Practice Advisory: Litigating Habeas Corpus Petitions for Pregnant, Postpartum, and Nursing People in ICE Detention

August 24, 2026

I. INTRODUCTION

Despite a binding agency directive that pregnant, postpartum, and nursing people generally should not be detained at all, ICE is arresting and detaining them in growing numbers, often in facilities that cannot provide adequate prenatal, obstetric, or postpartum care. Advocates have documented shackling during transport, solitary confinement, denial of prenatal vitamins and appropriate food, missed and delayed obstetric appointments, and hospitalizations for preventable complications.

This practice advisory outlines arguments to secure the release of a detained individual who is pregnant, postpartum (within one year of giving birth), or nursing, through a petition for a writ of habeas corpus.[1]

These arguments largely, though not exclusively, focus on ICE Directive 11032.4 (July 1, 2021) (the Directive), which provides that ICE "should not detain, arrest, or take into custody for an administrative violation of the immigration laws individuals known to be pregnant, postpartum, or nursing unless release is prohibited by law or exceptional circumstances exist." The Directive imposes specific, mandatory procedures whenever a pregnant, postpartum, or nursing person nonetheless comes into custody. Several district courts have ordered release or ordered the government to show cause why release was not required, based on ICE's failure to comply with the Directive. *See, e.g.*, *Shigwedha v. Acuna*, No. CV 26-2430, 2026 WL 2211525 (W.D. La. July 31, 2026); *San Juan v. Mullin*, 2026 WL 1962582 (W.D. La. July 7, 2026); *Sahin v. Rader*, No. 2:26-cv-00134, Minute Order, ECF No. 17 (D. Nev. Jan. 26, 2026); *De Leon Lopez v. Ladwig*, 2026 WL 19095 (W.D. La. Jan. 2, 2026).

This advisory:

[1] The Kennedy Human Rights Center and ACLU of Louisiana thank Gibson, Dunn & Crutcher LLP for its partnership in habeas litigation for pregnant petitioners. This advisory is for general informational purposes only and is not intended as, and should not be taken as, legal advice in any case, or as a substitute for independent legal counsel familiar with the circumstances of a specific case and the applicable local rules and precedents. The law in this area is developing at extraordinary speed; practitioners should carefully research the most up-to-date law when preparing a case.

- Summarizes ICE Directive 11032.4 and related detention standards governing the custody and care of pregnant, postpartum, and nursing people;
- Analyzes recent decisions granting relief and identifies features common to successful petitions;
- Outlines four principal claims: violation of the Administrative Procedure Act (APA), violation of the *Accardi* doctrine, denial of procedural due process, and denial of substantive due process (unconstitutional punishment and deliberate indifference to serious medical needs).
- Summarizes a July 2026 declaration of the American College of Obstetricians & Gynecologists (ACOG) on the medical risks of detaining pregnant people, and explains how to use it to support legal claims, attached as Appendix A.
- Addresses the government's anticipated arguments opposing release; and
- Provides, as Appendix B, a model habeas petition, with highlighted text to be adapted to the facts of a given case and the controlling precedent of the relevant circuit.

II. ICE DIRECTIVE 11032.4 AND THE GOVERNING LEGAL LANDSCAPE

A. The Directive's Mandatory Default Presumption Against Detention

ICE Directive 11032.4 establishes a default rule that "ICE should not detain, arrest, or take into custody for an administrative violation of the immigration laws individuals known to be pregnant, postpartum, or nursing unless release is prohibited by law or exceptional circumstances exist." Directive 11032.4 § 2. A person is "postpartum" for the one-year period immediately after giving birth and is "nursing" if breastfeeding a child "regardless of the passage of time since childbirth." *Id.* § 3.[2]

The Directive defines "exceptional circumstances" narrowly, existing only when (1) the individual poses national security concerns, or (2) the individual poses an imminent risk of death, violence, or physical harm to any individual. *Id.* § 3.4. It then imposes the following mandatory procedures:

- Detention of a pregnant, postpartum, or nursing person must be approved by the Field Office Director or a designee no lower than the Assistant Field Office Director level. *Id.* § 5.1.
- When a person already in custody is identified as pregnant, postpartum, or nursing, ICE personnel "must immediately notify" the Field Office Director or designee and appropriate medical staff "to determine if continued detention is appropriate." *Id.* § 5.4.

[2] U.S. Immigr. & Customs Enf't, Directive No. 11032.4, *Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals* (July 1, 2021), available at https://perma.cc/P98F-SR8N.

- ICE must verify that covered individuals are not detained "unless release is prohibited by law or exceptional circumstances exist," and must maintain a process for the "expeditious release, where legally authorized," of covered individuals already in custody. *Id.* § 4.2.
- If a covered person is detained, ICE must re-evaluate at least weekly whether continued detention remains appropriate, and must monitor, track, and report the person's status up through the ICE Director. *Id.* §§ 2.2, 5.3.
- The Directive also restricts the use of restraints on pregnant individuals absent extraordinary circumstances.

In nearly every recent case, the government has been unable to produce evidence that it followed any of these required steps.

B. The Directive Applies Even Where Detention Is Otherwise "Mandatory"

The Directive applies even if the petitioner might otherwise be subject to mandatory detention, because ICE always retains authority to release a detained person from mandatory detention on humanitarian parole. *See* 8 U.S.C. § 1182(d)(5)(A); *see also* 8 C.F.R. § 212.5(b)(2) (identifying "[w]omen who have been medically certified as pregnant" among those whose parole "would generally be justified only on a case-by-case basis for 'urgent humanitarian reasons' or 'significant public benefit,' provided the aliens present neither a security risk nor a risk of absconding"). Courts have enforced the Directive in favor of petitioners the government claimed were mandatorily detained. *See San Juan v. Mullin*, 2026 WL 1962582, at *2 (W.D. La. July 7, 2026).

C. Current Practice: ICE's February 2026 Data to Congress

ICE's own data confirm systemic noncompliance with the Directive. In a February 2026 response to a congressional inquiry, ICE described Directive 11032.4 as its "longstanding directive" reflecting current policy, but released data with that response showing at least 498 instances of ICE detention of pregnant, postpartum, and nursing women between January 1, 2025 and February 21, 2026, and 363 removals of covered individuals in the same period. *See* Dep't of Homeland Sec. Response to Senator Patty Murray and Others' September 18, 2025 Letter (Feb. 23, 2026), available at https://perma.cc/J9ZV-8HZG.

As of a February 16, 2026 snapshot, ICE was detaining 86 pregnant individuals (nine in their third trimester), 35 postpartum individuals, and 15 who were nursing. *Id.* In the first nine months of 2025, ICE could document only 23 instances of obstetrics and gynecology services for a covered detained population numbering in the hundreds. *Id.* ICE also documented 16 miscarriages in ICE custody in that period. *Id.*

ICE acknowledged that these figures are underinclusive because it "does not track postpartum or nursing information for all detention facilities." *Id.* The tracking failure itself violates the Directive's requirement that ICE "maintain information regarding all individuals

known to be pregnant, postpartum, and nursing detained in ICE custody" and report it monthly. Directive 11032.4 § 2.2.

D. Related Maternal Healthcare Standards

ICE's Performance-Based National Detention Standards (PBNDS 2011, revised 2016), § 4.4 (Medical Care (Women)), and counterpart provisions of the National Detention Standards, incorporated into contracts with third-party detention operators, require pregnancy-specific medical care, appropriate nutrition, and specialized obstetric services for anyone who is detained.

Departures from these standards can be used in a claim for release due to deliberate indifference of a serious medical need, discussed below in Section IV(D)(2), as evidence that the care being provided is objectively unreasonable.

The PBNDS requirements include:

- **§ 4.4(V)(A)**: every facility shall directly or contractually provide female detainees access to pregnancy services (pregnancy testing, routine or specialized prenatal care, postpartum follow-up, lactation services, abortion services); counseling and assistance in planning for the pregnancy; and routine age-appropriate gynecological care.
- **§ 4.4(V)(B)(1)**: within 12 hours of arrival, all female detainees receive information on women's health services.
- **§ 4.4(V)(B)(2)**: where initial screening indicates possible pregnancy, referral shall be initiated and a health assessment provided "as soon as appropriate or within two working days." Initial health assessment must include pregnancy testing for detainees aged 18–56 with documented results, and must inquire whether the detainee is currently nursing.
- **§ 4.4(V)(E)**: upon confirmation of pregnancy, detainee "shall be given close medical supervision"; access to prenatal and specialized care and comprehensive counseling covering nutrition, exercise, complications of pregnancy, prenatal vitamins, labor and delivery, postpartum care, lactation, family planning, and parental skills education.
- **§ 4.4(V)(E)**: facility administrator "shall ensure that the FOD [Field Office Director] is notified as soon as practicable of any female detainee determined to be pregnant, but no later than 72 hours after such determination."
- **§ 4.4(V)(E)**: medical provider "will identify any special needs (e.g. diet, housing, or other accommodations such as the provision of additional pillows) and inform all necessary custody staff and facility authorities." High-risk pregnancies require referral to a physician specializing in high-risk pregnancies. Chemically dependent pregnant detainees are per se high risk and require immediate obstetrician referral.
- **§ 4.4(V)(E)**: pregnancy management and outcomes "shall be monitored, quarterly, through a continuous quality improvement process."
- **§ 4.4(V)(E)(1)**: restraints: pregnant woman or woman in post-delivery recuperation "shall not be restrained absent truly extraordinary circumstances that render restraints absolutely necessary." Never permitted during active labor or delivery. Applies "whether during transport, in a detention facility, or at an outside medical facility." Three narrow exceptions permitting restraints only. Never face-down four-point, on her back, or in a belt constricting the area of the pregnancy; placed on left side if immobilized. Requires documented approval from on-site medical authority.

- **§ 4.4(V)(F)**: mental health assessments offered to any detainee who has given birth, miscarried, or terminated a pregnancy in the past 45 days.
- **§§ 4.4(III)–(IV):** References incorporate ACOG, *Guidelines for Women's Health Care* (3d ed. 2007) and National Commission on Correctional Health Care (NCCHC) standards. Expected Outcome 1 mandates compliance with NCCHC standards.

In 2026, ICE introduced the National Detention Standards, streamlining the PBNDS substantially. The 2026 standards address requirements for pregnant people in detention principally, though not exclusively, in sections 2.8(II)(I)(2) (restraints) and 4.3(II)(U) (medical standards). They omit explicit guarantees of intake notice, assessment deadlines, routine gynecological care, an affirmative duty to provide pregnancy services, quarterly quality monitoring, post-pregnancy mental health assessments, and the ACOG/NCCHC benchmarks and applicability framework.

The operative standard can vary based on facility, contract revision or renewal, transfer of the petitioner, and as new facilities open. If invoking the standards, practitioners must confirm which standard governed the facility at the time of the conduct challenged, and re-confirm after any transfer.

III. DECISIONS ORDERING RELEASE UNDER THE DIRECTIVE

This section outlines the reasoning courts have used when ordering the release of habeas petitioners based on their status as pregnant, postpartum, or nursing individuals. It draws from caselaw across the country.

A. Violation of Directive 11032.4

Several courts have held that Directive 11032.4 is binding on ICE and its violation is enforceable at habeas. *San Juan v. Mullin*, 2026 WL 1962582 (W.D. La. July 7, 2026) provides a common analysis. In *San Juan*, the petitioner was a nursing mother whose child was born on January 7, 2026. She was detained in Florida in May 2026 and transferred to mandatory detention in Louisiana three days later. The court granted habeas relief under the *Accardi* doctrine, the principle that agencies must comply with procedures they promulgate, ruling her detention violated Directive 11032.4. *See id.* It ordered her released within five business days, with a notice of compliance due 24 hours after release. *Id.*

The court's analysis proceeded in three steps. First, the court determined the petitioner was covered by the Directive. Because the petitioner's child was born less than a year earlier, she was "postpartum" under the Directive, and her claim that she was actively nursing at apprehension independently brought her within the Directive's ambit. *Id.* Second, the court placed the burden on the government to demonstrate compliance with the Directive, finding that "unless Respondents can demonstrate why Petitioner's release is prohibited by law or what exceptional circumstances exist, the Directive requires Petitioner's release." *Id.* Third, the court found that the government's failure to provide evidence of compliance sufficed to make out a violation. When the court invited

the government to demonstrate "the deliberative process ICE has undertaken to comply with its own directive," the government declined to respond with additional evidence. *Id.* The court then held that "Respondents have failed to demonstrate their adherence to the Directive," and *Accardi* therefore "necessitates Petitioner's release." *Id.*

Following *San Juan*, petitioners can argue that a Directive-based claim shifts the burden to the government to document compliance, including approval by the designated official, an exceptional-circumstances determination, and weekly re-evaluations. Other courts have analyzed the compliance question the same way. *See Sahin v. Rader*, No. 2:26-cv-00134, Minute Order, ECF No. 17 (D. Nev. Jan. 26, 2026) (continued detention of a woman with a high-risk pregnancy "egregiously violates ICE's binding policy directive"); *De Leon Lopez v. Ladwig*, 2026 WL 19095, at *7–8 (W.D. La. Jan. 2, 2026) (ordering the government to show cause within six days why a pregnant petitioner's detention comported with the Directive). Because these decisions can issue as unpublished minute orders on emergency motions, practitioners should also search recent dockets in their district for unreported Directive-based release orders and monitor practitioner networks for new decisions.

B. Preliminary and urgent relief

In *Shigwedha v. Acuna*, No. CV 26-2430, 2026 WL 2211525 (W.D. La. July 31, 2026), the petitioner was almost six months pregnant with twins. The court granted her release after she moved for a temporary restraining order, arguing that her detention violated Directive 11032.4 and the *Accardi* doctrine. *Id.* at *1. The government admitted the petitioner was pregnant and therefore covered by the Directive, but "made no attempt to show that she is a national security threat or otherwise presents an imminent risk of death, violence, or physical harm to any person," and "provided no information about the procedures it used to review her detention or even whether such a review has occurred at all," representing only that "the review remained pending." *Id.*

Following *Shigwedha*, practitioners should consider moving for urgent preliminary relief or asking for a short deadline for the government to demonstrate compliance with the Directive. In *Shigwedha*, the court ordered a status report on ICE's custody review within seven days. The government let the deadline pass and instead requested a further seven-day extension at 6:00 p.m. on the day the report was due, offering no justification beyond "awaiting receipt of information" from DHS. *Id.* The court held that "[t]he lack of a response from the government and DHS about its procedures for caring for and detaining Shigwedha makes finding anything other than a violation of the Directive impossible." *Id.*

The court also found irreparable harm for the purposes of a TRO established by the medical record, citing the petitioner's evidence that she had already experienced "physical decline" from the lack of treatment, including "weight loss, exhaustion, and iron deficiency." *Id.* at *2. The court further concluded that the risk of "death of herself or her unborn children" far outweighs the government's enforcement interest. *Id.*

C. Concession and waiver

Practitioners can argue that ICE's failure to respond in a timely or substantive manner to a habeas petition's allegations constitutes concession or waiver of opposition. In *Banegas v. Bondi*, 2026 WL 473162 (W.D. Wis. Feb. 19, 2026), the court directed the government to show cause why a nursing mother's release was prohibited by law or what exceptional circumstances existed under the Directive for her detention. The government conceded there were none, so the court ordered immediate release: "Having identified no exceptional circumstance or other legal reason why her release is impermissible under ICE Directive 11032.4, respondents are in violation of *Accardi* for failure to comply with an agency policy that plainly affects individual rights." *Id.* at *2.

In *Morales Lopez v. Maples*, 2026 WL 1433970 (S.D. Ind. May 21, 2026), the court ordered the immediate release of a pregnant petitioner, reasoning that because she was bond-eligible under § 1226(a), "her release is not prohibited by law" and release was "therefore mandatory" under the Directive and *Accardi*. The court considered the government's failure to respond to the *Accardi* argument as "waiver" of opposition. *Id.* Practitioners should therefore scrutinize any government response to an initial petition and press waiver and concession arguments squarely where applicable.

D. Deliberate Indifference

In *Marks v. Cicirello*, 2026 WL 1238537 (W.D.N.Y. May 6, 2026), the court ordered release on a medical-needs claim rather than a claim of violation of the Directive. The petitioner was postpartum and seeking adjustment of status under the Violence Against Women Act, but held in mandatory detention under 8 U.S.C. § 1231(a)(2) following an in absentia removal order. *Id.* at *1. She presented her own testimony and a medical expert at an evidentiary hearing; the government called no witnesses. *Id.* at *2. The court ordered release based on deliberate indifference to her serious medical needs, even though it rejected her claim that the Directive could compel release in the final-order posture. *Id.* at *3.

E. The Directive's Continued Operational Status

In *Maldonado v. Olson*, 795 F. Supp. 3d 1134 (D. Minn. 2025), an immigration judge had ordered a pregnant petitioner released on bond, but ICE invoked the automatic-stay regulation, 8 C.F.R. § 1003.19(i)(2), which suspends an immigration judge's release order upon DHS's notice of intent to appeal. The court held the petitioner likely to succeed on her claim that the automatic stay, as applied, violates procedural due process, rejected the government's jurisdiction-stripping arguments, and entered a preliminary injunction requiring her release on the IJ's bond terms. The court also found that Directive 11032.4 had not been revoked by Executive Order 14159 "entitled 'Protecting the American People Against Invasion,' . . . a broad policy statement of the current administration regarding immigration policy" that "contains no references to nursing mothers, let alone nursing mothers who lack any criminal history whatsoever." *Id.* at 1155.

IV. POTENTIAL HABEAS CLAIMS FOR PREGNANT, POSTPARTUM, AND NURSING INDIVIDUALS

This section briefly explains arguments that may support habeas claims for pregnant, postpartum, and nursing individuals in ICE detention, including those not previously recognized in caselaw. They include causes of action under: (A) the APA; (B) the *Accardi* doctrine; (C) procedural due process, based on violation of the Directive, and (D) substantive due process, based on inadequate medical care.[3]

A. APA

The APA requires courts to "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Practitioners should consider two APA claims related to the Directive.

First, practitioners can argue that the failure to apply the Directive is "not in accordance with law," because the Directive is binding law under the *Accardi* doctrine. *See infra* Section IV.B (explaining how *Accardi* makes internal directives enforceable law). Second, practitioners can argue that the decision to detain a pregnant, postpartum, or nursing individual is arbitrary and capricious because it "entirely fail[s] to consider an important aspect of the problem." *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). An agency that detains a person it knows to be pregnant without ever applying the directive that governs that decision—not to mention the underlying health and safety considerations on which it is based—has failed to consider the most important aspect of the problem.

Practitioners should anticipate two objections to an APA claim. First, courts may question whether detention is a final agency action enforceable under the APA. Some district courts have

[3] On the first three claims, practitioners should be aware that the circuits, and district courts within individual circuits, variously (and inconsistently) apply *Accardi* as a violation of the APA (which may require proof of a final agency action); a violation of the Due Process Clause (which may require proof of a constitutionally protected interest or substantial prejudice); and a standalone cause of action (which may require proof that the violated rule was intended to benefit the person suing). The framing dictates the elements of an *Accardi* violation, so practitioners should research local law and apply the framing that best corresponds, preserving arguments for alternative framings if appropriate. A court inclined to avoid constitutional rulings could grant relief via the APA or *Accardi*, while a court skeptical of APA review of detention could reach constitutional claims. Where the circuit does not recognize a free-standing *Accardi* claim, the substance of it can be folded into a count the circuit does recognize, with the free-standing version pleaded in the alternative to preserve the issue.

A more in-depth analysis of the *Accardi* doctrine, including suggestions on how best to frame it in accordance with the circuit in which you are practicing, is provided in Kennedy Human Rights Center, *Practice Advisory: Using the Accardi Doctrine to Seek Release from Immigration Detention* (August 2026). The advisory provides an overview of *Accardi* caselaw organized by circuit.

held that the ongoing decision to detain during removal proceedings is not a final agency action. *See, e.g.*, *Santiago v. Noem*, 2025 WL 2792588, at *5–6 (W.D. Tex. Oct. 2, 2025).

In response, practitioners can identify the discrete decisions that consummated the agency's decision-making process and from which legal consequences flowed. *See Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (setting out the test for final agency action); *see also Ramirez v. U.S. Immigr. & Customs Enf't*, 310 F. Supp. 3d 7, 22–23 (D.D.C. 2018) (finality met by agency decision to detain plaintiffs). These may include the decision to take a known-pregnant person into custody without the Directive's required approval; the refusal to engage in a § 5.4 determination whether continued detention is appropriate; or the denial of a release request, which practitioners may wish to make to the agency before filing a habeas petition.

Other courts may question whether the Directive is enforceable under the APA, reasoning that it "is a general statement of policy or rule of agency procedure or practice. As a result, it does not constitute a final agency action subject to APA review." *de Leon v. Ladwig*, 2026 WL 19095, at *7. In response, practitioners can argue that the final agency action at issue is not the decision to adopt the Directive, but the decision to refuse to comply with its mandates.

The government may also argue that APA claims are unavailable because habeas provides an adequate remedy. *See* 5 U.S.C. § 704. Practitioners can point out that the APA itself contemplates review "in any applicable form of legal action, including . . . writs of . . . habeas corpus," 5 U.S.C. § 703. They can explain that the underlying law being violated is the APA, while the cause of action remains habeas corpus.

B. *Accardi*

Violations of an agency's own procedures are actionable. As the Fourth Circuit put it: "An agency of the government must scrupulously observe rules, regulations, or procedures which it has established. When it fails to do so, its action cannot stand and courts will strike it down." *United States v. Heffner*, 420 F.2d 809, 811 (4th Cir. 1970). The *Accardi* doctrine takes its name from an immigration habeas case, *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260 (1954), which vacated a removal order for failure to comply with an agency regulation. *Morton v. Ruiz*, 415 U.S. 199, 235 (1974), extended the principle to internal procedures intended to provide a benefit or protect fundamental rights: "Where the rights of individuals are affected, it is incumbent upon agencies to follow their own procedures."

Lower courts have held that *Accardi* is not "limited to rules attaining the status of formal regulations," *Montilla v. INS*, 926 F.2d 162, 167 (2d Cir. 1991). Nor does a boilerplate "no-rights" disclaimer defeat enforcement, so long as the policy is adopted for the benefit of the persons it covers. *See Damus v. Nielsen*, 313 F. Supp. 3d 317, 336–38 (D.D.C. 2018); *Abdi v. Duke*, 280 F. Supp. 3d 373, 389 (W.D.N.Y. 2017).

Courts applying these principles to the Directive have held that it "plainly affects individual rights," *Banegas*, 2026 WL 473162, at *2, and is therefore enforceable under *Accardi*. *See, e.g.*,

Morales Lopez, 2026 WL 1433970. In the Fifth Circuit, *Shigwedha* treated the Directive as binding without hesitation, describing "[r]egulations like the Directive" as "binding on agencies, including ICE." *Shigwedha v. Acuna*, 2026 WL 2211525, at *1 (citing *Richardson v. Joslin*, 501 F.3d 415, 418 (5th Cir. 2007)). Once the Directive is found binding under *Accardi*, courts typically treat the failure to follow its provisions as proof of an *Accardi* violation.

C. Procedural Due Process

Practitioners can consider a procedural due process claim that ICE's failure to follow the Directive's mandatory decisional procedures violates Due Process. Courts typically analyze procedural due process claims under the three-factor balancing test from *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), though some courts have found that an *Accardi* violation is itself a due process violation. *See* Kennedy Human Rights Center, *Practice Advisory: Using the Accardi Doctrine to Seek Release from Immigration Detention* (August 2026).

Under *Mathews*, a typical analysis for a pregnant, postpartum, or nursing individual might argue:

- *Private interest.* The petitioner's interest is not only "the most elemental of liberty interests," *Hamdi v. Rumsfeld*, 542 U.S. 507, 529 (2004), but also her interest in her own life and health and her child's. Continued detention in a facility that cannot provide obstetric care or separates a mother from her newborn or nursing child places those interests at irreversible risk.
- *Risk of erroneous deprivation.* Where no official made the custody determinations required by the Directive, the risk of erroneous deprivation is certain. The Directive's unfollowed procedures are evidence of the value of additional safeguards. *See Khabazha v. United States Immigr. & Customs Enf't*, 2025 WL 3281514, at *7 (S.D.N.Y. Nov. 25, 2025) (using *Accardi* violation to establish erroneous-deprivation risk).
- *Government interest.* Detention of a pregnant, postpartum, or nursing person who the government does not contend is dangerous or a flight risk wastes resources: predawn multi-hour transports for specialist care, emergency hospitalizations, litigation. Release would relieve those burdens. The Directive is ICE's own judgment that detention of pregnant people is generally not in the agency's interest.

D. Substantive Due Process

Two distinct claims can be made under substantive due process: that detention in the particular circumstances is unconstitutional punishment and that it constitutes deliberate indifference to a serious medical need.

1. Unconstitutional Punishment

Civil immigration detainees may not be subjected to conditions that "amount to punishment." *Bell v. Wolfish*, 441 U.S. 520, 535 (1979). A condition is punitive if it is not "reasonably related to a legitimate governmental objective," *id.* at 539, an objective inquiry that does not turn on an official's state of mind. This principle applies to immigration detention through the Fifth Amendment. *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001).

A punishment claim is distinct from a medical-needs claim, and should be pleaded separately, because it attacks the fact and totality of the detention conditions as serving no legitimate purpose where the government identifies neither danger nor flight risk. It relies on facts specific to the petitioner's conditions of confinement: for example, denial of a medically necessary diet, unreliable access to safe drinking water, restraints during transport, or detention in a facility that cannot provide access to pregnancy-specific medical care. *See, e.g., Vazquez Barrera v. Wolf*, 455 F. Supp. 3d 330, 339 (S.D. Tex. 2020) (discussing medically vulnerable people in ICE detention and holding that "Preventing [a detained person] from protecting [her] own health . . . does not reasonably relate to a legitimate governmental purpose and thus[] violates the Fifth Amendment.").

2. Deliberate Indifference to Serious Medical Needs

Where the facts support it, practitioners should consider pleading a separate count for denial of adequate medical care. The governing standard varies by circuit. Some circuits ask whether the failure to provide adequate care was objectively unreasonable. *See Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017); *Charles v. Orange Cnty.*, 925 F.3d 73, 87 (2d Cir. 2019) (immigration detention); *Gordon v. Cnty. of Orange*, 888 F.3d 1118, 1124–25 (9th Cir. 2018). In others, the petitioner must show an official subjectively knew of and disregarded a substantial risk of serious harm. *See James v. Smith*, 152 F.4th 594, 609 (5th Cir. 2025). Even there, knowledge may be inferred "from the very fact that the risk was obvious." *Farmer v. Brennan*, 511 U.S. 825, 842 (1994).

A high-risk pregnancy is a paradigmatic serious medical need requiring continuous, specialized care. See *Mori v. Allegheny Cnty.*, 51 F. Supp. 3d 558, 575 (W.D. Pa. 2014); *accord*, e.g., *Goebert v. Lee Cnty.*, 510 F.3d 1312, 1326–28 (11th Cir. 2007) (pregnant detainee leaking amniotic fluid); *Pool v. Sebastian Cnty.*, 418 F.3d 934, 944–45 (8th Cir. 2005) (bleeding and cramping during pregnancy); *Coleman v. Rahija*, 114 F.3d 778, 785–86 (8th Cir. 1997) (substantial risk of pre-term labor is a serious medical need); *Boswell v. Cnty. of Sherburne*, 849 F.2d 1117, 1122–23 (8th Cir. 1988) (bleeding and cramping by pregnant woman establishes serious medical need). A petitioner need not wait for catastrophe: a substantial risk of serious harm suffices. *See Helling v. McKinney*, 509 U.S. 25, 33 (1993).

Some courts hold conditions-of-confinement claims non-cognizable in habeas. *See, e.g.*, *De Leon Lopez*, 2026 WL 19095, at *5–6 (citing *Rice v. Gonzalez*, 985 F.3d 1069, 1070 (5th Cir. 2021)). Practitioners should thus consider framing a medical claim as a challenge to the legality of

continued detention itself, arguing that the detention is unconstitutional and the remedy sought is release because the facility cannot provide the petitioner with adequate medical care and the custodian therefore cannot detain her consistently with the Fifth Amendment. This claim can be supported both by specific facts about the petitioner's medical needs and evidence concerning the lack of available appropriate care for those needs. Both propositions can be supported by a legal declaration by the American College of Obstetricians & Gynecologists (ACOG), attached to this advisory as Appendix A and further described below.

V. THE ACOG DECLARATION: MEDICAL EVIDENCE FOR CLAIMS

The American College of Obstetricians & Gynecologists (ACOG), the nation's leading professional organization of obstetric and gynecologic clinicians, with more than 60,000 members, has executed a declaration by its Chief Medical Officer, Christina Davidson, MD, FACOG, a board-certified maternal-fetal medicine specialist, addressing the medical risks of detaining pregnant people. A copy is attached here as Appendix A. The declaration is not case-specific, but practitioners can use it to support elements of claims already discussed, as further explained below. ACOG's guidance has been repeatedly cited by courts, including the Supreme Court, as an authoritative voice of science and medicine on obstetric care. This Part summarizes the declaration's findings and explains how to deploy them claim by claim.

A. Factual Propositions in the ACOG Declaration

Pregnancy is a serious medical condition requiring ongoing evaluation and treatment to protect the health of the pregnant patient and fetus. The declaration explains that prenatal care exists to identify complications early, often before the patient is aware of them. The standard of care requires visits monthly through 28 weeks, every two weeks from 28 to 36 weeks, and weekly thereafter, with routine physical assessments, laboratory testing, and mental-health screening at each visit. Decl. ¶¶ 9, 11–16, 22. According to the CDC, as many as 85% of pregnancy-related maternal deaths in the United States may be preventable with appropriate prenatal care, and infants whose mothers received no prenatal care are roughly five times more likely to die in their first year. *Id.* ¶ 10. Serious conditions commonly go undetected without active monitoring. An estimated 5–9% of pregnant women develop gestational diabetes, which, unmanaged, raises the risk of preeclampsia, hypertensive disorders, macrosomia, premature birth, and stillbirth. *Id.* ¶¶ 18–20.

Complications can escalate quickly, and delays in care may be dangerous. Many dangerous complications begin with common symptoms: headaches, swelling, bleeding, pelvic pain, decreased fetal movement, or signs of infection. These can become lethal if evaluated too late. *Id.* ¶¶ 27–31. The declaration cites studies finding that inadequate or absent prenatal care nearly doubles the odds of serious newborn complications or death, that delays in accessing obstetric services nearly triple that risk, and that high-quality prenatal care reduces neonatal mortality by roughly 41%. *Id.* ¶ 26. "Timely intervention is often the difference between a manageable complication and a life-threatening emergency." *Id.* ¶ 32.

Detention presents significant structural barriers to the health and safety of pregnant patients and fetuses. The declaration identifies five structural features of detention that endanger pregnant people, each mapped to supporting medical, governmental, and public-health literature:

(1) detained people cannot independently seek emergency care and often depend on non-medical custodial staff to recognize symptoms, followed by multi-step authorization and transport processes that delay evaluation and treatment, *Id.* ¶¶ 33–36;

(2) carceral settings like detention amplify communicable disease, with prevalence several-fold to tenfold higher for pathogens such as hepatitis C and tuberculosis. Pregnancy physiology increases both susceptibility and severity, and certain infections directly harm the fetus, *id.* ¶¶ 38–41;

(3) detention causes and exacerbates mental-health disorders. Studies find depression prevalence as high as 68%, anxiety 54%, and PTSD 42% among detained noncitizens. Perinatal depression, anxiety, and PTSD are associated with preterm birth, low birth weight, and growth restriction, while stress exacerbates hypertension and diabetes, *id.* ¶¶ 23, 42–45;

(4) detention nutrition is often inadequate for fetal development. A 2025 congressional investigation found systemic denial of adequate food and water in ICE facilities, with pregnant women reporting persistent hunger. Deficiencies in nutrients such as folate and iron are associated with neural tube defects and growth restriction, *id.* ¶¶ 46–48; and

(5) physical restraints on pregnant people can be "medically dangerous." Falls already affect roughly 25% of pregnancies, restraints increase fall risk while preventing self-protection, and restraints impair circulation, impede labor, and delay emergency obstetric intervention, *id.* ¶¶ 49–52. The declaration concludes that "placing and holding pregnant patients in detention poses serious medical and mental health risks for both the pregnant patient and the fetus." *Id.* ¶ 55.

B. Using the Declaration in a Deliberate Indifference Claim

Practitioners can consider using the ACOG declaration to support claims premised on deliberate indifference to medical needs in at least four ways.

First, the declaration can support establishment of the objective element in a medical needs claim. Pregnancy, even an uncomplicated pregnancy, is a serious medical condition whose mismanagement creates a substantial risk of serious harm, Decl. ¶¶ 9–17, 53. So the petitioner need not wait for a crisis to establish risk. *See Helling*, 509 U.S. at 33.

Second, the declaration can be used to supply the benchmark against which adequate medical care is measured. ACOG's guidance requires that care for detained people "follow the same guidelines and recommendations" as for everyone else, Decl. ¶ 37. So deviations from that benchmark can be used as evidence of care falling below it: missed care visits (¶ 11), absence of condition-specific nutrition (¶¶ 46–48), unshared laboratory results (¶¶ 13–15), and delayed emergency evaluation (¶¶ 30–32), among others, are relevant.

Third, in subjective-standard circuits, the declaration can be used to argue the obviousness of the risk of withholding prenatal care through quantified, consensus findings of the leading professional body.

Fourth, the declaration can support a structural argument for release as the remedy. The barriers the declaration identifies, including dependence on custodial staff, authorization and transport delays, disease exposure, and restraint practices, among others, are inherent features of detention rather than fixable deficiencies, Decl. ¶¶ 33–36, 54. So practitioners can argue that no conditions-improvement order can cure the violation, and release is the only adequate remedy.

C. Using the Declaration in the *Mathews* Procedural Due Process Analysis

Practitioners can also use the ACOG declaration to strengthen each *Mathews* factor.

On the private interest, it can be used to supplement a general liberty interest with an evidence-supported interest in life and health because continued detention risks irreversible harms like maternal death, stillbirth, and preterm birth that, per the CDC data reported in the declaration, are largely preventable with appropriate care. Decl. ¶¶ 10, 26, 53–55.

On the risk of erroneous deprivation, the declaration gives the court a concrete measure of the risk posed by each week of improper detention. The standard of care escalates week by week in the third trimester, *id.* ¶ 11, complications compound with delay, *id.* ¶¶ 26–32, and the deprivation is therefore not static but accelerating, especially in a facility in which non-medical staff mediate all access to care, *id.* ¶¶ 34–35. This makes delay uniquely dangerous and release correspondingly valuable.

On the government interest, the declaration demonstrates that detaining a pregnant person is medically expensive and administratively burdensome. It requires specialized transports, emergency hospitalizations, and heightened monitoring. So release reduces the government's burdens.

D. Other Uses: Punishment, Irreparable Harm, and the Directive Claims

For an unconstitutional punishment claim, the ACOG declaration gives expert medical evidence supporting arguments that conditions of detention like inadequate nutrition, unreliable water, restraints during transport, and structural barriers to emergency care bear no reasonable relationship to any legitimate purpose and affirmatively endanger the petitioner.

For emergency relief, the declaration supports irreparable-harm findings. It documents that the threatened injuries may be imminent, escalating, and beyond any later remedy, the showing a TRO requires.

And in claims under *Accardi*, the declaration can be used to demonstrate that the Directive is intended to provide a benefit or protect an individual's rights. It can also support an APA claim that a decision to detain in violation of the Directive is arbitrary and capricious because it fails to

consider an important aspect of the problem: the risk to the health and safety of a pregnant individual or her child.

VI. ANTICIPATING THE GOVERNMENT'S DEFENSES

A. Jurisdiction-Stripping Arguments

The government routinely argues that 8 U.S.C. § 1252(a)(5), (b)(9), and (g) strip jurisdiction over claims for release from detention. Practitioners can rebut by arguing that a habeas petition challenging the lawfulness of detention challenges neither a removal order nor the decision to commence proceedings. *See Zadvydas*, 533 U.S. at 687–88; *Demore v. Kim*, 538 U.S. 510, 516–17 (2003); *Jennings v. Rodriguez*, 583 U.S. 281, 294–95 (2018). The bar in § 1252(g) in particular is "cabined to three discrete actions" and does not foreclose an independent constitutional challenge to detention. *Ozturk v. Hyde*, 136 F.4th 382, 396 (2d Cir. 2025) (citation modified); *Marks v. Cicirello*, 2026 WL 1238537 (applying *Ozturk* and staying removal to preserve adjudication of the petition). District courts in every circuit, including the Fifth, have overwhelmingly rejected the government's arguments in the current wave of litigation. *See, e.g.*, *Lopez-Arevelo v. Ripa*, 801 F. Supp. 3d 668, 676–79 (W.D. Tex. 2025).

B. The Entry Fiction

Expect the argument that unadmitted noncitizens detained under § 1225(b)(2)(A) have no due process rights concerning detention under *Shaughnessy v. United States ex rel. Mezei*, 345 U.S. 206 (1953), and *DHS v. Thuraissigiam*, 591 U.S. 103 (2020). Practitioners can respond that noncitizens within the United States are protected by the Fifth Amendment regardless of the lawfulness of their presence and "once an alien enters the country," due process applies. *Zadvydas*, 533 U.S. at 693. The entry fiction concerns the process owed in admission and exclusion decisions, not the constitutionality of confinement.

C. Merits Defenses to the Directive Claims

Beyond the argument that the Directive provides no substantive rights due to its boilerplate disclaimer, addressed in Part IV.B, the government may argue that the Directive addresses only the initial decision to detain, not continued custody. This is refuted by the Directive's text: §§ 4.2, 5.3, 5.4 govern persons already in custody and require weekly re-evaluation.

The government may also argue that "exceptional circumstances" exist under the Directive. Practitioners should hold the government to the Directive's two narrow definitions and to its failure to have made any contemporaneous determination.

The government may also argue that compliance with the Directive occurred. Practitioners should demand the documents that show this, including memorialization of the § 5.1 approval, the weekly § 5.3 re-evaluations, and reporting up to the Director. As discussed above, courts have ordered release where the government failed to demonstrate adherence to the Directive or found

waiver of argument or concession where the government produced nothing or failed to respond at all.

Expect also the argument that the Directive "does not prohibit detention of pregnant aliens" but merely "provides for certain considerations." *M.O.G.R. v. Warden, Stewart Detention Center*, 2025 WL 3460936, at *5 (M.D. Ga. Dec. 2, 2025). First, practitioners can respond that the Directive's operative provisions are mandatory, as indicated through language like "must immediately notify" and approval "must" come from specified officials. The default under the Directive is release absent two narrow, objectively verifiable exceptions. Second, *M.O.G.R.* turned on its facts: the petitioner's intake pregnancy test was negative, so ICE did not know she was pregnant when it detained her, and the record showed accommodations and scheduled obstetric care, underscoring that the knowledge element and a documented record of noncompliance are essential. Third, *M.O.G.R.* involved a final order of removal, the posture addressed next.

D. Timing, Final Orders, and the "Prohibited by Law" Exception

The principal adverse decisions denying release to pregnant petitioners turn on timing. In *Lopera Ramirez v. Harper*, 2026 WL 1067923 (W.D. La. Apr. 20, 2026), the court denied the petition of a pregnant woman because, after she failed to perfect her appeal of the IJ's removal order, the order became final and she entered the 90-day removal period, during which detention is statutorily mandatory. *See* 8 U.S.C. § 1231(a)(2). A footnote in the Directive recognizes individuals "in the 90-day removal period" as a category for whom release is "prohibited by law." *Id.* at *1 n.1; *accord M.O.G.R.*, 2025 WL 3460936, at *5; *Marks*, 2026 WL 1238537, at *5 n.3 (expressing the same doubt in the final-order posture).

Practitioners should first consider distinguishing *Lopera Ramirez* and cases it relies on by arguing that even under mandatory detention provisions, release is not prohibited by law because ICE always has authority to release on humanitarian parole. Second, where a final order or other mandatory detention facts exist, and the medical care facts support it, practitioners can still raise the deliberate-indifference claim, which resulted in release in *Marks*. Third, once § 1231(a)(6) final-order detention extends beyond the 90-day removal period, detention becomes discretionary, so if the "prohibited by law" exception did apply to § 1231(a)(2), it no longer applies past the 90-day mark.

Practitioners may also consider arguing in the alternative that even during the removal period the Directive's care, monitoring, and reporting obligations continue to bind ICE and inform the constitutional analysis.

VII. PRACTICE POINTERS

- *Prepare legal filings before detention.* Practitioners whose clients are known to ICE to be pregnant, postpartum, or nursing and who face check-ins, hearings, or other enforcement touchpoints should consider preparing habeas papers in advance so that relief can be sought immediately upon detention, before the client is transferred out of

the district. In the same regard, practitioners should affirmatively inform ICE if their clients are pregnant, postpartum, or nursing in advance of any known touchpoint or if their clients are currently detained.

- *Document coverage and notice.* Establish, with declarations and medical records, that the petitioner is pregnant, postpartum (birth within one year), or nursing, and that ICE knew. The Directive applies to individuals "known" to be pregnant. Allege every disclosure (at arrest, at intake screening, in medical requests) and every corroborating fact (visible pregnancy, prenatal records in ICE's possession, hospitalizations from custody).
- *Plead specific violations of the Directive's procedures.* Allege each required step, and where facts support it, that they did not occur: § 5.1 approval, § 3.4 exceptional-circumstances determination, § 5.4 immediate notification, § 5.3 weekly re-evaluations, restraint restrictions. Ask the court to order the government to demonstrate compliance on a short timeline and argue that the government's failure to meet such a deadline itself compels the conclusion that the Directive was violated.
- *Build the medical record.* File the ACOG declaration (see Part V) with the petition or a motion for relief. Pair it with records from the facility and outside providers and, where possible, an individualized declaration from an obstetrician or maternal-fetal medicine specialist connecting ACOG's general findings to the petitioner's conditions. Track hospitalizations, missed appointments, unfilled prescriptions, and unreported test results. Document any physical deterioration in custody.
- *Frame emergency relief to preserve the writ.* Where delivery is approaching or complications have emerged, seek a TRO or preliminary injunction on the ground that emergency relief is necessary to make the habeas remedy effective.

VIII. SUPPORTING MATERIALS

Two appendices accompany this advisory.

Appendix A is the ACOG declaration discussed in Part V, which should be filed as an exhibit and cited by paragraph as the model petition illustrates.

Appendix B includes a model petition for a writ of habeas corpus challenging the detention of a pregnant, postpartum, or nursing person, pleading counts under the APA, procedural due process, substantive due process, and the *Accardi* doctrine:

(1) violation of the *Accardi* doctrine for failure to follow Directive 11032.4, enforceable under the APA as agency action not in accordance with law;

(2) violation of the APA because the decision to detain is arbitrary and capricious and not the product of reasoned decision-making in light of the medical evidence;

(3) violation of procedural due process under *Mathews*, with the Directive supplying the process to which the petitioner is entitled; and

(4) violation of substantive due process, encompassing both punitive detention and deliberate indifference to serious medical needs.

Highlighted, bracketed text must be adapted to the facts of the case, and the *Accardi* count's framing must be conformed to the forum. *See* Kennedy Human Rights Center, *Practice Advisory: Using the Accardi Doctrine to Seek Release from Immigration Detention* for a circuit-by-circuit analysis.

For support or coordination on federal litigation strategy, contact:

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APPENDIX A

Declaration of the American College of Obstetricians & Gynecologists

Christina Davidson, MD, FACOG, Chief Medical Officer

DECLARATION OF AMERICAN COLLEGE OF OBSTETRICIANS & GYNECOLOGISTS

I, Dr. Christina Davidson, MD, FACOG, being of lawful age, declare and state as follows:

1. I am the Chief Medical Officer of the American College of Obstetricians & Gynecologists ("ACOG") and am authorized to make this declaration on ACOG's behalf.

2. I am a nationally recognized academic leader and board-certified maternal-fetal medicine specialist. I earned my bachelor's degree from Howard University and my medical degree from the University of Texas Medical School at Houston, where I also completed my fellowship in maternal–fetal medicine after a residency at Christus St. Joseph Hospital in Houston, Texas. I am a tenured professor at Baylor College of Medicine, and I have over twenty five years of clinical experience.

3. I have led national and statewide quality committees, chairing the Texas Perinatal Quality Collaborative Obstetrics Committee and the Society for Maternal–Fetal Medicine Patient Safety and Quality Committee. I have held the positions of Vice Chair of Quality and Patient Safety for the Department of Obstetrics and Gynecology at Baylor College of Medicine and the Chief Quality Officer for Obstetrics and Gynecology at Texas Children's Hospital. I previously served as Texas Children's inaugural System Chief Health Equity Officer, a role in which I advanced strategic initiatives to promote equitable care delivery and improve health outcomes for women and children. I additionally served as the Chief of the Obstetrics and Gynecology Service at Ben Taub Hospital, a safety-net hospital serving a diverse patient population in the Texas Medical Center. I currently oversee ACOG's clinical guidance development, quality improvement, and clinical practice activities.

4. In my role as Chief Medical Officer, I am familiar with ACOG's mission, its clinical guidance and educational materials, and the processes by which ACOG develops, reviews, publishes, and maintains materials addressing prenatal care, pregnancy complications, obstetric emergencies and the potential impact of detention conditions during pregnancy.

5. ACOG is the United States's leading group of clinicians providing evidence-based obstetric and gynecologic care. As a private, voluntary nonprofit membership organization of more than 60,000 members, ACOG advocates for equitable, exceptional, and respectful care for all women and people in need of obstetric and gynecologic care; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing patients and their families and communities.

6. ACOG's briefs and practice guidelines have been cited by numerous courts as an authoritative voice of science and medicine relating to obstetric and gynecologic health care.[1]

7. The opinions expressed in this declaration are based on ACOG's corporate knowledge, published clinical guidance and practice advisories.

8. ACOG has agreed to provide this declaration on a *pro bono* basis. ACOG is independent of the parties, counsel, and this Court, and it has no personal interest in the outcome of these proceedings.

Statement of Facts

I. Pregnancy Is a Significant Medical Condition Requiring Prenatal Care

[1] *See Stenberg v. Carhart*, 530 U.S. 914 (2000); *Whole Woman's Health v. Hellerstedt*, 579 U.S. 582 (2016); *June Medical Services v. Russo*, 591 U.S. _ (2020); *Texas Health Presbyterian Hospital of Denton v. D.A.*, 569 S.W.3d 126 (Tex. 2018); *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000).

9. Prenatal care is one of the most common preventive services in the United States, designed to improve the health and well-being of pregnant individuals and fetuses through evidence-based services, including screening, medical care, anticipatory guidance, and support.[2] Pregnancy, labor and childbirth carry evolving, sometimes rapid-onset risks to both the pregnant patient and the fetus.[3] One purpose of prenatal care is to identify pregnancy complications early—often before a patient is aware of them—so they can be treated before worsening, potentially affecting the patient and fetus' long-term health, or becoming life threatening.[4]

10. According to the U.S. Centers for Disease Control (CDC), a substantial majority—as high as 85%—of pregnancy-related maternal deaths in the United States may be preventable with appropriate prenatal care.[5] Further, infants whose mothers received no prenatal care are an estimated 5 times more likely to die in their first year of life.[6]

A. Routine Prenatal Care Is Essential to Avoid Complications and Prevent Infection, Disease and Other Adverse Outcomes

11. The traditional approach to the provision of prenatal care for a pregnant patient exhibiting no complications is to be seen monthly until 28 weeks of pregnancy, bi-weekly between 28 and 36 weeks of pregnancy, and weekly thereafter.[7] However, obstetrician–gynecologists and other maternity care professionals may tailor the visit frequency and monitoring schedule as determined by the medical and social needs of the pregnant individual.[8]

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[2] Am. Acad. of Pediatrics & Am. Coll. of Obstet. & Gyn. ("ACOG"), *Guidelines for Perinatal Care* (8th ed. 2017).
[3] *See* Nat'l Acads. of Scis., Eng'g & Med. ("NASEM"), *Birth Settings in America: Outcomes, Quality, Access, and Choice* (2020), www.nationalacademies.org/read/25636.
[4] *See* AAP & ACOG, *Perinatal Care* at 8.
[5] *See* Ctrs. for Disease Ctrl. & Prev. ("CDC"), *Pregnancy-Related Deaths* (2022), www.cdc.gov/maternal-mortality/php/data-research/mmrc/index.html.
[6] *See* Danielle Ely *et al.*, *Infant Mortality by Selected Maternal Characteristics and Race and Hispanic Origin in the United States, 2019*–2021, 74 Nat. Vital Stat. Rep. 3 (March 2024), www.cdc.gov/nchs/data/nvsr/nvsr73/nvsr73-03.pdf.
[7] *See Perinatal Care* at 150.
[8] *See* ACOG Clin. Consen. No. 8, *Tailored Prenatal Care Delivery for Pregnant Individuals* (May 2025), https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2025/04/tailored-prenatal-care-delivery-for-pregnant-individuals.

12. At these routine visits, a clinician typically monitors the health of the pregnant patient and fetus through various measures, including physical assessments to monitor weight, blood pressure, maternal and fetal heart rate, among other health indicators. Providers also perform routine medical exams to assess and prevent potential complications like vaginal bleeding and infection.[9]

13. Clinicians also collect blood and urine samples to monitor the pregnant patient and fetus through laboratory testing. For example, early in pregnancy, tests are performed to assess for infections like HIV and other sexually transmitted infections (STI). If left untreated, STIs can lead to pelvic inflammatory disease, increasing the risk of ectopic pregnancy and infertility, and are associated with adverse pregnancy outcomes including preterm birth, maternal morbidity, and neonatal complications.

14. Early identification of elevated risks allows for closer monitoring, informed decision-making, and, when appropriate, timely medical intervention.[10]

15. Therefore, when these routine tests and assessments are not performed—or are performed late—serious, but treatable conditions can go undetected until they become dangerous to the pregnant patient and/or the fetus.

16. As pregnancy progresses, frequent monitoring through physical and medical assessments and laboratory testing is essential to monitor maternal and fetal health, fetal growth, and to evaluate ongoing risk for conditions like gestational diabetes, among others.[11] Even in an

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[9] *See Perinatal Care* at 150.

[10] *See* CDC, *Screening for Birth Defects* (Nov. 27, 2023), www.cdc.gov/birth-defects/diagnosis/screening-for-birth-defects.html; *see also* Laura M. Carlson & Neeta L. Vora, *Prenatal Diagnosis*, 44 Obst. & Gyn. Clinics N. Am. 245 (2017), https://doi.org/10.1016/j.ogc.2017.02.0.

[11] *See* ACOG Comm. Op. No. 797, *Prevention of Group B Streptococcal Early-Onset Disease in Newborns* (Feb. 2020), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/prevention-of-group-b-streptococcal-early-onset-disease-in-newborns, and ACOG Practice Bulletin No. 201, *Pregestational Diabetes Mellitus* (Dec. 2018), Obstet. & Gyn. 132(6):p e228-e248 (Dec. 2018), doi: 10.1097/AOG.0000000000002960.

uncomplicated pregnancy, a pregnant patient experiences a wide range of physiological challenges, such as a substantial rise in blood volume, digestive difficulties, increased production of clotting factors, significant weight gain, and changes to breathing.[12] These and other changes put pregnant patients at greater risk of complications like blood clots, nausea, hypertensive disorders, and anemia, among others.[13]

17. Pregnancy can also exacerbate pre-existing health conditions—including diabetes, kidney disease, hypertension and other cardiac diseases, asthma, autoimmune disorders, and pulmonary diseases—and contribute to new conditions such as hyperemesis gravidarum (excessive nausea and vomiting), preeclampsia, deep vein thrombosis, and gestational diabetes. Many women seek emergency care at least once during a pregnancy.[14]

B. Active Monitoring is Essential to Avoid Common Pregnancy Conditions

18. Medical and public health literature demonstrates that many serious chronic conditions like diabetes and hypertension remain undetected without active monitoring.[15] For example, recent estimates from the CDC suggest that 25% of all adult women living with diabetes in the U.S. go undiagnosed.[16] Pregnancy further increases the risk of developing diabetes. An estimated 5-9% of pregnant women in the U.S. will develop new onset diabetes, or gestational

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[12] *See* John M. Kepley *et al.*, *Maternal Changes*, S.S. Physiology (2023), www.ncbi.nlm.nih.gov/books/NBK539766/; *see also* Maged Costantine, *Physiologic and pharmacokinetic changes in pregnancy*, 5 Pharmacol. 65 (2014), doi: 10.3389/fphar.2014.00065.

[13] *See* CDC, *Pregnancy Complications* (Feb. 6, 2025), www.cdc.gov/maternal-infant-health/pregnancy-complications/index.html.

[14] *See, e.g.,* Shayna D. Cunningham *et al.*, *Association Between Maternal Comorbidities and Emergency Department Use Among a National Sample of Commercially Insured Pregnant W*omen, 24 Acad. Emerg. Med. 940 (2017), https://onlinelibrary.wiley.com/doi/10.1111/acem.13215; Agency for Healthcare Research & Quality, *Healthcare Cost and Utilization Project, Emergency Department and Inpatient Utilization and Cost for Pregnant Women: Variation by Expected Primary Payer and State of Residence*, 2019, at 30 tbl. D.1 (Dec. 14, 2021), https://hcup-us.ahrq.gov/reports/ataglance/HCUPanalysisHospUtilPregnancy.pdf.

[15] *See* CDC, *Trends in Multiple Chronic Conditions Among US Adults, by Age, Sex, and Race and Ethnicity, 2013–2023*, 22 Preventing Chronic Disease E80 (Apr. 10, 2025), www.cdc.gov/pcd/issues/2025/24_0539.htm.

[16] Jane Gwira *et al.*, *Prevalence of Total, Diagnosed, and Undiagnosed Diabetes in Adults*, NCHS Data Brief No. 516 (Nov. 2024), www.cdc.gov/nchs/products/databriefs/db516.htm.

diabetes, during their pregnancy.[17] Regardless of its onset, diabetes during pregnancy poses significant risks to both the pregnant person and the fetus.

19. If not properly managed, diabetes increases the risk of serious maternal complications, including preeclampsia, hypertensive disorders, and progression to long-term cardiovascular disease,[18] all of which can develop quickly and without warning signs.[19]

20. For the fetus and neonate, maternal diabetes is associated with higher rates of congenital abnormalities, excessive fetal growth (macrosomia), premature birth, low birth weight and stillbirth. It can also lead to complications immediately after delivery, such as respiratory distress, low blood sugar requiring intensive care and chronic health issues. [20]

21. Similarly, prenatal care is essential to assess any vaginal bleeding, which can occur during any stage of pregnancy, ranging from light spotting to heavier bleeding.[21] Bleeding during early pregnancy is common, and may signal the implantation of an embryo in the lining of the uterus.[22] However, problems that can cause bleeding during early pregnancy also include infection, early pregnancy loss, and ectopic pregnancy.[23] Bleeding in mid and late pregnancy may also signal

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[17] *See* CDC, *Gestational Diabetes*, www.cdc.gov/diabetes/about/gestational-diabetes.html.
[18] *See*, ACOG Practice Bulletin No. 222, *Gestational Hypertension and Preeclampsia*, Obstet. & Gyn., 135(6):p e237-e260 Jun. 2020), doi: 10.1097/AOG.0000000000003891.
[19] *See* Lisa Leffert *et al.*, *Hypertensive disorders and pregnancy-related stroke: frequency, trends, risk factors, and outcomes*, Obstet. & Gyn. 125(1), 124–131. doi.org/10.1097/AOG.0000000000000590; Nicole Ford, *et al. Hypertensive Disorders in Pregnancy and Mortality at Delivery Hospitalization - United States, 2017–2019*, CDC Morb. Mortal. Wkly. Rep. 2022;71:585–591, doi: http://dx.doi.org/10.15585/mmwr.mm7117a1; Xuming Dai and Joseph A. Diamond, *Intracerebral hemorrhage: a life-threatening complication of hypertension during pregnancy*, J Clin. Hypertens., 2007; 9(11):897-900, doi:10.1111/j.1524-6175.2007.06613; *see also* Sarah Partridge *et al.*, *Inadequate prenatal care utilization and risks of infant mortality and poor birth outcome: a retrospective analysis of 28,729,765 U.S. deliveries over 8 years*, 10 Am. J. Perinatol. (Nov. 2012) at 787-93, doi: 10.1055/s-0032-1316439 (finding that inadequate prenatal care (fewer than the recommended number of visits) carries an adjusted odds rate (OR) of approximately 3.75 for premature birth (< 37 weeks) in a population-based study of nearly 29 million U.S. deliveries and that, using World Health Organization (WHO) criteria, (<5 visits), inadequate care was associated with an adjusted OR of 6.21 for preterm birth).
[20] *See* CDC, *Gestational Diabetes*; ACOG Practice Bulletin No. 222, *Gestational Hypertension.*
[21] Cleveland Clinic, *Bleeding During Pregnancy* (2024), my.clevelandclinic.org/health/symptoms/22044-bleeding-during-pregnancy.
[22] Univ. of Pitts, Med. Ctr., *Bleeding During Pregnancy*, www.upmc.com/conditions/p/pregnancy-bleeding.
[23] *Id.*

a maternal or fetal health issue, such as cervical cancer, placental abruption, placenta previa, premature rupture of membranes, intrauterine growth restriction, or low birth weight, any of which could result in hospital admission.[24] Pregnant patients are thereby encouraged to promptly contact their provider if they experience vaginal bleeding at any time during pregnancy. It is equally essential that providers be readily available to provide timely assessment and treatment to prevent serious complications.[25]

22. Finally, routine visits provide an opportunity for patients to raise questions about their pregnancy and to report any concerns, and for clinicians to screen for common mental health conditions, like anxiety and depression, which may first present during pregnancy.[26]

23. Pregnancy has been shown to induce, or exacerbate existing, mental-health conditions.[27] This is particularly true for patients with a history of abuse or trauma, who are more likely to suffer from emotional dysregulation and perinatal depression.[28] Stress and fear of deportation have also been shown to result in heightened anxiety and depression that can exacerbate preexisting conditions such as high blood pressure, diabetes, and high body fat.[29]

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[24] Arezoo Karimi *et al.*, *Vaginal bleeding in pregnancy and adverse clinical outcomes,* Obstet. & Gyn. 44(1), doi.org/10.1080/01443615.2023.2288224; *see also* Ichchha Madan *et al.*, *The frequency and clinical significance of intra-amniotic infection and/or inflammation in women with placenta previa and vaginal bleeding*, J. Perinat. Med. 38 (3), 275–279 (2010).
[25] *See* Cleveland Clinic, *Bleeding During Pregnancy*; Univ. Pitts. Med. Ctr., *Bleeding During Pregnancy*.
[26] *Perinatal Care* at 153.
[27] *See, e.g.*, Kimberly A. Yonkers *et al.*, *Diagnosis, Pathophysiology, and Management of Mood Disorders in Pregnant and Postpartum Women*, Obstet. & Gyn.117:961, 963 (Apr. 2011), doi: 10.1097/AOG.0b013e31821187a7; F. Carol Bruce *et al.*, *Maternal Morbidity Rates in a Managed Care Population*, Obstet. & Gyn. 111(5):1089-95 (May 2008), doi: 10.1097/AOG.0b013e31816c441a.
[28] *See, e.g.*, M. Rocha *et al.*, *Trauma and Posttraumatic Stress Disorder as Important Risk Factors for Gestational Metabolic Dysfunction*, Am. J. Perinatol. 6;41(14):1895–1907 (Mar. 2024), doi: 10.1055/a-2260-5051.
[29] ACOG Comm. Stat. No. 25: *Advocating for Safe and Equitable Obstetric and Gynecologic Care for Immigrants*, Obstet. & Gyn. 147(4):p 598-607 (Apr. 2026), doi: 10.1097/AOG.000000000y0006213 *citing* Das S., *Immigration policy is health policy*, Index. Assn. for Pop. Health Science, https://iaphs.org/immigration-policy-is-health-policy-confronting-the-health-costs-of-anti-immigrant-rhetoric/.

24. For all of these reasons, prenatal care in the form of screenings, tests and risk assessment must be readily available to ensure the health and wellbeing of the pregnant person, fetus and infant.[30]

C. High Risk Pregnancies and Medical Emergencies Require Immediate and/or Specialized Care

25. In addition to the routine testing, screening and medical assessments described above, pregnant patients with high-risk pregnancies, or who experience a medical emergency during pregnancy, may require access to immediate or emergency care and/or access to specialized care. The "ability to access higher-level care without delay is critical for the safety of the woman, fetus, and newborn."[31]

26. Delayed or absent evaluation of pregnancy symptoms can allow otherwise treatable complications to progress into life-threatening emergencies for both the pregnant patient and fetus. A 2020 study found that inadequate or absent prenatal care nearly doubled the odds of serious newborn complications or death (odds ratio 1.9), and delays in accessing obstetric services increased this risk almost threefold (odds ratio 2.8).[32] A 2025 review estimated that high-quality prenatal care reduces neonatal mortality by about 41%, illustrating the protective effect of timely care.[33]

27. Many dangerous complications begin with common symptoms that become lethal if ignored or evaluated too late. Severe headaches, visual changes, and new swelling can signal preeclampsia, which can progress to seizures, stroke, organ failure, or placental abruption if not

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[30] *See* NASEM, *Birth Settings* at 87.
[31] *Id.* at 86.
[32] Ocilia Carvalho *et al.*, *Delays in Obstetric Care Increase the Risk of Neonatal Near-Miss Morbidity Events and Death*, 20 BMC Preg. & Childbirth 1, 437 (2020), doi: 10.1186/s12884-020-03128-y.
[33] Mohammed Albarqi, *The Impact of Prenatal Care on the Prevention of Neonatal Outcomes,*13 Healthcare No. 9 at 1076 (2025), doi:10.3390/healthcare13091076.

treated.[34] Heavy bleeding or severe abdominal pain may indicate ectopic pregnancy, abruption, or placenta previa, all of which can lead to catastrophic hemorrhage if care is delayed.[35]

28. Decreased fetal movement, preterm contractions or fluid leakage, and signs of infection (fever, foul discharge, painful urination) are strongly associated with stillbirth, preterm birth, sepsis, and neonatal intensive care when not promptly addressed.[36]

29. Cardiopulmonary symptoms (shortness of breath, chest pain, syncope) and untreated perinatal mood symptoms also contribute significantly to preventable maternal deaths through cardiomyopathy, embolism, and other conditions.[37] In these circumstances, any pregnancy, even for a patient without pre-existing conditions or indicators of risk, can suddenly become life-threatening when complications arise. Therefore, it is imperative for pregnant patients to be able to reach a hospital with obstetric and gynecological services quickly.

30. Certain symptoms during pregnancy require immediate medical evaluation, often on an emergency basis. These symptoms include, but are not limited to, vaginal bleeding; severe abdominal or pelvic pain; persistent headaches, vision changes, or swelling (possible signs of preeclampsia); decreased or absent fetal movement; fever or other signs of infection; and sudden dizziness, weakness, or fainting.[38]

31. These symptoms can indicate serious conditions like hemorrhage, placental abruption, preeclampsia, or infection. If left untreated, these conditions can worsen rapidly and lead to permanent injury or death of the mother and/or a fetus or neonate.[39]

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[34] *See* CDC, *Pregnancy Complications*; Creswell, *Global and regional causes*.
[35] *See* HHS, *Pregnancy complications*, www.womenshealth.gov/pregnancy/youre-pregnant-now-what/pregnancy-complications; CDC, *Pregnancy Complications*; Cleveland Clinic, *Pregnancy Complications*.
[36] *See id.*
[37] *See id.*
[38] CDC, *Urgent Maternal Warning Signs and Symptoms*, HEAR HER Campaign (Feb. 17, 2026), www.cdc.gov/hearher/maternal-warning-signs/index.html. *See also* World Health Org., *Counselling for Maternal and Newborn Health Care* (2013) at 8, www.ncbi.nlm.nih.gov/books/NBK304178/.
[39] CDC, *Urgent Maternal Warning Signs.*

32. When a patient presents with any of these symptoms, the situation should be treated as urgent and the clinician should arrange for immediate evaluation, often in a hospital setting. Timely intervention is often the difference between a manageable complication and a life-threatening emergency.[40]

II. Detention Conditions Have Been Shown to Pose Significant Health Risks for Pregnant Patients and Fetuses

A. Detention Settings Often Lack Access to Immediate and Specialized Care

33. Pregnancy in custody or detention is medically recognized as high risk because pregnant people in detention often have preexisting medical or mental health conditions and remain dependent on institutional systems for access to prenatal care, emergency evaluation, nutrition, and transport, all of which can heighten the risk of adverse outcomes when care is delayed or inconsistent.[41]

34. Detained and incarcerated people cannot independently present to an emergency department; they are wholly dependent on correctional staff—many of whom have no medical training—to recognize symptoms or timely respond to the patient's self-reported symptoms.

35. Further, even after symptoms are reported or observed, facility staff must go through a series of steps to authorize, transport, and facilitate timely obstetric evaluation, all of which compromise a pregnant person's ability to obtain prompt evaluation and treatment. [42]

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[40] *Id.*

[41] ACOG, Comm. Op. No. 830, *Incarcerated Pregnant Indiv.*; *see also* NCCHC, Position Statement, *Nonuse of Restraints for Pregnant and Postpartum Incarcerated Individuals* (Feb. 14, 2022), ncchc.org/position-statements/nonuse-of-restraints-for-pregnant-and-postpartum-incarcerated-individuals-2025; NCCHC, *Pregnancy and Postpartum* Care; U.S. Dep't of Justice, *Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional Custody* (Mar. 2014), www.ojp.gov/library/publications/best-practices-use-restraints-pregnant-women-and-girls-under-correctional; U.S. Gov't Account. Off., GAO-20-330, *Immigration Detention: Care of Pregnant Women in DHS Facilities* (2020), www.gao.gov/assets/gao-20-330.pdf.

[42] *See* ACOG, Comm. Op. No. 830, *Incarc. Pregnant Indiv.*; *see also* Nat'l Comm'n on Corr. Health Care ("NCCHC"), *Pregnancy and Postpartum Care in Correctional Settings* (2018), https://www.ncchc.org/wp-content/uploads/Pregnancy-and-Postpartum-Care-2018.pdf; U.S. Gov't Accountability Off., GAO-20-330, *Immigration Detention*; Physicians for Human Rights ("PHR"), *Health Harms Experienced by Pregnant Women in*

36. Medical, scientific and government sources underscore that systems and facilities that impede prompt symptom reporting, evaluation by qualified clinicians, and immediate treatment, such as prisons and ICE detention facilities, can endanger both the pregnant patient and the fetus by increasing the risk of preventable complications.[43]

37. Reproductive health care for incarcerated or detained individuals should follow the same guidelines and recommendations as for those who are not incarcerated, in order to ensure respectful, consistent, high-quality care throughout reproductive health, pregnancy, and the postpartum period, and to affirm these individuals' dignity.[44]

B. Detention Settings Increase the Risk of Communicable Diseases

38. Public health authorities and peer-reviewed research consistently find that communicable diseases including HIV, hepatitis B and C, MRSA, as well as respiratory pathogens occur at substantially higher rates in carceral settings than in the general population.[45]

39. These facilities function as "amplifiers" of disease transmission due to overcrowding, close contact, and other environmental conditions, with documented increases ranging from several-fold higher prevalence (*e.g.*, HIV, hepatis B and MRSA) to roughly tenfold increases (*e.g.*, hepatitis C and tuberculosis) [46] and rapid outbreaks across multiple pathogens.[47]

U.S. Immigration Detention, (Nov. 2019), phr.org/wp-content/uploads/2019/12/PHR-Pregnant-Women-in-Immigration-Custody-Fact-Sheet-Nov-2019.pdf.

[43] ACOG, Comm. Op. 830, *Incarc. Pregnant Indiv.*; *see also* NCCHC, *Pregnancy and Postpartum.*

[44] *See* ACOG, Comm. Op. No. 830, *Incarc. Pregnant Indiv.*

[45] Newton E. Kendig *et al.*, *Infection Prevention and Control in Correctional Settings*, 30 Emerging Infectious Diseases no. 13, 88, 88–93 (2024), https://doi.org/10.3201/eid3013.230705; CDC, *At-a-Glance: CDC Recommendations for Correctional and Detention Settings Testing, Vaccination, and Treatment for HIV, Viral Hepatitis, TB, and STIs* (Aug. 10, 2022), https://stacks.cdc.gov/view/cdc/120256; Maeve McNamara *et al*, *Advancing Hepatitis C Elimination through Opt-Out Universal Screening and Treatment in Carceral Settings*, Emerg. Infect. Dis. 2024;30(13):80-87, doi.org/10.3201/eid3013.230859.

[46] Kendig, *Infection Prevention* at 88–93.

[47] *See id.*

40. Pregnancy also alters cardiovascular, respiratory, and immune physiology in ways that can increase both susceptibility to certain communicable diseases and the severity of maternal illness, particularly in the third trimester.[48] Government public-health agencies note that infections such as influenza, varicella, hepatitis E, COVID-19, and some food- and vector-borne pathogens are associated with higher rates of hospitalization, cardiopulmonary complications, and, in some cases, maternal mortality for pregnant, as compared to nonpregnant, adults.[49] These heightened risks reflect a combination of factors including: reduced immunity, increased oxygen demand, and reduced lung capacity. Together, these factors can worsen outcomes when viral pneumonias or systemic infections occur.[50]

41. Communicable diseases can also directly or indirectly harm the fetus through vertical transmission across the placenta, exposure during delivery, or secondary effects of severe maternal illness.[51] U.S. and international health authorities identify several pathogens—such as toxoplasmosis, Zika virus, parvovirus B19, HIV, varicella, and rubella—that have been linked to pregnancy loss, fetal anemia, structural brain and eye anomalies, hearing and vision impairment, growth restriction, and long-term neurodevelopmental disabilities.[52]

C. Detention Settings Increase the Risk of Mental Health Disorders that Impact Maternal and Fetal Health

[48] *See* Andrew Mockridge and Kirsty Maclennan, *Physiology of Pregnancy*, 23 Physiology 347 (2022), https://doi.org/10.1016/j.mpaic.2022.02.027; *see also* Elisabeth Sappenfield *et al.*, *Pregnancy and Susceptibility to Infectious Diseases*, Infectious Diseases in Obstet. and Gyn. 752852 (2013), https://doi.org/10.1155/2013/752852; Manoj Kumar *et al.*, *Infections and Pregnancy: Effects on Maternal and Child Health*, Front. Cell. Infect. Microbiol., 12:873253 (Jun. 7, 2022), https://doi.org/10.3389/fcimb.2022.873253.
[49] *See* CDC, *About Infectious Agents*; Denise Jamieson *et al.*, *Emerging infections and pregnancy,* Emerg Infect Dis. 2006 Nov;12(11):1638-43. doi: 10.3201/eid1211.060152.
[50] *See* Elisabeth Sappenfield, *et al.*, *Pregnancy and susceptibility to infectious diseases*, Infect. Dis. Obstet. Gynecol. 2013:752852, doi: 10.1155/2013/752852.
[51] *See id.*; *see also* Kumar, *Infections and Pregnancy.*
[52] *See* CDC, *About Infectious Agents*; Jamieson, *Emerging infections.*

42. Medical literature consistently shows that individuals in ICE detention experience disproportionately high rates of mental health disorders, with prevalences as high as 68% for depression, 54% for anxiety and 42% for post-traumatic stress disorder (PTSD).[53] Many factors contribute to these extremely high rates, including that many individuals enter detention with significant pre-existing traumas, such as past sexual abuse, violence, persecution, exploitation, and family separation.[54]

43. Detention settings have also been shown to contribute to the development of new mental health disorders and exacerbate existing disorders due to a combination of factors including exposure to chronic stress, loss of autonomy, social isolation, inadequate access to mental health care services and exposure to new or continuing trauma. For example, there are numerous, consistent reports of physical and emotional abuse and sexual assault in ICE detention, all of which may contribute to psychological harms.[55]

44. Mental health disorders during pregnancy, particularly conditions such as depression, anxiety, and PTSD, pose significant risks to both maternal and fetal health and are associated with adverse outcomes including preterm birth, low birth weight, intrauterine growth restriction and developmental delays in children.[56]

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[53] Irina Verhülsdonk *et al.*, *Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-Analysis*, 7 BJPsych Open e204 (2021); *see also* Altaf Saadi *et al.*, *Duration in Immigration Detention and Health Harms*, 8 JAMA Network Open e2456164 (2025); Brooke McCormick, *Prolonged Immigration Detention Tied to Poor Health, PTSD, and Mental Illness*, Am. J. Managed Care (Jan. 28, 2025), https://www.ajmc.com/view/prolonged-immigration-detention-tied-to-poor-health-ptsd-and-mental-illness; Omid Dadras & Mohammad Sediq Hazratzai*, The Silent Trauma: U.S. Immigration Policies and Mental Health*, Lancet Reg'l Health Ams. 101048 (2025).

[54] *See id. See also* Myriam Vidal Valero, *Mental Health Impacts of Immigration Enforcement*, Am. Psych. Ass'n (2025), https://www.apa.org; Zachary Steel *et al., Impact of Immigration Detention on Mental Health*, 188 Br. J. Psychiatry 58 (2006).

[55] Nicole Lue *et al.*, *Trends in Sexual Assault Against Detainees in U.S. Immigration Detention Centers*, 329 JAMA 338, 338–39 (Jan. 24, 2023), doi: 10.1001/jama.2022.22938; PBS News, *Hundreds of immigrants have reported sexual abuse at ICE facilities* (Jul. 21, 2023), https://www.pbs.org/newshour/nation/hundreds-of-immigrants-have-reported-sexual-abuse-at-ice-facilities-most-cases-arent-investigated.

[56] *See* Nancy K. Grote *et al.*, *A Meta-analysis of Depression During Pregnancy and the Risk of Preterm Birth, Low Birth Weight, and Intrauterine Growth Restriction*, Arch. Gen. Psychiatry. 2010 Oct; 67(10):1012-24. doi:

45. Further, exposure to trauma and other psychological stressors elevates cortisol levels and can disrupt maternal-placental endocrine and immune regulation, which can increase the risk of preeclampsia and alter fetal brain development and stress response systems, with potential lifelong consequences.[57]

D. Detention Settings Lack Adequate Nutrition That is Essential for Fetal Development

46. It is well established in medical literature that maternal nutrition is a critical determinant of healthy fetal growth and organ development and that undernutrition and poor diet quality can impair fetal growth and increase the risk of long-term disease in the child.[58]

47. Medical literature further describes how specific micronutrients (*e.g.*, folate, iron, and fatty acids, among others) support brain development, red blood cell production, and placental function, and that deficiencies in these nutrients are associated with neural tube defects, growth restriction, and impaired neurodevelopment.[59] Access to nutrient-dense diet during pregnancy, together with prenatal supplementation, promotes maternal health and fetal development.[60]

10.1001/archgenpsychiatry.2010.111; Falk A.C. Voit *et al.*, *Maternal Mental Health and Adverse Birth Outcomes*, 17 PLoS One. 2022 Aug 31;17(8):e0272210. doi:10.1371/journal.pone.0272210; Sophie Grigoriadis *et al.*, *Maternal Anxiety During Pregnancy and the Association with Adverse Perinatal Outcomes*, 79 J. Clin. Psychiatry 2018 Sep 4;79(5):17r12011. doi: 10.4088/JCP.17r12011.

[57] *See* Claire S. Traylor *et al.*, *Effects of Psychological Stress on Adverse Pregnancy Outcomes*, 2 Am. J. Obstetrics & Gynecology MFM 100229 (2020); Divya Tadanki *et al.*, *Comprehensive Review of the Impact of Maternal Stress on Fetal Development*, 3 Pediatric Discovery e70004 (2025); Mary E. Coussons-Read, *Effects of Prenatal Stress on Pregnancy and Human Development: Mechanisms and Pathways*, 6 Obstetrics Med. 52 (2013).

[58] *See* Michelle Kominiarek & Rajan Priya, *Nutrition Recommendations in Pregnancy and Lactation*, 100 Med. Clinics N. Am. 1199, 1199–1215 (2016), https://doi.org/10.1016/j.mcna.2016.06.004. *See also* Janna Morrison *et al.*, *Nutrition in Pregnancy*, 8 Nutrients 342 (2016), https://doi.org/10.3390/nu8060342; Aikaterini Apostolopoulou *et al.*, *Effects of Nutrition on Maternal Health, Fetal Development, and Perinatal Outcomes*, 16 Nutrients 375 (2024), https://doi.org/10.3390/nu16030375.

[59] *See* Elizabeth Prado & Kathryn Dewey, *Nutrition and brain development in early life*, 72 Nutrition Reviews 4 (Apr. 2014) at 267–284, doi.org/10.1111/nure.12102; Janna Morrison and Timothy Regnault, *Nutrition in Pregnancy*, 8 Nutrients 6 at 342 (Jun. 2016), doi:10.3390/nu8060342.

[60] Nicole Marshall *et al.*, *The importance of nutrition in pregnancy and lactation*, 226 Am. J. Obstet. & Gyn. 5 at 607-632 (May 2022), https://www.ajog.org/article/S0002-9378(21)02728-9/fulltext; *see also* Nat'l Inst. Health, *Dietary supplements and life stages* (May 2026), ods.od.nih.gov/factsheets/Pregnancy-HealthProfessional.

48. A 2025 congressional investigation of ICE detention facilities in more than 20 states found systemic denial of adequate food and water in ICE detention facilities, insufficient and contaminated meals, unreliable access to potable water, and resulting malnutrition and dehydration. In particular, pregnant women in ICE detention reported insufficient, or nutritionally inadequate, food and persistent hunger.[61]

E. Physical Restraints Place the Pregnant Patient at Risk

49. "Despite the extremely reduced risk of assault and escape among incarcerated pregnant people due to their physical condition, especially while in labor, they continue to be shackled during pregnancy, childbirth and postpartum period."[62]

50. The use of restraints such as shackles, waist chains, or leg irons during pregnancy and the postpartum period has been "identified as medically dangerous" and "against national and international standards of care."[63] In 2010, the American Medical Association adopted a resolution and drafted model legislation prohibiting the use of restraints for pregnant women in their second and third trimesters, during labor and delivery and postpartum "absent compelling grounds to

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[61] *See* Sen. Jon Ossoff, *Medical Neglect & Denial of Adequate Food or Water in U.S. Immigration Detention* (Oct. 2025), https://www.ossoff.senate.gov/wp-content/uploads/2025/10/25.10.24_Sen.-Ossoff-Medical-Neglect-Denial-of-Adequate-Food-or-Water-in-U.S.-Immigration-Detention.pdf.

[62] Camille Kramer *et al.*, *Shackling and pregnancy care policies in US prisons and jails*, Matern. Child Health J. (Jan. 27, 2003) (1):186-196. doi: 10.1007/s10995-022-03526-y; *see also* Caroline Kitchener, *et al.*, N.Y. Times, *Pregnant in ICE Detention: Handcuffs and Pleas for Medical Care* (Mar. 20, 2026), https://www.nytimes.com/2026/03/20/us/politics/pregnant-women-ice-detention.html; Pedro Camacho, Latin Times, (Pregnant women describe 'appalling' treatment in ICE custody, including shackling during miscarriages) (May 12, 2026), https://www.msn.com/en-us/news/us/pregnant-women-describe-appalling-treatment-in-ice-custody-including-shackling-during-miscarriages/ar-AA22ZXAH; Sarah Vogel, Solitary Watch, *Pregnant Women in ICE Detention Face Isolation, Shackling, and Medical Neglect* (Oct. 29, 2025), https://solitarywatch.org/2025/10/29/pregnant-women-in-ice-detention-face-isolation-shackling-and-medical-neglectand-other-news-on-solitary-confinement-this-week/.

[63] *Id.*

believe that she poses a threat of harm to herself or others or poses a substantial escape risk and cannot be reasonably contained by other means."[64]

51. Medical and correctional health literature shows that the use of physical restraints increases the risk of falls and, at the same time, impedes a patient's ability to protect themself during a fall.[65] Falls are already one of the most common forms of injury for pregnant women, "affecting 25% of pregnant women, often result[ing] from increased body weight and shifts in weight distribution and balance."[66] Studies show that falls are the second leading cause of injury during pregnancy and account for one-fifth to one-third of all trauma cases in pregnancy leading to medical care or hospitalization.[67]

52. Restraints can also impair circulation, impede labor progress, hinder clinicians' ability to perform necessary examinations or procedures, and cause delays in emergency obstetric interventions.[68] Professional standards therefore recommend that restraints not be used during labor and delivery and otherwise be avoided during pregnancy except in narrowly defined, serious security circumstances.[69]

Conclusion

53. In summary, pregnancy is a significant medical condition that requires consistent, accessible, and timely prenatal care to identify and manage risks inherent to both the pregnant

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[64] AMA, *An Act to prohibit the shackling of pregnant prisoners* ¸www.ama-assn.org (2010); *see also* Staff, *AMA Passes Resolution Prohibiting Shackling of Pregnant Prisoners in Labor*, Prison Leg. News (Dec. 15, 2010), www.prisonlegalnews.org/news/2010/dec/15.
[65] *See id.*; *see also* Equal Justice Init., *Shackling of Pregnant Women in Jails and Prisons Continues* (Jan. 28, 2020), eji.org/news/shackling-of-pregnant-women-in-jails-and-prisons-continues; U.S. Dep't of Justice, *Best Practices in the Use of Restraints with Pregnant Women and Girls Under Correctional* Custody (Apr. 2014), www.ojp.gov/library/publications/best-practices-use-restraints-pregnant-women-and-girls-under-correctional; U.S. Gov't Account. Off., GAO-20-330, *Immigration Detention.*
[66] Sharon Goldman *et al.*, *Hospitalization of injured pregnant women*, Isr. J. Health Policy Res. (Nov. 12, 2025) 14(1):65. doi: 10.1186/s13584-025-00727-y.
[67] *Id.*
[68] *See id.*
[69] *See id.*

patient and fetus. The medical evidence demonstrates that early and continuous care substantially reduces maternal and infant morbidity and mortality, while delays or gaps in care may allow otherwise treatable conditions to progress into life-threatening emergencies.

54. Detention settings present numerous structural barriers to timely and adequate prenatal and emergency obstetric care. These barriers include, but are not limited to, patient dependence on nonmedical staff, delays in evaluation and treatment, limited access to specialized and emergency services, increased exposure to communicable disease, inadequate nutrition, and detention protocols, like the use of physical restraints, that may increase the risk of physical harm. Detention settings can also cause, or exacerbate, mental health conditions.

55. For all of these reasons, placing and holding pregnant patients in detention poses serious medical and mental health risks for both the pregnant patient and the fetus.

* * *

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Dated: July 15, 2026

Executed in: Washington, DC

By: 

Dr. Christina Davidson, MD, FACOG
Chief Medical Officer
American College of Obstetricians & Gynecologists

APPENDIX B

Model Petition for a Writ of Habeas Corpus

For a pregnant, postpartum, or nursing person in ICE detention

UNITED STATES DISTRICT COURT
FOR [INSERT DISTRICT]

[NAME], *Petitioner-Plaintiff*, *v.* [NAME], in his/her official capacity as [Acting] Field Office Director of the [CITY] Field Office of U.S. Immigration and Customs Enforcement, Enforcement and Removal Operations; [NAME], Warden, [DETENTION FACILITY]; [NAME], in his/her official capacity as [Acting] Director of U.S. Immigration and Customs Enforcement; [NAME], in his/her official capacity as Secretary of the U.S. Department of Homeland Security; and [NAME], in his/her official capacity as [Acting] Attorney General of the United States, *Respondents-Defendants*.	Case No. _____ **Verified Petition for Writ of Habeas Corpus Pursuant to 28 U.S.C. § 2241**

[DRAFTING NOTE: HIGHLIGHTED TEXT MUST BE ADAPTED TO THE FACTS AND TO THE LAW OF YOUR CIRCUIT. THIS MODEL ASSUMES A PETITIONER DETAINED WHILE PREGNANT; ADAPT REFERENCES THROUGHOUT IF THE PETITIONER IS POSTPARTUM (WITHIN ONE YEAR OF GIVING BIRTH) OR NURSING. DELETE ALL NOTES BEFORE FILING.]

I. INTRODUCTION

1. This case challenges the unlawful detention of [NAME] (Petitioner), who is [NUMBER] weeks pregnant [IF APPLICABLE: with a pregnancy her medical providers have classified as high-risk], and who is currently in the custody of U.S. Immigration and Customs Enforcement (ICE) at [DETENTION FACILITY].

2. ICE's own binding policy, ICE Directive 11032.4, *Identification and Monitoring of Pregnant, Postpartum, or Nursing Individuals* (July 1, 2021) (the Directive), provides that ICE "should not detain, arrest, or take into custody for an administrative violation of the immigration laws individuals known to be pregnant, postpartum, or nursing unless release is prohibited by law or exceptional circumstances exist." Directive § 2, available at https://perma.cc/P98F-SR8N.

3. No exceptional circumstances exist here. Petitioner poses no national security concern and no imminent risk of death, violence, or physical harm to anyone; she has [NO CRIMINAL RECORD / DESCRIBE RECORD]. Nor is her release prohibited by law. Yet ICE detained her, knowing she was pregnant, and has kept her detained without ever making the determinations, obtaining the approvals, or conducting the weekly re-evaluations that the Directive requires.

4. [SUMMARIZE MEDICAL SITUATION AND INADEQUACY OF CARE, E.G.: Petitioner's pregnancy is complicated by [CONDITIONS]. The facility where she is detained cannot provide the specialized care her pregnancy requires: [SUMMARIZE—e.g., no obstetric services on site, long-distance transports for prenatal care, no pregnancy-appropriate diet, missed appointments, hospitalizations].]

5. As the American College of Obstetricians & Gynecologists (ACOG) explains, pregnancy is a serious medical condition requiring consistent, timely prenatal care; delays in care allow treatable complications to progress into life-threatening emergencies; and detention settings pose structural barriers to that care such that "placing and holding pregnant patients in detention poses serious medical and mental health risks for both the pregnant patient and the fetus." Declaration of Christina Davidson, MD, FACOG (ACOG Decl.) ¶¶ 9–10, 26–32, 53–55 (Ex. [__]).

6. Respondents-Defendants' actions violate the *Accardi* doctrine, the Administrative Procedure Act (APA), and the Due Process Clause of the Fifth Amendment to the U.S. Constitution, both because Respondents have disregarded the mandatory procedures and presumption of release established by their own Directive and because Petitioner is detained under conditions that endanger her and her unborn child.

7. Petitioner brings this action for habeas relief ordering Respondents to release her.

II. JURISDICTION AND VENUE

8. This Court has subject matter jurisdiction under art. I, § 9, cl. 2 of the U.S. Constitution (the Suspension Clause); 28 U.S.C. § 2241 (habeas corpus); 28 U.S.C. § 1331 (federal question); the All Writs Act, 28 U.S.C. § 1651; and the Declaratory Judgment Act, 28 U.S.C. §§ 2201–2202. District courts have jurisdiction under 28 U.S.C. § 2241 to hear habeas claims by noncitizens challenging the lawfulness of their civil immigration detention. *Zadvydas v. Davis*, 533 U.S. 678, 687 (2001); *Demore v. Kim*, 538 U.S. 510, 516–17 (2003).

9. This action challenges only the lawfulness of Petitioner's civil detention. It does not challenge any removal order or seek review of any removal proceeding. Accordingly, 8 U.S.C. § 1252 does not bar this Court's review. Section 1252(g) is cabined to three discrete actions: the commencement of proceedings, adjudication of cases, and execution of removal orders. It does not foreclose an independent challenge to unlawful detention. *See Reno v. Am.-Arab Anti-Discrimination Comm.*, 525 U.S. 471, 482 (1999).

10. Venue is proper under 28 U.S.C. § 2241(a) and 28 U.S.C. § 1391(e)(1) because Petitioner is detained at [DETENTION FACILITY, ADDRESS], within this district, her immediate custodian is in this district, and a substantial part of the events giving rise to this action occurred in this district. *See Rumsfeld v. Padilla*, 542 U.S. 426, 443–47 (2004).

III. EXHAUSTION OF REMEDIES

11. Exhaustion of administrative remedies under 28 U.S.C. § 2241 is prudential, not jurisdictional, and is excused where administrative remedies are unavailable or wholly inappropriate to the relief sought, or where exhaustion would be futile. [CITE CIRCUIT LAW, E.G., FIFTH CIRCUIT: *Gallegos-Hernandez v. United States*, 688 F.3d 190, 194 (5th Cir. 2012).]

12. Exhaustion is excused here. Petitioner and her unborn child face irreparable injury from continued detention and inadequate prenatal care. Moreover, ICE has never applied its own Directive to Petitioner's custody, and no procedure exists by which Petitioner can obtain from the agency the individualized custody determination she seeks. Any attempt to exhaust would be futile. [IF APPLICABLE: Petitioner or her counsel requested her release from ICE on [DATE], and ICE [DENIED THE REQUEST / DID NOT RESPOND].]

IV. PARTIES

13. Petitioner [NAME] is a [AGE]-year-old citizen of [COUNTRY] who has lived in the United States for [LENGTH OF TIME]. She is [NUMBER] weeks pregnant, with an anticipated delivery date of [DATE]. [ADD KEY EQUITIES: FAMILY, U.S.-CITIZEN CHILDREN, EMPLOYMENT, COMMUNITY TIES, PENDING APPLICATIONS FOR RELIEF, ABSENCE OF CRIMINAL HISTORY.] She is currently detained at [DETENTION FACILITY] in [CITY, STATE].

14. Respondent-Defendant [NAME] is the Warden of [DETENTION FACILITY], where Petitioner is detained, and is Petitioner's immediate physical custodian. He/She is sued in his/her official capacity.

15. Respondent-Defendant [NAME] is ICE's [Acting] Field Office Director for the [CITY] Field Office of ICE Enforcement and Removal Operations. Under Directive 11032.4 § 5.1, the Field Office Director (or a designee no lower than Assistant Field Office Director) is the official who must approve the detention of a pregnant, postpartum, or nursing person. He/She oversees ICE enforcement, removal, and detention operations in the area of responsibility that includes the facility where Petitioner is detained, is a legal custodian of Petitioner, and is sued in his/her official capacity.

16. Respondent-Defendant [NAME] is the [Acting] Director of ICE, is responsible for ICE's detention operations and for the monitoring, tracking, and reporting of detained pregnant, postpartum, and nursing individuals required by Directive 11032.4 §§ 2.2, 5.3, is a legal custodian of Petitioner, and is sued in his/her official capacity.

17. Respondent-Defendant [NAME] is the Secretary of the U.S. Department of Homeland Security (DHS), the parent agency of ICE, is legally responsible for the administration of the immigration laws, is a legal custodian of Petitioner, and is sued in his/her official capacity.

18. Respondent-Defendant [NAME] is the [Acting] Attorney General of the United States and is sued in his/her official capacity.

V. STATEMENT OF FACTS

A. Petitioner's Background and Detention

19. [PROVIDE PETITIONER'S BACKGROUND: AGE; LENGTH OF RESIDENCE; FAMILY, INCLUDING U.S.-CITIZEN CHILDREN; EMPLOYMENT AND

COMMUNITY TIES; ABSENCE OF CRIMINAL HISTORY; ANY PENDING APPLICATIONS FOR IMMIGRATION RELIEF OR BENEFITS.]

20. [DESCRIBE THE ARREST AND ANY PRIOR CUSTODY HISTORY: DATE, PLACE, AND CIRCUMSTANCES OF ICE ARREST; WHETHER PETITIONER WAS PREVIOUSLY RELEASED ON RECOGNIZANCE, PAROLE, BOND, OR AN ORDER OF SUPERVISION; TRANSFERS BETWEEN FACILITIES; USE OF RESTRAINTS DURING ARREST OR TRANSPORT, WHICH DIRECTIVE 11032.4 SEPARATELY RESTRICTS FOR PREGNANT INDIVIDUALS.]

21. [DETAIL EVERY DISCLOSURE AND EVERY WAY ICE KNEW OR LEARNED OF THE PREGNANCY: STATEMENTS AT ARREST, INTAKE MEDICAL SCREENING, PREGNANCY TEST IN CUSTODY, MEDICAL RECORDS, COUNSEL'S OR FAMILY'S NOTIFICATIONS TO ICE OR DHS.]

B. Petitioner's Pregnancy and the Inadequacy of Care in Detention

22. [DESCRIBE THE PREGNANCY AND MEDICAL CONDITIONS IN DETAIL, E.G.: GESTATIONAL AGE AND DUE DATE; HIGH-RISK CLASSIFICATION; CONDITIONS SUCH AS GESTATIONAL DIABETES, HYPERTENSION, ANEMIA, PRIOR COMPLICATED DELIVERIES, FETAL DIAGNOSES; TREATING PROVIDERS' RECOMMENDATIONS.]

23. [DESCRIBE EACH DEFICIENCY IN CARE, WITH DATES, E.G.: DELAY BEFORE FIRST OBSTETRIC VISIT; MISSED OR DELAYED SPECIALIST APPOINTMENTS; FAILURE TO PROVIDE A PREGNANCY- OR CONDITION-APPROPRIATE DIET; LACK OF RELIABLE ACCESS TO SAFE DRINKING WATER; UNFILLED PRESCRIPTIONS; TEST RESULTS NOT SHARED WITH PETITIONER OR HER PROVIDERS; LONG-DISTANCE TRANSPORTS FOR CARE; HOSPITALIZATIONS; ABSENCE OF ANY PLAN FOR DELIVERY OR NEONATAL CARE AT THE FACILITY. DOCUMENT ANY PHYSICAL DECLINE PETITIONER HAS ALREADY EXPERIENCED IN CUSTODY (E.G., WEIGHT LOSS, EXHAUSTION, IRON DEFICIENCY).]

24. [IF APPLICABLE:] The facility cannot provide on site the specialized care Petitioner's pregnancy requires, and has no plan for her delivery or for neonatal care. [DETAIL: DISTANCE AND FREQUENCY OF OUTSIDE TRANSPORTS; STATEMENTS BY FACILITY STAFF THAT THE FACILITY IS NOT EQUIPPED FOR A BIRTH.]

C. The Serious Health Risks Detention Poses to Petitioner and Her Child [INCLUDE THIS SECTION ONLY FOR A PREGNANT PETITIONER OR MODIFY WITH FACTS FROM ACOG DECLARATION FOR A POSTPARTUM PETITIONER]

25. Pregnancy is a significant medical condition requiring consistent, accessible, and timely prenatal care, whose purpose is to identify complications early, often before the patient is aware of them, so they can be treated before becoming life-threatening. ACOG Decl. ¶ 9. The standard of care requires visits monthly through 28 weeks of pregnancy, every two weeks from 28 to 36 weeks, and weekly thereafter, with physical assessments, laboratory testing, and mental-health screening at each visit. *Id.* ¶¶ 11–16, 22. Petitioner, at [NUMBER] weeks, is at the stage at which the standard of care requires [bi-weekly/weekly] monitoring. [COMPARE THE CARE PETITIONER HAS ACTUALLY RECEIVED.]

26. The stakes of inadequate care are grave and largely preventable: according to the CDC, as many as 85% of pregnancy-related maternal deaths in the United States may be preventable with appropriate prenatal care, and infants whose mothers received no prenatal care are approximately five times more likely to die in their first year. ACOG Decl. ¶ 10. Inadequate or absent prenatal care nearly doubles the odds of serious newborn complications or death, and delays in accessing obstetric services nearly triple that risk. *Id.* ¶ 26. Common symptoms like vaginal bleeding, severe abdominal pain, persistent headaches, vision changes, swelling, decreased fetal movement, and signs of infection can signal conditions that "worsen rapidly and lead to permanent injury or death of the mother and/or a fetus or neonate" and "require immediate medical evaluation, often on an emergency basis." *Id.* ¶¶ 30–31. "Timely intervention is often the difference between a manageable complication and a life-threatening emergency." *Id.* ¶ 32. [IF APPLICABLE: MAP PETITIONER'S CONDITIONS AND SYMPTOMS TO THESE PARAGRAPHS, E.G.: Petitioner has been diagnosed with gestational diabetes, a condition ACOG identifies as posing serious risks to mother and fetus if unmanaged, ¶¶ 18–20; she has experienced [SYMPTOMS], which ACOG identifies as requiring immediate emergency evaluation, ¶¶ 30–31.]

27. Detention can also endanger the pregnant patient and the fetus. Detained people cannot independently seek emergency care and must instead depend on non-medical custodial staff to recognize symptoms, followed by multi-step authorization and transport processes that can delay evaluation and treatment. ACOG Decl. ¶¶ 33–36. Carceral settings amplify communicable diseases to which pregnancy increases susceptibility and severity, *id.* ¶¶ 38–41; detention is associated with high rates of depression, anxiety, and PTSD, which are themselves associated with preterm birth, low birth weight, and growth restriction, *id.* ¶¶ 42–45; detention diets can lack the nutrition critical to fetal development—a 2025 congressional investigation found systemic denial of adequate food and water in ICE facilities, with pregnant women reporting persistent hunger, *id.* ¶¶ 46–48; and the use of restraints on pregnant people is "medically dangerous" and against national standards of care, *id.* ¶¶ 49–52. [MAP TO PETITIONER'S EXPERIENCE: DELAYED RESPONSES TO SYMPTOMS; DIET AND WATER ACCESS; RESTRAINTS; MENTAL-HEALTH EFFECTS.]

28. Reproductive health care for detained individuals should follow the same guidelines and recommendations as for those who are not detained. ACOG Decl. ¶ 37. ACOG concludes that, because of these structural barriers, "placing and holding pregnant patients in detention poses serious medical and mental health risks for both the pregnant patient and the fetus," *id.* ¶¶ 54–55.

29. Petitioner does not contend that the detention of a pregnant person is invariably unconstitutional. But ACOG's findings establish the serious, sometimes irreversible harms that detention can inflict. As alleged above, those harms have been or will be inflicted here, where ICE has disregarded its own Directive and the facility cannot meet the standard of care her pregnancy requires.

D. ICE's Failure to Comply with Directive 11032.4

30. Upon information and belief, no Field Office Director or qualifying designee ever approved Petitioner's detention, as Directive § 5.1 requires.

31. Upon information and belief, ICE never determined that Petitioner poses national security concerns or an imminent risk of death, violence, or physical harm to any individual, the

only two "exceptional circumstances" the Directive recognizes, § 3.4. Nor did ICE ever determine under the Directive that Petitioner's release is prohibited by law.

32. Upon information and belief, when ICE identified or was informed that Petitioner was pregnant, ICE personnel did not "immediately notify" the Field Office Director or designee and appropriate medical staff to determine whether continued detention was appropriate, as Directive § 5.4 requires.

33. Upon information and belief, ICE has not re-evaluated Petitioner's custody on at least a weekly basis, and has not monitored, tracked, and reported her status to the ICE Director, as Directive §§ 2.2, 5.3, and 5.4 require.

34. No court or agency has ever held a custody hearing or made any individualized determination that Petitioner is a flight risk or a danger to the community, or that her detention serves any legitimate purpose. [IF APPLICABLE: DESCRIBE ANY IMMIGRATION COURT PROCEEDINGS AND NOTE THAT NEITHER THE GOVERNMENT NOR THE IMMIGRATION JUDGE RAISED OR APPLIED DIRECTIVE 11032.4.]

VI. LEGAL FRAMEWORK

A. ICE Directive 11032.4 Establishes a Mandatory Default Against Detaining Pregnant, Postpartum, and Nursing People

35. Directive 11032.4 provides that ICE "should not detain, arrest, or take into custody for an administrative violation of the immigration laws individuals known to be pregnant, postpartum, or nursing unless release is prohibited by law or exceptional circumstances exist." Directive § 2. A person is "postpartum" for one year after giving birth, and "nursing" if breastfeeding a child regardless of the passage of time since childbirth. *Id.* § 3.

36. The Directive defines "exceptional circumstances" to exist only where the individual (1) poses national security concerns or (2) poses an imminent risk of death, violence, or physical harm to any individual. *Id.* § 3.4. It requires that any detention of a covered person be approved by the Field Office Director or a designee no lower than Assistant Field Office Director, *id.* § 5.1; that ICE personnel who identify a covered person already in custody "immediately notify" the Field Office Director or designee and medical staff to determine whether continued detention is appropriate, *id.* § 5.4; that ICE verify that covered persons are not detained absent legal prohibition on release or exceptional circumstances and maintain a process for their "expeditious release, where legally authorized," *id.* § 4.2; and that ICE re-evaluate any covered person's detention at least weekly and monitor, track, and report her status to the ICE Director, *id.* §§ 2.2, 5.3, 5.4.

B. Agencies Must Follow Their Own Rules under the *Accardi* Doctrine

37. Under the *Accardi* doctrine, a foundational principle of administrative law, agencies must follow their own procedures, rules, and policies. *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 265–68 (1954); *Morton v. Ruiz*, 415 U.S. 199, 235 (1974) ("Where the rights of individuals are affected, it is incumbent upon agencies to follow their own procedures."). The doctrine is not "limited to rules attaining the status of formal regulations," *Montilla v. INS*, 926 F.2d 162, 167 (2d Cir. 1991), and extends to policy directives adopted for the benefit of the individuals they cover, *Damus v. Nielsen*, 313 F. Supp. 3d 317, 336–38 (D.D.C.

2018) (ICE parole directive). A boilerplate disclaimer does not defeat enforcement. *See id.* at 338; *Abdi v. Duke*, 280 F. Supp. 3d 373, 389 (W.D.N.Y. 2017).

38. Applying these principles, courts have enforced Directive 11032.4 and ordered relief for detained pregnant and postpartum petitioners. *See De Leon Lopez v. Ladwig*, 2026 WL 19095, at *7–8 (W.D. La. Jan. 2, 2026) ("If Petitioner['s] continued detention and denial of parole do not comport with the policy set forth in ICE Directive 11032.4, then the Court must require Respondents to abide by their own policy."); *Sahin v. Rader*, No. 2:26-cv-00134, Minute Order, ECF No. 17 (D. Nev. Jan. 26, 2026) (continued detention of woman with high-risk pregnancy "egregiously violates ICE's binding policy directive"); *San Juan v. Mullin*, 2026 WL 1962582, at *2 (W.D. La. July 7, 2026) (continued detention of nursing, postpartum mother violated *Accardi* in light of the Directive and "necessitates Petitioner's release"); *Banegas v. Bondi*, 2026 WL 473162, at *2 (W.D. Wis. Feb. 19, 2026) (ordering release of nursing mother where government identified no exceptional circumstance, as the Directive "plainly affects individual rights"); *Morales Lopez v. Maples*, 2026 WL 1433970 (S.D. Ind. May 21, 2026) (ordering immediate release of pregnant petitioner because release was "not prohibited by law" and therefore was not "mandatory" under the Directive); *Shigwedha v. Acuna*, No. CV 26-2430, 2026 WL 2211525 (W.D. La. July 31, 2026) (granting temporary restraining order and release of pregnant petitioner under *Accardi* where the government produced no evidence of exceptional circumstances, required custody reviews, or medical treatment).

39. The APA requires courts to "hold unlawful and set aside agency action" that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). The APA's reference to "law" "means, of course, any law, and not merely those laws that the agency itself is charged with administering." *FCC v. NextWave Pers. Commc'ns Inc.*, 537 U.S. 293, 300 (2003). Directive 11032.4 is "any law" under *Accardi*.

C. Due Process Governs Civil Immigration Detention

40. "The Due Process Clause applies to all persons within the United States, including aliens, whether their presence here is lawful, unlawful, temporary, or permanent." *Zadvydas*, 533 U.S. at 693. "Freedom from imprisonment—from government custody, detention, or other forms of physical restraint—lies at the heart of the liberty that [the Due Process] Clause protects." *Id.* at 690. The only legitimate purposes of civil immigration detention are preventing flight and protecting the community from danger, *id.* at 690–91.

41. Because immigration detention is civil, a detained person may not be subjected to conditions that "amount to punishment," *Bell v. Wolfish*, 441 U.S. 520, 535 (1979), and is entitled to adequate care for her serious medical needs, *see Estelle v. Gamble*, 429 U.S. 97, 104 (1976). [CITE CIRCUIT STANDARD, E.G., FIFTH CIRCUIT: *Hare v. City of Corinth*, 74 F.3d 633, 639 (5th Cir. 1996) (en banc); SECOND CIRCUIT: *Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017); NINTH CIRCUIT: *Gordon v. Cnty. of Orange*, 888 F.3d 1118, 1124–25 (9th Cir. 2018).]

VII. CLAIMS FOR RELIEF

Count One
***Accardi* Doctrine**
Failure to Follow ICE Directive 11032.4

42. Petitioner realleges and incorporates by reference all paragraphs above as if fully set forth here.

43. Under the *Accardi* doctrine, agencies must follow their own procedures, rules, and policies, and Petitioner has a right to have set aside agency action that violates them. *Accardi*, 347 U.S. at 268; *Morton*, 415 U.S. at 235.

44. Directive 11032.4 is binding on ICE. Its operative provisions are mandatory and it was adopted for the benefit of pregnant, postpartum, and nursing people in ICE custody, including Petitioner. Its boilerplate disclaimer does not defeat its enforcement.

45. ICE made a determination to take Petitioner, a person known to be pregnant, into custody and to continue her detention without any exceptional-circumstances determination and without approval by the Field Office Director or qualifying designee. It further decided to deny her the required weekly custody re-evaluations. These decisions consummated the agency's decisionmaking process as to her custody and determined her rights and obligations. Each is a final agency action. *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997).

46. Those final agency actions violate the Directive and are therefore not in accordance with law. Where, as here, the government cannot document compliance with the Directive's mandatory procedures, courts have held that *Accardi* requires release. *San Juan*, 2026 WL 1962582, at *2 ("Respondents have failed to demonstrate their adherence to the Directive," which "necessitates Petitioner's release"); *Shigwedha*, 2026 WL 2211525, at *1 (the government's failure to provide any information about its review of a pregnant petitioner's detention "makes finding anything other than a violation of the Directive impossible").

47. The Directive was adopted for Petitioner's benefit, and its violation has prejudiced her. Had Respondents applied the Directive, its terms would have required her release, because she poses no national security concern, poses no imminent risk of harm to anyone, and because her release is not prohibited by law, as ICE has authority to release Petitioner on humanitarian parole. Yet she remains detained under conditions that the medical consensus establishes endanger her and her unborn child. ACOG Decl. ¶¶ 53–55.

48. Respondents' detention of Petitioner violates the Directive and *Accardi*, so she should be released.

Count Two
Administrative Procedure Act, 5 U.S.C. § 706(2)(A)
Agency Action Not in Accordance with Law, Arbitrary and Capricious

49. Petitioner realleges and incorporates by reference all paragraphs above as if fully set forth here.

50. Under the APA, a court shall "hold unlawful and set aside agency action . . . found to be . . . not in accordance with law." 5 U.S.C. § 706(2)(A). Agency action that violates the agency's own binding rules is not in accordance with law.

51. ICE's decision to detain Petitioner is "not in accordance with law" because it violates Directive 11032.4, which is binding on the agency.

52. Also under the APA, a court shall "hold unlawful and set aside agency action . . . found to be . . . arbitrary [or] capricious." 5 U.S.C. § 706(2)(A). Agency action is arbitrary and capricious if it is not the product of "reasoned decisionmaking." *Michigan v. EPA*, 576 U.S. 743, 750 (2015); *see also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29 (1983). The agency must "examine the relevant data and articulate a satisfactory explanation for its action including a rational connection between the facts found and the choice made," and its action is arbitrary and capricious if the agency "entirely failed to consider an important aspect of the problem" or "offered an explanation for its decision that runs counter to the evidence before the agency." *Id.* at 43.

53. ICE's decision to detain Petitioner is not the product of reasoned decisionmaking, in light of the facts before the agency.

54. First, the decision runs counter to the evidence before the agency. ICE knew Petitioner was pregnant. It possessed [HER MEDICAL RECORDS / SCREENING RESULTS / PROVIDERS' RECOMMENDATIONS], and it had no evidence that she poses a danger, a flight risk, a national security concern, or an imminent risk of harm to anyone.

55. Second, the decision entirely failed to consider important aspects of the problem: the serious, escalating, and irreversible medical risks that detention poses to Petitioner and her unborn child, *see* ACOG Decl. ¶¶ 9–10, 26–36, 53–55, and the availability of obvious, less harmful alternatives before the agency, including release, humanitarian parole under 8 U.S.C. § 1182(d)(5)(A) and 8 C.F.R. § 212.5(b)(2), and conditions of supervision. *State Farm*, 463 U.S. at 43, 51; *Dep't of Homeland Sec. v. Regents of the Univ. of Cal.*, 591 U.S. 1, 30 (2020) (agency must consider obvious alternatives).

56. Third, the decision is an unacknowledged and unexplained departure from ICE's own governing policy. The Directive establishes a presumption of release for pregnant, postpartum, or nursing individuals. ICE detained Petitioner without acknowledging that policy or explaining any departure from it, and without the "more detailed justification" required where the "prior policy has engendered serious reliance interests that must be taken into account." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515–16 (2009); *see also Regents*, 591 U.S. at 30. Pregnant, postpartum, and nursing women, their families, and their medical providers reasonably relied on ICE's published presumption against detaining these individuals in structuring medical care and family caregiving.

57. Because ICE's decision to detain Petitioner was not the product of reasoned decisionmaking, it is arbitrary and capricious, should be set aside, and Petitioner should be released.

Count Three
Violation of the Fifth Amendment: Procedural Due Process

Detention Without the Process Required by ICE Directive 11032.4

58. Petitioner realleges and incorporates by reference all paragraphs above as if fully set forth here.

59. Petitioner has a fundamental liberty interest in freedom from detention. *Zadvydas*, 533 U.S. at 690. Noncitizens within the United States are protected by the Fifth Amendment regardless of the lawfulness of their presence.

60. Courts evaluate a procedural due process claim under *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976), which requires balancing (1) the private interest at stake; (2) the risk of erroneous deprivation of that interest through the procedures used, and the probable value of additional safeguards; and (3) the government's interest, including the burdens that additional procedures would entail.

61. Directive 11032.4 is the process to which Petitioner is entitled before she may be detained at all: an exceptional-circumstances determination, approval by the Field Office Director or qualifying designee, immediate notification and review upon identification that she was pregnant, postpartum, or nursing, and weekly re-evaluations of her custody. Directive §§ 3.4, 5.1, 5.3, 5.4.

62. The first *Mathews* factor favors Petitioner. Her interest is freedom from physical confinement, "the most elemental of liberty interests" under *Hamdi v. Rumsfeld*, 542 U.S. 507, 529 (2004) (plurality opinion). The first factor also encompasses her interest in her own life and health and that of her unborn child. As many as 85% of pregnancy-related maternal deaths may be preventable with appropriate prenatal care, infants deprived of prenatal care are approximately five times more likely to die in their first year, and the harms at stake are irreversible. ACOG Decl. ¶¶ 10, 53–55.

63. The second factor favors Petitioner. Respondents followed none of the Directive's safeguards, and no court or agency has ever made any individualized determination justifying Petitioner's detention. The risk of erroneous deprivation is therefore not just high, but escalating, because the standard of prenatal care intensifies week by week and delayed evaluation allows treatable complications to become life-threatening emergencies. ACOG Decl. ¶¶ 11, 26–32. Requiring Respondents to follow their own Directive is of obvious value.

64. The third factor favors Petitioner. The government has no legitimate interest in detaining a pregnant woman it does not contend is dangerous or a flight risk, in violation of its own policy. Her detention affirmatively burdens the government with the costs of specialized transports, outside medical care, and emergency hospitalizations, while release would relieve those burdens.

65. Respondents' violations substantially prejudiced Petitioner and affected the outcome of the agency's custody decision. Had Respondents complied with the Directive, its terms would have required her release. Noncompliance has produced unnecessary detention that endangers Petitioner and her unborn child.

66. Respondents' detention of Petitioner without the process required by their own Directive violates procedural due process under the Fifth Amendment. No process could retroactively cure the deprivation, and each additional week of detention carries escalating and

irreversible medical risk. The Directive itself also mandates release on these facts. So the appropriate remedy is immediate release.

Count Four
Violation of the Fifth Amendment: Substantive Due Process
Punitive Detention and Deliberate Indifference to Serious Medical Needs

67. Petitioner realleges and incorporates by reference all paragraphs above as if fully set forth here.

68. A person in civil detention may not be subjected to conditions that "amount to punishment," *Bell v. Wolfish*, 441 U.S. 520, 535 (1979). A condition is unconstitutional punishment if it is not "reasonably related to a legitimate governmental objective," an objective inquiry that does not turn on any official's state of mind. *Id.* at 539.

69. Petitioner's detention and its conditions are punitive because they bear no reasonable relationship to any legitimate governmental interest. [SUMMARIZE PUNITIVE CONDITIONS, E.G.: Petitioner is denied the medically indicated diet for her [CONDITION] even as the facility monitors that condition; she lacks reliable access to safe drinking water; she has been [SHACKLED/RESTRAINED] during transport in violation of the Directive; she is detained in a facility that concededly cannot manage her delivery.] These conditions are affirmatively dangerous by professional medical standards. "Preventing [a detained person] from protecting [her] own health from a high risk of serious illness or death does not reasonably relate to a legitimate governmental purpose and thus, violates the Fifth Amendment." *Vazquez Barrera v. Wolf*, 455 F. Supp. 3d 330, 339 (S.D. Tex. 2020).

70. Petitioner is also being detained with deliberate indifference to her serious medical needs. A high-risk pregnancy [COMPLICATED BY [CONDITIONS]] is a paradigmatic serious medical need requiring continuous, specialized care. ACOG Decl. ¶¶ 9–17, 25–32; *see also Mori v. Allegheny Cnty.*, 51 F. Supp. 3d 558, 575 (W.D. Pa. 2014); *Goebert v. Lee Cnty.*, 510 F.3d 1312, 1326–28 (11th Cir. 2007); *Coleman v. Rahija*, 114 F.3d 778, 785–86 (8th Cir. 1997). A petitioner need only show a substantial risk of serious harm, not that harm has already occurred. *See Helling v. McKinney*, 509 U.S. 25, 33 (1993). Courts have ordered the release of petitioners on precisely this claim. *See Marks v. Cicirello*, 2026 WL 1238537 (W.D.N.Y. May 6, 2026) (ordering release of postpartum petitioner on deliberate-indifference grounds after an evidentiary hearing, notwithstanding a final order of removal).

71. The care provided to Petitioner in detention is constitutionally inadequate. [SUMMARIZE, WITH DATES: DELAYED OR DENIED OBSTETRIC CARE (COMPARE THE VISIT CADENCE REQUIRED BY ACOG DECL. ¶ 11); UNTREATED OR UNDERTREATED CONDITIONS; FIRST-LINE TREATMENTS WITHHELD; TEST RESULTS NOT PROVIDED TO PETITIONER OR HER PROVIDERS; ACUTE SYMPTOMS DISMISSED; HOSPITALIZATIONS; THE FACILITY'S STRUCTURAL INABILITY TO PROVIDE OBSTETRIC OR NEONATAL CARE.]

72. Because immigration detention is civil, the adequacy of Petitioner's care is properly assessed under an objective standard asking whether the denial of care was reasonably related to a legitimate governmental interest, *Bell*, 441 U.S. at 539, or objectively unreasonable. In the alternative, even under a subjective deliberate-indifference standard, the facts suffice: Respondents

had subjective knowledge of Petitioner's pregnancy and its complications: [E.G., THEY MONITOR THE CONDITIONS THEY DECLINE TO TREAT AND TRANSPORT HER TO OUTSIDE SPECIALISTS BECAUSE THE FACILITY CANNOT MEET HER NEEDS]. The risks of inadequate prenatal care are obvious, as documented by consensus findings of a leading professional medical body, not matters of debatable medical judgment. *See* ACOG Decl. ¶¶ 10, 26–32, 53–55. Subjective knowledge may be inferred "from the very fact that the risk was obvious." *Farmer v. Brennan*, 511 U.S. 825, 842 (1994).

73. The barriers to adequate care here are not correctable deficiencies, so no order improving conditions could cure the violation. Petitioner's detention is unconstitutional punishment and deliberate indifference to her serious medical needs, in violation of substantive due process, and the appropriate remedy is release.

VIII. PRAYER FOR RELIEF

WHEREFORE, Petitioner respectfully requests that this Court:

1. Assume jurisdiction over this matter;

2. Enjoin Petitioner's removal from the United States and her transfer outside the jurisdiction of this Court pending adjudication of this Petition;

3. Declare that Respondents' detention of Petitioner violates the *Accardi* doctrine, the Administrative Procedure Act, and the Due Process Clause of the Fifth Amendment;

4. Grant a writ of habeas corpus and order Petitioner's immediate release from custody, without bond and without conditions or restraints on her liberty;

5. Order that Petitioner not be re-detained, re-arrested, or taken back into custody absent further order of this Court, and that Respondents file a notice of compliance within 24 hours of her release;

6. [IF CIRCUIT LAW ALLOWS:] Award Petitioner costs and reasonable attorneys' fees; and

7. Grant such other and further relief as the Court deems just and proper.

DATED: [ ]

/s/ Petitioner Attorney Name
[Attorney Name]
[State or Fed. Dist. Bar No. if local rules require]
[FIRM NAME/ORG]
[Street]
[City, State Zip]
Phone: [ ]
Fax: [ ]
[Email]

Attorney for Petitioner

28 U.S.C. § 2242 VERIFICATION STATEMENT

I am submitting this verification on behalf of the Petitioner because I am the Petitioner's attorney. I have discussed with the Petitioner the events described in this Petition. On the basis of those discussions and my review of the records in this matter, I hereby verify that the statements made in this Petition are true and correct to the best of my knowledge, information, and belief.

DATED: [DATE]

_____

[SIGNATURE BLOCK]
Attorney for Petitioner-Plaintiff