CBP's policies and standards were followed in the case or whether the policies were adequate to ensure that the Border Patrol is trained, equipped, and prepared to carry out the stressful responsibility of providing care to children in its custody—particularly when children are in CBP custody for prolonged periods.

Perhaps most troubling of all is the fact that the public summary of the OIG's report of investigation about the 8-year-old's death—which is less than a page in length—excludes such crucial details that the information it provides is inaccurate and misleading.

The Committee's examination of these two deaths—which has been greatly impeded by the refusal of the Department to provide all of the documents subpoenaed by the Committee—is still ongoing, but the many critical shortcomings in the work of the OIG raise significant concerns about the thoroughness of the office's reviews as well as the willingness of the office to conduct in-depth examinations of sensitive topics. These shortcomings are discussed in more detail below.

I am also greatly concerned by the issues the Committee on Oversight and Reform raised in a letter to you today regarding management of the OIG.¹ Among other matters, the Oversight Committee’s letter notes that you have been unwilling to testify before Congress about the OIG’s work—something that the Homeland Security Committee has also experienced first-hand. As you know, the coronavirus pandemic has required the Committee to delay a planned hearing to examine the deaths of children in CBP custody. Although you have received an invitation to testify at that planned hearing, Committee staff received an email from your office yesterday in which your staff indicated that you would not testify before the Committee on this matter. Instead, you intend the OIG to be represented by a subordinate.² This is unacceptable.

The shortcomings in the OIG’s reports on the children who died in CBP custody give me great concern about the ability of the OIG to carry out significant oversight of the Department of Homeland Security (DHS) on other important issues, including our nation’s response to the coronavirus. I therefore request written responses to the questions posed at the end of the letter no later than April 9, 2020.

Background

On December 8, 2018, a 7-year-old child died in CBP custody. On December 14, 2018, the DHS OIG “announced that it will investigate the death of a 7-year-old migrant child who recently died after being taken into Border Patrol custody.” The Inspector General’s announcement promised that, “At the culmination of its investigation, DHS OIG will provide a final report to the DHS Secretary, the Congress, and the public.”³

On December 24, 2018, an 8-year-old child died in CBP custody. The OIG also opened an investigation of the death of the 8-year-old child.

One year later, on December 20, 2019, the OIG announced it had completed its investigation of the 7-year-old child’s death. Rather than publicly releasing its final report on this death, the OIG made public an approximately half-page summary of its investigation of the 7-year-old’s death. This public summary stated, in bold text, “**The investigation found no misconduct or malfeasance by DHS personnel**” and presented seven cursory, bulleted statements about select details of the 7-year-old’s death.⁴ The OIG provided the full report—in redacted form—on the 7-year-old’s death to the Committee. It totals 133 pages.

¹ Letter from Chairwoman Carolyn Maloney, Committee on Oversight and Reform, to Inspector General Joseph V. Cuffari, Department of Homeland Security (March 26, 2020).

² Email from Staff, Inspector General, Department of Homeland Security, to Staff, Committee on Homeland Security (March 25, 2020).

³ Department of Homeland Security, Office of Inspector General, “Inspector General Announces Investigation of Migrant Child’s Death” (Dec. 14, 2018) (online at www.oig.dhs.gov/news/press-releases/2018/12142018/inspector-general-announces-investigation-migrant-childs-death).

⁴ Department of Homeland Security, Office of Inspector General, “The Office of the Inspector General Completes Investigation of the Death of Seven-Year-Old Guatemalan Child Who Died in U.S. Border Patrol Custody” (Dec. 20, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/pr/2019/dojpr-122019-dhs-oig-completes-investigation-death-seven-year-old-guatemalan-child.pdf).

That same day, the OIG also made public a summary of its investigation of the death of the 8-year-old. This summary was approximately two-thirds of a page in length. This summary also stated, in bold text, **“The investigation found no misconduct or malfeasance by DHS personnel,”** and presented ten cursory, bulleted statements about select details of the 8-year-old’s death.⁵ The OIG also provided the full report about the 8-year-old’s death—in redacted form—to the Committee. It totals 200 pages.

Public Summary of At Least One of the Reports Is Inaccurate and Misleading

According to the OIG’s report of investigation of the 8-year-old’s death, the child and the child’s father were taken into custody by CBP on the afternoon of December 18, 2018, in El Paso, Texas. The OIG report indicates that both the child and the child’s father “appeared to be healthy” at the time they were taken into custody. By December 24, 2018, after several transfers among CBP facilities, the child and the child’s father had been transferred to a CBP facility in New Mexico.⁶

According to the “DETAILS” section of the OIG’s Report of Investigation, which presents a summary of the OIG’s investigative findings, a Border Patrol agent reported that, on the morning of December 24, 2018—six days after the child and the child’s father were taken into CBP custody—the child’s father told a Border Patrol agent that the child “did not feel well, had a sore throat, an upset stomach, and a fever.”⁷

Border Patrol agents took the child to a hospital twice on December 24, 2018. The first trip occurred in the morning. The medical records associated with the child’s first trip to the hospital that day—which CBP’s Office of Professional Responsibility obtained from the hospital and which are also included as an attachment to the OIG’s report on the child’s death—show that the child tested positive for Influenza B. Further, the OIG’s report indicates that on the afternoon of December 25, 2018, a CBP staff member traveled to the hospital where the 8-year-old child was treated and had telephonic contact with the hospital’s Public Information Officer, who informed the CBP staff member that during the child’s first trip to the hospital on December 24, the child “had tested positive for Influenza B.”⁸

According to a Memorandum of Activity included in the OIG’s report of investigation on the 8-year-old child’s death, “On March 29, 2019, the Department of Homeland Security Office of Inspector General, El Paso, TX received copies of the complete findings from the New Mexico

⁵ Department of Homeland Security, Office of Inspector General, “The Office of the Inspector General Completes Investigation of the Death of Eight-Year-Old Guatemalan Child Who Died in U.S. Border Patrol Custody” (Dec. 20, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/pr/2019/dojpr-122019-dhs-oig-completes-investigation-death-eight-year-old-guatemalan-child.pdf).

⁶ Department of Homeland Security, Office of Inspector General, *Report of Investigation: Circumstances Surrounding the Custodial Death of [8-Year-Old Child]*, (I19-BP-ELP-06106) (Dec. 13, 2019).

⁷ *Id.*

⁸ *Id.*

Medical Examiner's Office, Albuquerque, NM concerning the death" of the child. The Memorandum of Activity notes that these "reports are contained within this investigative file."⁹

The front page of the "Death Investigation Summary" of the 8-year-old's death prepared by the Office of the Medical Investigator at the University of New Mexico School of Medicine and included as an attachment to the OIG's report states the "CAUSE OF DEATH" as:

"Complications of influenza B infection with Staphylococcus aureus superinfection and sepsis."¹⁰

However, in the public summary of the 8-year-old's death, the OIG included the following bullet:

"The state medical examiner's autopsy report found the child died from sepsis caused by Staphylococcus aureus bacteria."¹¹

Another bullet included in the public summary states the following:

"The hospital staff diagnosed the child with an upper respiratory infection, prescribed amoxicillin and acetaminophen, and discharged the child, who was returned to the USBP [U.S. Border Patrol] facility."¹²

Despite the fact that the child was diagnosed with Influenza B and the cause of the child's death included complications of Influenza B, there is no mention of Influenza B in the public summary of the OIG's investigation of the child's death.

Finally, two consecutive bullets in the summary state the following:

"The child's condition improved briefly and subsequently worsened. USBP again transported the child and father to the hospital; upon arrival, the child was unresponsive and pronounced dead."¹³

These bullets omit the critical fact that the child's health had been deteriorating for hours (and that the deterioration had included vomiting) before the child was transported back to the hospital the second time. The OIG's report also indicates that Border Patrol agents themselves acknowledge

⁹ *Id.*

¹⁰ Office of the Medical Examiner, University of New Mexico School of Medicine, Death Investigation Summary, Case Number: 2018-07403 (March 25, 2019).

¹¹ Department of Homeland Security, Office of Inspector General, "The Office of the Inspector General Completes Investigation of the Death of Eight-Year-Old Guatemalan Child Who Died in U.S. Border Patrol Custody" (Dec. 20, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/pr/2019/dojpr-122019-dhs-oig-completes-investigation-death-eight-year-old-guatemalan-child.pdf).

¹² *Id.*

¹³ *Id.*

that they were not aware of how serious the child's condition was, and that they would have transported the child more rapidly had they been aware.

The exclusion of this information is simply inexplicable, and it renders the public summary of this report of investigation both inaccurate and misleading.

Inspector General's Office Failed to Examine Key Questions About 8-Year-Old Child's Death

Although it is a question critical to a thorough understanding of the circumstances of the 8-year-old child's death, it is unclear from the OIG's report if the Border Patrol agents who cared for the 8-year-old child were aware that the child had tested positive for Influenza B.

The timeline included in the OIG's report states that during the child's first hospital visit on the morning of December 24, 2018, the child "was diagnosed with influenza B and was given acetaminophen prior to . . . release." However, there is significant evidence indicating that the Border Patrol agents involved in the child's care were never informed that the child had tested positive for Influenza B. For example, the written discharge instructions included with the medical records pertaining to the child's first hospital visit were for the treatment of an "Upper Respiratory Infection, Pediatric."¹⁴

The OIG's report does not examine why the child was discharged with instructions for managing an upper respiratory infection when the child had tested positive for Influenza B. The report also does not discuss what the Border Patrol agents who managed the child's care knew about the child's Influenza B diagnosis (if anything).

It appears that the medical records pertaining to the child's first visit to the hospital on December 24, 2018, may have been amended by hospital personnel shortly after the child's death to indicate that the child's father and a Border Patrol agent had verbalized their understanding of the discharge instructions. However, it is unclear what exactly this amendment meant, why it was added, or whether there were any discharge instructions in addition to the written papers included in the medical records.¹⁵

The OIG apparently failed to examine these issues during its investigation of the death of the 8-year-old child. A senior OIG official indicated in a briefing with the Committee that the Inspector General's office never had a forensic analysis of the medical records of the 8-year-old child conducted and did not interview any of the hospital staff involved in providing care to the child.¹⁶ At this late date, it may be impossible ever to have a full accounting of these issues.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

Just as the public summary of the OIG's investigation of the child's death does not mention that the child was diagnosed with Influenza B, the public summary also does not discuss any of the many questions that arise regarding whether Border Patrol agents were informed that the child had Influenza B.

Malfeasance and Misconduct Were Never Alleged

The one-page summaries of the investigations of the deaths of the 7-year-old and 8-year-old issued by the OIG proclaim in bold text that there was no malfeasance or misconduct by DHS personnel who cared for the children. However, in a briefing with Committee staff, a senior OIG official made clear that malfeasance and misconduct were not alleged at the time of the children's deaths, and no allegations of malfeasance and misconduct were discovered during the course of the OIG's investigation of the children's deaths.¹⁷ Further, there is nothing in the evidence that the Committee has seen that suggests that there was malfeasance or misconduct on the part of any of the CBP personnel who cared for either child. However, the public summaries of the OIG's investigations do not discuss the fact that there were apparently never any allegations of malfeasance or misconduct against any of the CBP personnel who cared for either child.

That said, there is no reference in either report to any rule, regulation, or policy setting forth the standard for "malfeasance" or "misconduct" against which the conduct of CBP personnel was assessed. When asked what the standards were during a briefing with Committee staff, a senior OIG official offered various undefined concepts, such as whether the conduct met the "standard of reasonableness," whether Border Patrol agents treated the circumstances as "dire" once it became clear how sick the children were, and whether there was any form of neglect (albeit none of these terms are defined in the OIG's record of investigation).¹⁸

The absence of any allegation of malfeasance or misconduct raises many questions about why the absence of malfeasance and misconduct was pronounced as the conclusion of the OIG's investigations of both children's deaths. The absence of any allegation of malfeasance or misconduct also raises the question of why this investigation was conducted by the OIG's criminal investigators rather than OIG's programmatic reviewers who had knowledge of CBP's policies for caring for individuals in CBP custody and who could have examined both whether these policies were followed in these cases and whether the policies were adequate. This issue is discussed in more detail in the next section of this letter.

No Assessment Was Made of Whether CBP Standards Were Adequate or Followed

Although the deaths of the 7-year-old and the 8-year-old in CBP custody do not appear to raise concerns of agent malfeasance or misconduct, the children's deaths do raise numerous questions about whether CBP policies and procedures were adequate to prepare CBP personnel to carry out

¹⁷ Department of Homeland Security, Office of Inspector General, Staff Briefing with Committee on Homeland Security (March 18, 2020).

¹⁸ *Id.*

the highly stressful responsibility of caring for seriously ill children and whether existing policies were followed in these cases.

CBP has issued a manual setting forth “National Standards on Transport, Escort, Detention, and Search” (TEDS), which provides instructions on how CBP should care for individuals in the agency’s custody. However, the OIG’s reviews of the deaths of the 7-year-old and 8-year-old do not discuss whether the standards set forth in the TEDS manual are adequate to address the scenarios Border Patrol agents faced in caring for these children, or whether these standards were followed in these cases. In fact, during a briefing with Committee staff, a senior OIG official who oversaw the investigations of the children’s deaths expressed a lack of familiarity with the TEDS standards and stated the reviews were not intended to examine the adequacy of the TEDS standards or their application in these cases but to “determine whether or not the actions taken were reasonable under the circumstances.”¹⁹

The OIG’s failure to examine the TEDS standards in light of the children’s deaths is inexplicable and represents a missed opportunity to determine whether policy revisions are needed. Two of the many policy issues that are raised by the children’s deaths standards are discussed below.

Infectious Disease Control

In the case of the 8-year-old’s death, while it remains unclear whether the agents who were managing the child’s care knew that the child had Influenza B, it appears that they had been informed that the child had an upper respiratory infection—meaning that they were aware that the child had a contagious condition.

According to the OIG’s report, after the 8-year-old returned to a CBP station following the first visit to the hospital on the morning of December 24, 2018, the child was alternately held in a holding cell and in a more open area at the front of the station, where agents could keep a closer eye on the child.²⁰ These arrangements highlight the inherent tension between holding a child with an infectious condition in an area where agents—who were clearly busy managing a high number of migrants—could pay close attention to the child’s evolving symptoms but where the child would potentially expose other people (including Border Patrol agents) to illness, and holding the child in an area where the child would be isolated but the child’s condition could not be as closely monitored. This situation raises numerous questions about the appropriateness of holding individuals with infectious conditions in CBP custody.

The TEDS manual states the following regarding contagious diseases among individuals held in CBP custody:

“*Contagious Disease:* If an officer/agent suspects or a detainee reports that a detainee may have a contagious disease, the detainee should be separated whenever operationally

¹⁹ *Id.*

²⁰ Department of Homeland Security, Office of Inspector General, *Report of Investigation: Circumstances Surrounding the Custodial Death of [8-Year-Old-Child]*, (I19-BP-ELP-06106) (Dec. 13, 2019).

feasible, and all other appropriate precautions must be taken and required notifications made, according to the operational office's policies and procedures."²¹

The report produced by the OIG does not discuss whether this standard was followed in the case of the 8-year-old child or whether this standard is adequate. During a briefing with Committee staff, a senior OIG official indicated that the Inspector General's office did not examine any issues pertaining to CBP's management of infectious diseases.²²

In the case of the 8-year-old child, the risks associated with keeping a child with an infectious condition in close proximity to other individuals in CBP custody may have been more than theoretical. Evidence in the OIG's report suggests that a child held in the same cell as the 8-year-old was transported to the hospital the next day and diagnosed with a cold. The child recovered.²³

The Inspector General's finding that another child held in the same cell as the 8-year-old became so ill that the child had to be transported to the hospital the day after the 8-year-old died raises numerous additional questions about infectious disease control at CBP, but in a briefing with Committee staff, a senior OIG official indicated that the Inspector General's office did not examine any information pertaining to the medical care of any other detainees, including the child held in the same cell as the 8-year-old child.²⁴

Informed Consent Among Detainees

The OIG's report indicates that on several occasions after the 8-year-old child returned to the CBP facility after the child's first hospital visit on December 24, 2018, the father of the child was asked if he wanted to return to the hospital because the child was continuing to experience symptoms.²⁵ In at least once instance, the child was observed to be exhibiting severe symptoms several hours after the child had returned from the first visit to the hospital and approximately four-and-a-half hours before the Border Patrol agents determined that the child's condition had worsened to the point that the child needed to be taken back to the hospital. Specifically, the child was observed to be having trouble breathing and complaining about stomach pains. At that point, the child's father and the child were asked if they wanted to return to the hospital, but they declined."²⁶

²¹ Department of Homeland Security, U.S. Customs and Border Protection, National Standards on Transport, Escort, Detention and Search (Oct. 2015).

²² Department of Homeland Security, Office of Inspector General, Staff Briefing with Committee on Homeland Security (March 18, 2020).

²³ Department of Homeland Security, Office of Inspector General, *Report of Investigation: Circumstances Surrounding the Custodial Death of [8-Year-Old-Child]*, (I19-BP-ELP-06106) (Dec. 13, 2019).

²⁴ Department of Homeland Security, Office of Inspector General, Staff Briefing with Committee on Homeland Security (March 18, 2020).

²⁵ Department of Homeland Security, Office of Inspector General, *Report of Investigation: Circumstances Surrounding the Custodial Death of [8-Year-Old-Child]* (I19-BP-ELP-06106) (Dec. 13, 2019).

²⁶ *Id.*

This finding raises numerous questions directly relevant to the TEDS standards, which state:

“Medical Emergencies: Emergency medical services will be called immediately in the event of a medical emergency (e.g., heart attack, difficulty breathing) and the call will be documented in the appropriate electronic system(s) of record. Officers/Agents must notify the shift supervisor of all medical emergencies as soon as possible after contacting emergency services.”²⁷

At issue is not only whether this standard was followed in the case of the 8-year-old, but whether the TEDS manual should be revised to address how the issue of informed consent should be handled among people in custody, particularly when severe symptoms—such as difficulty breathing—are observed in an accompanied child. However, the OIG did not examine any of these issues.

Relevant Records Not Collected

The OIG failed to collect all relevant evidence during the reviews of the deaths of the two children in CBP custody. During a briefing with Committee staff, a senior OIG official indicated that the reviews of the children’s deaths were just “hitting the high points.”²⁸ In fact, the OIG failed to collect evidence that was referenced in its own report of investigation. For example, regarding the 8-year-old child, when the child was transported to the hospital the first time on the morning of December 24, 2018, Border Patrol agents reported they were in contact via text message about the child.²⁹ However, according to a senior OIG official, the Inspector General’s office did not collect these phone records, and also did not collect email records or other similar records of correspondence regarding the child’s care or death.³⁰

Inspector General’s Office Conducted Investigation of CBP with CBP Personnel Due to Inadequate Staffing

The OIG conducted the review of the death of the 8-year-old child “in conjunction with” staff from CBP’s Office of Professional Responsibility—even though the actions of CBP personnel were under examination.³¹ Standards for investigations applicable to all Offices of Inspector General state that the “investigative organization must be free, both in fact and appearance, from

²⁷ Department of Homeland Security, U.S. Customs and Border Protection, National Standards on Transport, Escort, Detention and Search (Oct. 2015).

²⁸ Department of Homeland Security, Office of Inspector General, Staff Briefing with Committee on Homeland Security (March 18, 2020).

²⁹ Department of Homeland Security, Office of Inspector General, *Report of Investigation: Circumstances Surrounding the Custodial Death of [8-Year-Old-Child]*, (I19-BP-ELP-06106) (Dec. 13, 2019).

³⁰ Department of Homeland Security, Office of Inspector General, Staff Briefing with Committee on Homeland Security (March 18, 2020).

³¹ *Id.*

impairment to independence; must be organizationally independent; and must maintain an independent attitude.”³² During a briefing with Committee staff, a senior OIG official indicated that the decision to have CBP personnel involved in an Inspector General’s review of CBP’s actions was not made lightly, but that it was necessary because the CBP personnel could help “force multiply” at a time when most of the Inspector General’s staff in the Rio Grande Valley were engaged in investigating the death of the 7-year-old child.³³ Based on information provided to Committee staff during their briefing with the OIG, it appears that the decision to allow CBP personnel to participate in an Inspector General’s review of CBP was made largely by one senior official—after discussion with senior CBP personnel.

This situation raises numerous concerns about the independence of the OIG’s investigation, as well as about the level of staffing of the Inspector General’s office and about the process for deciding to allow staff of an agency under review to participate in the Inspector General’s review of the agency. Further, the involvement of personnel from CBP in the OIG’s investigation is not mentioned in the public summary of the Inspector General’s review of the 8-year-old child’s death. Instead, the public summary says only:

“The Office of Inspector General (OIG) for the Department of Homeland Security (DHS) recently completed an investigation into the death of a Guatemalan child who died in U.S. Border Patrol (USBP) custody.”³⁴

Questions

Given the many shortcomings apparent in the OIG’s review of the deaths of two children in CBP custody, I request to receive by April 9, 2020, written answers to the following questions:

1. By what date will the OIG amend the public summary of its review of the 8-year-old child’s death to include additional information regarding the circumstances of the child’s death, including, at a minimum, the fact that the child was diagnosed with Influenza B and that complications of Influenza B were cited as a cause of death in the autopsy report on the child’s death?
2. Why were the investigations of the children’s deaths limited to criminal investigations? What specifically does malfeasance mean in the context of the investigations? Which standards or criteria were CBP’s actions evaluated against? How were those evaluations conducted and by whom?

³² Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Investigations* (Nov. 15, 2011) (online at www.ignet.gov/sites/default/files/files/invprg1211appi.pdf).

³³ Department of Homeland Security, Office of Inspector General, Staff Briefing with Committee on Homeland Security (March 18, 2020).

³⁴ Department of Homeland Security, Office of Inspector General, “The Office of the Inspector General Completes Investigation of the Death of Eight-Year-Old Guatemalan Child Who Died in U.S. Border Patrol Custody” (Dec. 20, 2019) (online at www.oig.dhs.gov/sites/default/files/assets/pr/2019/dojpr-122019-dhs-oig-completes-investigation-death-eight-year-old-guatemalan-child.pdf).

3. Given that several more children have died in CBP custody since the 7-year-old and the 8-year-old died in December 2018, will the OIG conduct a thorough review of the adequacy of CBP's TEDS standards for guiding the care of children held in detention, including when such detention lasts longer than 72 hours? If so, by what date will this review be completed?
4. During a briefing with Committee staff, OIG officials indicated that the Inspector General's office is conducting investigations into the deaths of two additional minors in CBP custody. Will you commit to releasing to the public the reports of investigation into these deaths?
5. By what date will the Inspector General's office adopt written protocols reiterating the OIG's independence from the agencies of DHS it is charged with overseeing and making clear that personnel from agencies under investigation may never participate in the OIG's investigation of that agency?
6. Does the Committee have your commitment that you, personally, will testify at the Committee's hearing to examine the deaths of children in CBP custody when it is rescheduled?

I thank you for your urgent attention to these troubling matters and look forward to receiving your written responses to my questions.

Sincerely,



BENNIE G. THOMPSON
Chairman