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22 **UNITED STATES DISTRICT COURT**  
23 **CENTRAL DISTRICT OF CALIFORNIA**  
24 **EASTERN DIVISION – RIVERSIDE**

25 FAOUR ABDALLAH FRAIHAT;  
26 MARCO MONTOYA AMAYA;  
27 RAUL ALCO CER CHAVEZ; JOSE  
28 SEGOVIA BENITEZ; HAMIDA ALI;  
MELVIN MURILLO HERNANDEZ;  
JIMMY SUDNEY; JOSÉ BACA

Case No. 19-cv-01546

**CLASS ACTION**

**Complaint for Declaratory and  
Injunctive Relief for Violations of the  
Due Process Clause of the Fifth**

1 HERNÁNDEZ; EDILBERTO  
2 GARCÍA GUERRERO; MARTIN  
3 MUÑOZ; LUIS MANUEL  
4 RODRIGUEZ DELGADILLO;  
5 RUBEN DARÍO MENCÍAS SOTO;  
6 ALEX HERNANDEZ;  
7 ARISTOTELES SANCHEZ  
8 MARTINEZ; and SERGIO SALAZAR  
9 ARTAGA; on behalf of themselves and  
10 all those similarly situated; INLAND  
11 COALITION FOR IMMIGRANT  
12 JUSTICE, an organization; and AL  
13 OTRO LADO, an organization,

14 Plaintiffs,

15 v.

16 U.S. IMMIGRATION AND  
17 CUSTOMS ENFORCEMENT;  
18 U.S. DEPARTMENT OF  
19 HOMELAND SECURITY;  
20 KEVIN MCALEENAN, in his official  
21 capacity as Acting Secretary, U.S.  
22 Department of Homeland Security;  
23 MATTHEW T. ALBENCE, in his  
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26 Enforcement;  
27 DEREK N. BRENNER, in his official  
28 capacity as Deputy Director, U.S.  
Immigration and Customs  
Enforcement; TIMOTHY S.  
ROBBINS, in his official capacity as  
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Enforcement and Removal Operations;  
TAE JOHNSON, in his official  
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Custody Management, Enforcement  
and Removal Operations; STEWART  
D. SMITH, in his official capacity as  
Assistant Director, Immigration and

**Amendment and Section 504 of the  
Rehabilitation Act, 29 U.S.C. § 794,  
et. seq.**

1 Customs Enforcement Health Service  
2 Corps; JACKI BECKER KLOPP, in  
3 her official capacity as Assistant  
4 Director of Operations Support,  
5 Enforcement and Removal Operations;  
6 and DAVID P. PEKOSKE, in his  
7 official capacity as Senior Official  
8 Performing Duties of the Deputy  
9 Secretary, Department of Homeland  
10 Security,

11 Defendants.

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**GLOSSARY OF TERMS**

**A**

ACA American Correctional Association  
ADA Americans with Disabilities Act  
Adelanto Adelanto ICE Processing Center (CA)  
AFOD ICE Assistant Field Office Director  
AIC American Immigration Council  
AILA American Immigration Lawyers Association  
Albany County Albany County Correctional Facility (NY)  
Alexandria Alexandria Staging Facility (LA)  
ASL American Sign Language  
Aurora Aurora ICE Processing Center (CO)

**B**

Berks County Berks County Jail (PA)  
BOP Bureau of Prisons  
Brooks County Brooks County Detention Center (TX)

**C**

CCS Correct Care Solutions (now Wellpath)  
CMD ICE Custody Management Division  
Corizon Corizon Correctional Healthcare  
CORs Contracting Officer's Representatives  
CPR Cardiopulmonary Resuscitation  
CRCL: Office of Civil Rights and Civil Liberties

**D**

DACA Deferred Action for Childhood Arrivals  
DDR Detainee Death Review  
Detention Facilities Facilities that hold ICE detainees for more than 72 hours  
DHS Department of Homeland Security  
DMC Detention Monitoring Council  
Dodge County Dodge County Detention Center (WI)  
DOJ Department of Justice  
DRC Disability Rights California  
DSMs Detention Service Monitors  
DWN Detention Watch Network

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**E**

EKG Electrocardiogram  
 El Centro El Centro Service Processing Center (CA)  
 El Paso El Paso Processing Center (TX)  
 Elizabeth Elizabeth Detention Center (NJ)  
 Eloy Eloy Detention Center (AZ)  
 EMS Emergency Medical Services  
 ERO Enforcement and Removal Operations  
 Essex Essex County Correctional Facility (NJ)  
 Etowah Etowah County Detention Center (AL)

**F**

Farmville Immigration Centers of America—Farmville (VA)  
 Florence Florence Correctional Center (AZ)  
 Folkston Folkston ICE Processing Center (GA)

**G**

GAO Governmental Accountability Office  
 GEO The GEO Group Inc.

**H**

Hall County Hall County Detention Center (GA)  
 Hall Hall County Jail (NE)  
 HSA Health Services Administrator  
 Henderson Henderson County Jail (NV)  
 HIV Human Immunodeficiency Virus  
 Houston Houston Contract Detention Center (TX)  
 HRW Human Rights Watch  
 HSA Health Services Administrator  
 Hudson County Hudson County Correctional Facility  
 Hutto T. Don Hutto Residential Center (TX)

**I**

ICE Immigration and Customs Enforcement  
 ICIJ Inland Coalition for Immigrant Justice  
 IGSA Intergovernmental Service Agreement  
 IHSC ICE Health Service Corps  
 Imperial Imperial Detention Facility (CA)  
 Inspection Worksheet Detention Inspection Form Worksheet  
 Irwin Irwin County Detention Center (GA)



1	<b>J</b>	
	Joe Corley	Joe Corley Detention Center (TX)
2		
3	<b>K</b>	
	Krome	Krome Service Processing Center (FL)
4		
5	<b>L</b>	
	LaSalle	LaSalle ICE Processing Center (LA)
6	LVN	Licensed Vocational Nurse
7		
8	<b>M</b>	
	Mesa Verde	Mesa Verde ICE Processing Center (CA)
9	MRI	Magnetic Resonance Imaging
10	<b>N</b>	
	Nakamoto	The Nakamoto Group Inc.
11	NIJC	National Immigrant Justice Center
12		
13	<b>O</b>	
	OAM	ICE Office of Acquisitions Management
14	ODO	ICE Office of Detention Oversight
	OIG	DHS Office of the Inspector General
15	Orange County	Orange County Jail (CA)
16	Otay Mesa	Otay Mesa Detention Center (CA)
17	Otero County	Otero County Processing Center (TX)
18	<b>P</b>	
	Pahrump	Pahrump Detention Center (NV)
19	PBNDS	Performance Based National Detention Standards
20	Port Isabel	Port Isabel Detention Center (TX)
21	PTSD	Post-Traumatic Stress Disorder
22	<b>R</b>	
	Rio Grande	Rio Grande Detention Center (TX)
23	River	River Correctional Center (LA)
24	Riverside	Riverside County Jail (CA)
25	RN	Registered Nurse
26	Rolling Plains	Rolling Plains Correctional Facility (TX)
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**S**

1 Salt Lake Salt Lake County Jail (UT)  
2 San Bernardino County San Bernardino County Detention Center (CA)  
3 San Diego County San Diego County Detention Facility (CA)  
4 San Luis San Luis Regional Detention Center (AZ)  
5 San Pedro San Pedro ICE Processing Center (CA)  
6 Section 504 Section 504 of the Rehabilitation Act  
7 SMRS ICE'S Online Case Management System  
8 South Texas/Pearsall South Texas Detention Complex (TX)  
9 Stewart Stewart Detention Center (GA)

**T**

10 Tallahatchie Tallahatchie County Correctional Facility (MS)  
11 Teller Teller County Jail (CO)  
12 Theo Lacy Theo Lacy Facility (CA)  
13 TTY Teletypewriter

**U**

14 Utah County Utah County Jail (UT)

**V**

15 Victorville Victorville Federal Correctional Complex (CA)

**Y**

16 York County York County Detention Center  
17 Yuba Yuba County Jail (CA)

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## INTRODUCTION

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1. Named Plaintiffs are men and women currently in the custody of Immigration and Customs Enforcement (“ICE”), a component of the United States Department of Homeland Security (“DHS”). On a daily basis, Plaintiffs and the record number<sup>1</sup> of immigrants currently in ICE custody are subjected to horrific, inhumane, punitive, and unlawful conditions of confinement. These human beings—many of whom have fled torture—are packed into immigration prisons in which they are denied healthcare; refused disability accommodations; and subjected to arbitrary and punitive isolation, a practice that is increasingly considered torture. Although ICE detains individuals in a patchwork—and currently ballooning—system of private prisons, county jails, and directly operated facilities, the inhumane and punitive conditions described herein are startlingly similar across the entire system. Far from coincidental, the commonality of these brutal conditions stems directly from ICE’s centralized policies, practices, and failures of meaningful oversight. The consequent risk of harm to detained individuals is substantial, irreparable, and ongoing. Dozens have unnecessarily died as a result of insufficient care. Countless more have endured needless suffering from delays in medical care, refusals to accommodate disabilities, and nearly constant isolation. Conditions in detention are so brutal that many people are forced to abandon viable claims for immigration relief and accept deportation out of a desperate desire to escape the torture they are enduring in detention on U.S. soil.

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2. Plaintiffs have a range of serious medical and mental health conditions including diabetes, cerebral palsy, chronic pain, hypertension, bipolar disorder, and schizophrenia. Plaintiffs have experienced the outright denial of care, delayed care, and substandard and insufficient care. For example, Plaintiff Alex Hernandez, who

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<sup>1</sup> Isabela Dias, *ICE Is Detaining More People Than Ever—and for Longer*, Pacific Standard (Aug. 1, 2019), <https://psmag.com/news/ice-is-detaining-more-people-than-ever-and-for-longer>.

1 has a torn rotator cuff, has been recommended for surgery by three separate  
2 orthopedic specialists at three different facilities, but ICE has yet to provide the  
3 surgery. Plaintiffs Martín Muñoz and Aristoteles Sanchez Martinez have diabetes  
4 and were denied their daily dosages of insulin on multiple occasions. Plaintiff  
5 Marco Montoya Amaya has a likely brain parasite but has not received any  
6 treatment for over a year, despite risk of serious complications like seizures,  
7 meningitis, and hydrocephalus.

8 3. Plaintiffs have also been subjected to arbitrary and unnecessary  
9 segregation. For example, Plaintiff Hamida Ali has schizophrenia, depression, and  
10 suicidal ideation. Although it is well known that prolonged isolation can both cause  
11 and exacerbate depression and suicidality, Ms. Ali spent approximately nine  
12 months in near-total isolation without even a guard adequately monitoring her  
13 wellbeing. Plaintiff Jose Segovia Benitez likewise has been subjected to isolation,  
14 notwithstanding the fact that it can exacerbate his depression and post-traumatic  
15 stress disorder (“PTSD”).

16 4. Plaintiffs with disabilities have been denied appropriate  
17 accommodations. For example, Plaintiff Raul Alcocer Chavez, who is Deaf, has  
18 been denied an American Sign Language (“ASL”) interpreter in detention, which  
19 has prevented him from receiving effective communication with medical staff and  
20 his lawyer. Plaintiff Sergio Salazar Artaga, who has cerebral palsy and extreme  
21 difficulty walking without falling, has been denied leg braces and delayed access to  
22 a shower chair. Plaintiff Faour Abdallah Fraihat has knee and back pain and a disc  
23 problem in his lower back that cause his legs to become numb when he tries to  
24 walk more than ten to fifteen feet. He was denied a wheelchair for over two years  
25 after staff took it away from him a month into being detained.

26 5. Defendants have the legal obligation to ensure that individuals in  
27 immigration detention receive adequate care and accommodations. Defendants also  
28 have the legal authority to release a substantial number of detained individuals on

1 their own recognizance, with bonds, or pursuant to other alternatives to detention,  
2 all of which have proven cost-effective and successful at assuring immigrants  
3 participate in their immigration proceedings. Defendants have nonetheless chosen  
4 to detain Plaintiffs and a record number of other immigrants, many for months and  
5 some for years. Some of these detained individuals are Lawful Permanent  
6 Residents, refugees, or longtime U.S. residents, while others have arrived more  
7 recently to seek asylum after fleeing persecution in their home countries. Though  
8 many asylum seekers risked their lives by traveling across continents to lawfully  
9 avail themselves of our nation's asylum laws and have violated no criminal laws,  
10 ICE chooses to detain them anyway.

11 6. ICE may lawfully detain civilly, but not imprison criminally,  
12 individuals it believes have no lawful basis for entering or remaining in the U.S.  
13 ICE may release most detained noncitizens on bond or parole, but overwhelmingly  
14 refuses to do so.

15 7. This Complaint challenges the conditions in the approximately 158  
16 facilities that hold ICE detainees for more than 72 hours ("Detention Facilities").<sup>2</sup>

17 8. On information and belief, ICE directly operates just five Detention  
18 Facilities, and has chosen to contract for the operation of the remaining 153  
19 facilities.<sup>3</sup> The contractors include local sheriffs' offices and private prison  
20 corporations, such as GEO Group ("GEO") and CoreCivic (formerly known as  
21 Corrections Corporation of America), which have long histories of failing to  
22 provide constitutional conditions of confinement for those they imprison.<sup>4</sup> Based on

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23  
24 <sup>2</sup> See ICE, *List of Over-72-Hour ICE Detention Facilities*,  
25 <https://www.ice.gov/doclib/detention/Over72HourFacilities.xlsx>. Upon information  
26 and belief, there may be additional ICE facilities operating that are not identified on  
27 this list.

28 <sup>3</sup> See *id.*

<sup>4</sup> See, e.g., Amanda Holpuch, *Reports Reveal 'Egregious' Conditions in US Migrant Detention Facilities*, *The Guardian* (June 7, 2019),

1 available data from ICE, at least half of Defendants’ detention beds are at facilities  
 2 operated by private, for-profit companies.<sup>5</sup> Defendants’ choice to contract with  
 3 these entities, Defendants’ lack of oversight over the provision of care at Detention  
 4 Facilities, and Defendants’ failure to promulgate and enforce sufficient written  
 5 policies to govern the care of detained individuals subjects Plaintiffs and the Class  
 6 to a substantial risk of serious harm.

7 9. Because of the widespread unconstitutional conditions at ICE  
 8 detention centers, organizational plaintiffs Inland Coalition for Immigrant Justice  
 9 (“ICIJ”) and Al Otro Lado have had to divert substantial resources to responding to  
 10 those conditions, frustrating their respective organizational missions and interests in  
 11 empowering immigrants with disabilities.

12 10. ICE Health Service Corps (“IHSC”), a component of ICE, is  
 13 responsible for overseeing medical care at all of these facilities, and it directly  
 14 provides healthcare at some Detention Facilities.<sup>6</sup>

15 11. Defendants are also responsible for ensuring detained individuals  
 16 receive reasonable disability accommodations and otherwise do not suffer

17  
 18  
 19 [https://www.theguardian.com/us-news/2019/jun/07/us-migrant-detention-facilities-](https://www.theguardian.com/us-news/2019/jun/07/us-migrant-detention-facilities-egregious-conditions-reports)  
 20 [egregious-conditions-reports](https://www.theguardian.com/us-news/2019/jun/07/us-migrant-detention-facilities-egregious-conditions-reports); Ryan Devereaux et al., *Immigrant Detainee Accuses*  
 21 *ICE Contractor CoreCivic of Locking Him in Solitary Over \$8*, The Intercept (Apr.  
 22 19, 2018), [https://theintercept.com/2018/04/19/solitary-confinement-immigration-](https://theintercept.com/2018/04/19/solitary-confinement-immigration-detention-ice-corecivic/)  
 23 [detention-ice-corecivic/](https://theintercept.com/2018/04/19/solitary-confinement-immigration-detention-ice-corecivic/); John Burnett, *Miss. Prison Operator Out; Facility Called*  
 24 *a ‘Cesspool,’* NPR (Apr. 24, 2012),  
 25 [https://www.npr.org/2012/04/24/151276620/firm-leaves-miss-after-its-prison-is-](https://www.npr.org/2012/04/24/151276620/firm-leaves-miss-after-its-prison-is-called-cesspool)  
 26 [called-cesspool](https://www.npr.org/2012/04/24/151276620/firm-leaves-miss-after-its-prison-is-called-cesspool).

27 <sup>5</sup> Livia Luan, *Profiting from Enforcement: The Role of Private Prisons in U.S.*  
 28 *Immigration Detention*, Migration Policy Institute (May 2, 2018),  
[https://www.migrationpolicy.org/article/profitting-enforcement-role-private-prisons-](https://www.migrationpolicy.org/article/profitting-enforcement-role-private-prisons-us-immigration-detention)  
[us-immigration-detention](https://www.migrationpolicy.org/article/profitting-enforcement-role-private-prisons-us-immigration-detention).

<sup>6</sup> *ICE Health Services Corps*, ICE, <https://www.ice.gov/ice-health-service-corps>;  
 see also *ICE Health Services Corps*, ICE <https://www.ice.gov/ero/ihsc>.

1 discrimination based on disability, and they are also responsible for proper  
2 monitoring and oversight of segregation and isolation practices and policies.

3 12. Of the approximately 55,000 beds at Detention Facilities, a substantial  
4 percentage are in rural areas, at least an hour away from services needed to provide  
5 medical and mental health care or disability accommodations, far from attorneys  
6 who could provide representation and advocate for better conditions, and far from  
7 advocates, watchdog organizations, and media whose monitoring could expose or  
8 prevent abusive and unconstitutional conditions.<sup>7</sup> For example, Plaintiff Melvin  
9 Murillo Hernandez is detained at LaSalle ICE Processing Center (“LaSalle”), a  
10 two-and-a-half hour drive to the nearest Level 1 Trauma Center. Plaintiffs Faour  
11 Abdallah Fraihat, Jimmy Sudney, José Baca Hernández, Jose Segovia Benitez, Luis  
12 Manuel Rodriguez Delgadillo, Raul Alcocer Chavez, and Ruben Darío Mencías  
13 Soto are all detained at Adelanto ICE Processing Center (“Adelanto”), and may  
14 need to be taken to Los Angeles, approximately two hours away, for specialty care.  
15 Plaintiff Aristoteles Sanchez Martinez is detained at Stewart Detention Center  
16 (“Stewart”), over 45 minutes away from qualified medical specialists to handle  
17 specialized treatment or emergency situations.<sup>8</sup>

18 13. Specifically, Defendants have failed to ensure that conditions of  
19 confinement in Detention Facilities comply with statutory and constitutional  
20 requirements. As a result, unlawful conditions of confinement exist systemically  
21 throughout immigration detention centers, and place Plaintiffs and members of the  
22 Class at a substantial risk of serious harm.

23 \_\_\_\_\_  
24 <sup>7</sup> See ICE, *List of Over-72-Hour ICE Detention Facilities*, *supra* note 2.

25 <sup>8</sup> See, e.g., Britnee Davis, *Man Detained by ICE at Stewart Detention Center Dies*  
26 *in Columbus Hospital*, *Ledger Enquirer* (July 25, 2019), [https://www.ledger-](https://www.ledger-enquirer.com/news/local/article233120673.html)  
27 [enquirer.com/news/local/article233120673.html](https://www.ledger-enquirer.com/news/local/article233120673.html); see also Charles Bethea, *A*  
28 *Medical Emergency, and the Growing Crisis at Immigration Detention Centers*,  
*The New Yorker* (Sep. 13, 2017), [https://www.newyorker.com/news/news-desk/a-](https://www.newyorker.com/news/news-desk/a-medical-emergency-and-the-growing-crisis-at-immigration-detention-centers)  
[medical-emergency-and-the-growing-crisis-at-immigration-detention-centers](https://www.newyorker.com/news/news-desk/a-medical-emergency-and-the-growing-crisis-at-immigration-detention-centers).

1           14.     Approximately 24 people have died in ICE custody in the last two  
2 years.<sup>9</sup> During this fiscal year alone, at least seven individuals in ICE custody have  
3 died.<sup>10</sup>

4           15.     Defendants are fully aware of the deplorable conditions in Detention  
5 Facilities. As described more fully below, Defendants have been informed  
6 repeatedly—by their own inspection units, by other governmental inspectors and  
7 agencies, by nongovernmental entities, and by numerous other sources—that  
8 systemic unlawful conditions of confinement are rampant among its Detention  
9 Facilities. Yet Defendants have consistently and repeatedly failed to take any  
10 effective steps to monitor, oversee, and administer Detention Facilities, and to  
11 ensure that these violations do not recur. Defendants have thus condoned or been  
12 deliberately indifferent to the conduct that results in these unlawful conditions of  
13 confinement.

14           16.     Likewise, Defendants fail to ensure detained Plaintiffs and similarly  
15 situated detained individuals with disabilities receive equal access, reasonable  
16 accommodations, and placement in the least restrictive and most integrated setting  
17 possible in violation of Section 504 of the Rehabilitation Act (“Section 504”),  
18 29 U.S.C. § 794. Defendants regularly deny assistive devices and therapy to  
19 individuals with vision, hearing, and mobility disabilities. For example, Plaintiff  
20

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21 <sup>9</sup> Lisa Riordan et al., *22 immigrants died in ICE detention centers during the past 2*  
22 *years*, NBC News, (Jan. 6, 2019),  
23 [https://www.nbcnews.com/politics/immigration/22-immigrants-died-ice-detention-](https://www.nbcnews.com/politics/immigration/22-immigrants-died-ice-detention-centers-during-past-2-years-n954781)  
24 [centers-during-past-2-years-n954781](https://www.nbcnews.com/politics/immigration/22-immigrants-died-ice-detention-centers-during-past-2-years-n954781); ICE News Release, *ICE detainee passes*  
25 *away in Houston-area hospital* (July 1, 2019),  
26 <https://www.ice.gov/news/releases/ice-detainee-passes-away-houston-area-hospital>;  
27 *see also* Ariana Sawyer, *Another Needless Death in US Immigration Detention*,  
28 Human Rights Watch (July 26, 2019).

26 <sup>10</sup> ICE News Release, *ICE detainee passes away in Houston-area hospital* (July 1,  
27 2019), [https://www.ice.gov/news/releases/ice-detainee-passes-away-houston-area-](https://www.ice.gov/news/releases/ice-detainee-passes-away-houston-area-hospital)  
28 [hospital](https://www.ice.gov/news/releases/ice-detainee-passes-away-houston-area-hospital); *see also* Ariana Sawyer, *Another Needless Death in US Immigration*  
*Detention*, Human Rights Watch (July 26, 2019).



1 Ruben Darío Mencías Soto, who has dislocated and herniated discs in his back, had  
2 both his wheelchair and crutches taken away by detention staff leaving him without  
3 an assistive device to walk and in immense pain. Defendants also regularly confine  
4 those with mental health disabilities, as well as other disabilities, in restrictive  
5 segregation housing because of their disabilities, often exacerbating underlying  
6 conditions. Plaintiff Hamida Ali has schizophrenia, which was exacerbated when  
7 she was left in isolation at Aurora ICE Processing Center (“Aurora”) for about nine  
8 months. Plaintiff José Baca Hernández, who is blind, has not been provided  
9 accommodations and has had to rely on other detained individuals to read his  
10 immigration documents to him.

11 17. Defendants have the legal obligation to ensure that the conditions of  
12 confinement of individuals in their custody comply with statutory and constitutional  
13 requirements by providing adequate health care, providing disability  
14 accommodations, and ensuring that individuals are not subjected to punitive  
15 isolation. Defendants, however, have utterly failed to live up to these obligations.

16 18. Indeed, Defendants routinely ignore their responsibility to monitor and  
17 oversee Detention Facilities. For example, in July 2019, four Colorado politicians  
18 conducted an oversight visit to Aurora.<sup>11</sup> They reported that ICE claimed it had no  
19 medical authority at this facility or at other for-profit detention centers.<sup>12</sup>

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21  
22 <sup>11</sup> Blair Miller, *Colorado’s Congressional Democrats Tour Aurora ICE Facility,*  
23 *Call for Changes*, The Denver Channel (Jul. 22, 2019 6:52 PM),  
[https://www.thedenverchannel.com/news/politics/colorados-congressional-](https://www.thedenverchannel.com/news/politics/colorados-congressional-democrats-tour-aurora-ice-facility-call-for-changes-and-its-closure)  
24 [democrats-tour-aurora-ice-facility-call-for-changes-and-its-closure](https://www.thedenverchannel.com/news/politics/colorados-congressional-democrats-tour-aurora-ice-facility-call-for-changes-and-its-closure).

25 <sup>12</sup> Denver 7, *Colorado Dems Speak After Tour of ICE Facility*, Facebook (Jul. 22,  
26 2019, 12:16 PM),  
[https://www.facebook.com/DenverChannel/videos/2358219197839326/UzpfSTU4](https://www.facebook.com/DenverChannel/videos/2358219197839326/UzpfSTU4MDAwODE6MTAxMDYwNDQ1OTk4MzAzMzk/)  
27 [MDAwODE6MTAxMDYwNDQ1OTk4MzAzMzk/](https://www.facebook.com/DenverChannel/videos/2358219197839326/UzpfSTU4MDAwODE6MTAxMDYwNDQ1OTk4MzAzMzk/); U.S. Immigration & Customs  
28 Enf’t, Letter Response to February 28, 2019 Letter re: Public Health Risks &  
Treatment of Detainees at Detention Facilities (on file with Plaintiffs’ counsel).



1           23. Mr. Fraihat has been in the United States for most of his life, and he  
2 fears returning to Jordan because he has received death threats since converting  
3 from Islam to Christianity. Prior to being detained, he was living in San Bernardino,  
4 California, where he owned a successful construction business. Mr. Fraihat has  
5 been detained at Adelanto since December 2016. He was previously detained by  
6 ICE in three other facilities from 2004 to 2009.

7           24. Mr. Fraihat lost vision in his left eye while detained at Adelanto. He  
8 was denied care as his vision deteriorated; ICE did not provide a surgery  
9 recommended by an off-site doctor in April 2019. In July 2019, a doctor told Mr.  
10 Fraihat that his vision could not be restored with laser surgery due to the degree of  
11 his vision loss. He also continues to have pain in his left eye.

12           25. Upon arrival to Adelanto in December 2016, Mr. Fraihat reported an  
13 issue with a disc in his back and knee and back pain. He was provided with a  
14 temporary wheelchair, but it was taken away after a month, and he did not receive  
15 another wheelchair until February 2019, after months of his daily requests going  
16 unanswered. For the more than one year in between, Mr. Fraihat was unable to get  
17 to the yard or to the cafeteria to eat. During that time, he had to rely on officers to  
18 bring him food, which did not always occur, often requiring him to depend on food  
19 he purchased from the commissary.

20           26. Plaintiff Faour Abdallah Fraihat challenges Defendants' failure to  
21 ensure constitutionally adequate medical and mental health care, failure to ensure  
22 proper administration of segregation, and failure to ensure required  
23 accommodations and other measures required to comply with Section 504 at  
24 Detention Facilities.

25           **B. Plaintiff Marco Montoya Amaya**

26           27. Plaintiff Marco Montoya Amaya is 41 years old and currently detained  
27 at Mesa Verde ICE Processing Center ("Mesa Verde"). For over a year, he has had  
28

1 a tentative diagnosis of end-stage neurocysticercosis—a progressive, invasive, and  
2 severe brain parasite—for which he has received no treatment.

3 28. Mr. Montoya Amaya has also been diagnosed with several mental  
4 health conditions, and he regularly experiences memory loss and confusion, as well  
5 as visual and auditory hallucinations.

6 29. Mr. Montoya Amaya is a qualified individual with a disability as  
7 defined in the Rehabilitation Act.

8 30. Mr. Montoya Amaya entered the United States in 2012 and lived in  
9 Napa, California. When he entered ICE detention, Mr. Montoya Amaya was  
10 detained at the Yuba County Jail, and he was later transferred to the Mesa Verde  
11 ICE Processing Center in March 2019.

12 31. Plaintiff Marco Montoya Amaya challenges Defendants’ failure to  
13 ensure constitutionally adequate medical and mental health care, failure to ensure  
14 proper administration of segregation, and failure ensure compliance with Section  
15 504 at Detention Facilities.

16 **C. Plaintiff Raul Alcocer Chavez**

17 32. Plaintiff Raul Alcocer Chavez is 26 years old and currently detained at  
18 Adelanto Detention Center. He is Deaf, communicates in ASL, and is a qualified  
19 individual with a disability as defined in the Rehabilitation Act.

20 33. Mr. Alcocer Chavez has not been provided with an ASL interpreter.  
21 As a result, he did not at first understand that Adelanto is a Detention Facility, has  
22 had great difficulty communicating with medical staff, and has been asked to sign  
23 documents he did not understand. He has also never been able to access a  
24 videophone, and thus has never had a call with a lawyer. Instead, he has received  
25 only very limited access to a teletypewriter (a “TTY”), an outdated device that he  
26 has great difficulty using because his reading and writing skills in English are  
27 limited, and limited access to Skype, which he is currently prevented from using.  
28

1           34. Mr. Alcocer Chavez is a past Deferred Action for Childhood Arrivals  
2 recipient from Mexico. Prior to being detained, he was living in Riverside,  
3 California, and he graduated from the California School for the Deaf. Mr. Alcocer  
4 Chavez has been detained at Adelanto since May 22, 2019. He has previously been  
5 detained by ICE at Pahrump Detention Center in Nevada.

6           35. Plaintiff Raul Alcocer Chavez challenges Defendants' failure to ensure  
7 constitutionally adequate medical and mental health care and their failure to ensure  
8 compliance with Section 504 at Detention Facilities.

9           **D. Plaintiff Jose Segovia Benitez**

10           36. Plaintiff Jose Segovia Benitez is a 38-year old U.S. Marine Corps  
11 veteran. He served in the Marine Corps for five years and did two tours of duty, one  
12 for Operation Iraqi Freedom and one for Operation Enduring Freedom. He was  
13 brought to the United States when he was a toddler, and he grew up wanting to  
14 serve in the military and fight for his country as soon as he turned 18. He lived in  
15 Long Beach, California, before he was detained.

16           37. In 2003, while deployed, Mr. Segovia Benitez was badly hurt by an  
17 explosive device. He came home from service with depression, anxiety, hearing  
18 loss, traumatic brain injury, and combat PTSD. He is a qualified individual with a  
19 disability as defined in the Rehabilitation Act.

20           38. Mr. Segovia Benitez also has a heart condition. Since arriving at  
21 Adelanto in January 2018, where he has since been detained, he has informed his  
22 doctors of intermittent chest pain, dizziness, and other cardiology-related  
23 symptoms, for which treatment has been delayed or denied. On at least one  
24 occasion, he required emergency care to treat his heart condition.

25           39. Mr. Segovia Benitez has assisted in translating for deaf detainees at  
26 Adelanto; although he is not fluent in ASL, he took three semesters of ASL at  
27 community college. He has translated without any prompting from Adelanto, and  
28

1 he has assisted several deaf detainees in their requests to access the  
2 accommodations and communication technologies to which they are entitled, and to  
3 which Adelanto has denied them access. He has been deeply angered and frustrated  
4 that deaf detainees do not have access to essential services they need.

5 40. Plaintiff Jose Segovia Benitez challenges Defendants' failure to ensure  
6 constitutionally adequate medical and mental health care and their failure to ensure  
7 compliance with Section 504 at Detention Facilities.

8 **E. Plaintiff Hamida Ali**

9 41. Plaintiff Hamida Ali is 28 years old and currently detained at the  
10 Teller County Jail in Colorado ("Teller"), which contracts with ICE to hold  
11 individuals in ICE custody. She was taken into ICE custody from the Salt Lake  
12 County Jail, where she was receiving psychotropic medications and had expressed  
13 suicidal ideation during her incarceration. She was transferred to ICE custody and  
14 taken to Aurora in October 2018. She has been diagnosed with schizophrenia for  
15 several years and is a qualified individual with a disability as defined in the  
16 Rehabilitation Act. Ms. Ali is a native Arabic speaker and speaks English with  
17 limited reading and writing skills.

18 42. Ms. Ali is a refugee from Sudan and has been in the United States for  
19 most of her life. Before her detention, she was living in Utah with her extended  
20 family and three young children, all of whom were born in Utah. Almost  
21 immediately after being transferred to ICE, she was placed on suicide watch and  
22 then isolated in a dorm alone for approximately nine months. As a result of her  
23 segregation, Ms. Ali experienced several episodes of extreme psychological distress  
24 and suicidal ideation. Since July 9, 2019, she has been in ICE custody at Teller  
25 County.

26 43. At least once since her transfer to Teller, she has had to stay overnight  
27 at Aurora for court and placed in isolation. Given ICE's unpredictable transfer  
28

1 practices, Ms. Ali remains at risk of being returned to Aurora and placed back in a  
2 dorm by herself or in another form of segregation at Teller or any other facility  
3 where she is housed.

4 44. Plaintiff Hamida Ali challenges Defendants' failure to ensure  
5 constitutionally adequate medical and mental health care, failure to ensure proper  
6 administration of the use of segregation, and failure to ensure compliance with  
7 Section 504 at Detention Facilities.

#### 8 **F. Plaintiff Melvin Murillo Hernandez**

9 45. Plaintiff Melvin Murillo Hernandez is 18 years old and currently  
10 detained at LaSalle in Jena, Louisiana.

11 46. Mr. Murillo Hernandez has multiple life-threatening food allergies, for  
12 which he was not given a special diet for more than six months while in ICE  
13 custody. As a result, he has suffered seven severe allergic reactions, four of which  
14 required hospitalization due to anaphylactic shock.

15 47. Mr. Murillo Hernandez has been placed in medical segregation since  
16 arriving at LaSalle in May 2019, solely based on his severe allergies. Though he  
17 relied on other detained individuals to bring him to facility staff during previous  
18 anaphylactic shocks in which he lost consciousness, he is now confined alone in a  
19 cell 24 hours a day. Facility staff now bring all of his meals, which consist mostly  
20 of eggs and rice, to his cell.

21 48. Mr. Murillo Hernandez is a qualified individual with a disability as  
22 defined in the Rehabilitation Act.

23 49. Prior to being detained at LaSalle, Mr. Murillo Hernandez, was  
24 detained at Tallahatchie County Correctional Facility ("Tallahatchie") and  
25 Mississippi and River Correctional Center ("River").  
26  
27  
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1           50. Plaintiff Melvin Murillo Hernandez challenges Defendants' failure to  
2 ensure constitutionally adequate medical and mental health care and their failure to  
3 ensure compliance with Section 504 in Detention Facilities.

4           **G. Plaintiff Jimmy Sudney**

5           51. Plaintiff Jimmy Sudney is 28 years old and currently detained at  
6 Adelanto. He has vision loss, mental health disabilities including PTSD, and high  
7 blood pressure, and is a qualified individual with a disability as defined in the  
8 Rehabilitation Act.

9           52. Mr. Sudney came to the United States as a Lawful Permanent Resident  
10 in 2012 and lived in Chandler, Arizona. Prior to being arrested in July 2014, Mr.  
11 Sudney was studying nursing at Arizona State University and working as a medical  
12 technician and certified caregiver at senior living, memory care, and retirement  
13 facilities.

14           53. Prior to arriving at Adelanto in May 2018, Mr. Sudney was detained at  
15 Eloy Detention Center ("Eloy"), where he had been in ICE custody since December  
16 2016.

17           54. Mr. Sudney has experienced numerous delays in care for his vision.  
18 Prior to being transferred to ICE, he had two surgeries to address his vision loss,  
19 but was transferred before his third scheduled surgery in December 2016. The third  
20 surgery was scheduled to address glaucoma, a second-degree cataract, and a  
21 detaching retina. While at Eloy, Mr. Sudney required emergency off-site care  
22 related to his eye on three separate occasions. Mr. Sudney continues to lose vision  
23 in his eye—it is blurry when he reads, stays red, and he is starting to see flashing  
24 light and dripping on his eye.

25           55. In retaliation for filing a grievance against an officer, Mr. Sudney was  
26 improperly placed in segregation at Adelanto for a week. While in isolation, Mr.  
27  
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1 Sudney heard banging in and around his cell that triggered a PTSD flashback in  
2 which he relived the earthquake in Haiti where his house collapsed around him.

3 56. Plaintiff Jimmy Sudney challenges Defendants' failure to ensure  
4 constitutionally adequate medical and mental health care, failure to ensure proper  
5 administration of the use of segregation, and failure to ensure compliance with  
6 Section 504 at Detention Facilities.

#### 7 **H. Plaintiff José Baca Hernández**

8 57. Plaintiff José Baca Hernández is 23 years old and currently detained at  
9 Adelanto. Mr. Baca is blind and is a qualified individual with a disability as defined  
10 in the Rehabilitation Act.

11 58. Mr. Baca has been in the United States for most of his life. Prior to  
12 detention, he was living in Orange County, California, working as a dishwasher,  
13 and seeking a U-Visa because he was the victim of a crime in the United States.  
14 Prior to being transferred to Adelanto in April 2018, Mr. Baca was detained at  
15 ICE's Theo Lacy Facility ("Theo Lacy").

16 59. Mr. Baca became blind in January 2015 after being shot. Since being  
17 in ICE custody, Mr. Baca has not been provided effective communication. He has  
18 to rely on his cell mates, attorneys, and, at times, guards to read any documents,  
19 including those related to his medical care and immigration case. When Mr. Baca  
20 needs to submit a written request, as required to meet with an ICE officer or access  
21 medical care, he has to rely on others to write it for him.

22 60. Plaintiff José Baca Hernández challenges Defendants' failure to ensure  
23 constitutionally adequate medical and mental health care, failure to ensure proper  
24 administration of the use of segregation, and failure to ensure compliance with  
25 Section 504 at Detention Facilities.  
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**I. Plaintiff Edilberto García Guerrero**

1  
2 61. Plaintiff Edilberto García Guerrero is 47 years old. He was a long-time  
3 resident of Utah prior to being detained by ICE in April 2018. His wife and teenage  
4 daughter are both U.S. citizens and still reside in Utah. Mr. García Guerrero speaks  
5 Spanish and has limited reading and writing skills.

6 62. Mr. García Guerrero is currently detained at Aurora. He has chronic  
7 pain in his neck and shoulder on his left side. This chronic pain is the result of an  
8 attack he suffered while in ICE custody during the spring of 2019. Mr. García  
9 Guerrero also has low vision in his left eye and is hard of hearing in his left ear,  
10 both of which has been left untreated since the attack. He has alerted the facility to  
11 these issues and has still not received treatment.

12 63. Additionally, Mr. García Guerrero has extreme pain and swelling in  
13 his right ankle. Several years prior to his detention, he fell off a roof, shattering his  
14 leg and requiring reconstructive surgery, including the placement of screws in his  
15 right ankle. More recently, Mr. García Guerrero suffered another injury to his right  
16 ankle, which occurred after falling down while his ankles were shackled in ICE  
17 custody. An outside specialist recommended surgical intervention. However, the  
18 GEO group, which operates the facility under a contract with ICE, has long refused  
19 to provide the surgery, choosing to treat it as “elective” until, on information and  
20 belief, days before the filing of this Complaint.

21 64. Plaintiff Edilberto García Guerrero challenges Defendants’ failure to  
22 ensure constitutionally adequate medical and mental health at Detention Facilities.

**J. Plaintiff Martín Muñoz**

23  
24 65. Plaintiff Martín Muñoz has been detained at Adelanto Detention  
25 Center for more than two years. He has insulin-dependent Type 2 diabetes, high  
26 cholesterol, high blood pressure, depression, and anxiety.

27 66. Mr. Muñoz has been in the United States for more than 40 years. Prior  
28 to being detained, he was living in Riverside County, California, where he worked

1 as a handyman for more than 25 years. He has four grown children who are United  
2 States citizens.

3 67. In September 2017, Mr. Muñoz had an insulin overdose when  
4 Adelanto staff administered more than triple his regular dose. Because the  
5 administration of too much insulin can lead to a hypoglycemic coma, Mr. Muñoz  
6 was taken to medical observation when Adelanto staff realized the mistake, and  
7 Adelanto staff wrote him a letter admitting fault. In the aftermath of this overdose,  
8 Mr. Muñoz was never evaluated by a doctor.

9 68. Mr. Muñoz has also gone without insulin and high blood pressure  
10 medication several times while in ICE detention. In February 2019, he went without  
11 insulin for six days because his doctor had not timely refilled his prescription; in  
12 Spring 2019, Adelanto ran out of high blood pressure medication and it took two  
13 weeks for Mr. Muñoz to receive it again. In Summer 2019, he again did not receive  
14 insulin for 10 days, following a medical encounter in which staff told him that  
15 insulin was not in the system for him. At the end of July, he went a week without  
16 Lipitor, his cholesterol medication, despite asking a nurse for it at pill pass three  
17 times.

18 69. Plaintiff Martín Muñoz challenges Defendants' failure to ensure  
19 constitutionally adequate medical care and failure to ensure compliance with  
20 Section 504 at Detention Facilities.

### 21 **K. Plaintiff Luis Manuel Rodriguez Delgadillo**

22 70. Plaintiff Luis Manuel Rodriguez Delgadillo is 29 years old and has  
23 been detained at Adelanto since March 2019.

24 71. Mr. Rodriguez Delgadillo is a nearly lifelong California resident; most  
25 of his family members are United States citizens, including his two small children.  
26 Prior to his detention, he resided in Palm Desert, California.  
27  
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1           72. Prior to his detention, Mr. Rodriguez Delgadillo had been diagnosed  
2 with schizophrenia and bipolar disorder, for which he was taking medication, and  
3 he is a qualified person with a disability as defined in the Rehabilitation Act. After  
4 years of instability and acute psychotic episodes, with the support of his family and  
5 in the care of a treating psychiatrist, Mr. Rodriguez Delgadillo had finally achieved  
6 some measure of mental health stability before he was detained. However, since his  
7 detention at Adelanto, his shifting medication regime, lack of therapy and failure of  
8 mental health staff to mitigate stressors, have all caused his mental health to  
9 noticeably decline.

10           73. Mr. Rodriguez Delgadillo has missed court on two occasions due to  
11 placement in medical observation after expressing suicidal or other harmful  
12 ideation. His detention has thus been prolonged by inadequate mental health  
13 treatment.

14           74. Plaintiff Luis Manuel Rodriguez Delgadillo challenges Defendants'  
15 failure to ensure constitutionally adequate medical and mental health care and  
16 failure to ensure compliance with Section 504 at Detention Facilities.

17           **L. Plaintiff Ruben Darío Mencías Soto**

18           75. Plaintiff Ruben Darío Mencías Soto came to the United States to seek  
19 refuge. Mr. Mencías Soto is 36 years old and has been detained at Adelanto since  
20 December 2018.

21           76. Mr. Mencías Soto is a qualified individual with a disability as defined  
22 in the Rehabilitation Act. Since December 2018, he has suffered from severe back  
23 and leg pain due to a nerve compression and a herniated disc in his back after  
24 falling in the shower at Adelanto. Due to his pain, he is unable to walk without  
25 assistance, and facility staff have given him a single physical therapy appointment.

26           77. Additionally, though Mr. Mencías Soto requires both a wheelchair and  
27 crutches to fully access the Adelanto facility, staff at various times have taken both  
28

1 of those mobility aids away from him. Mr. Mencías Soto remains without crutches,  
2 and his mobility is severely limited. He had a wheelchair taken away from him for  
3 over a month, such that he was regularly unable to go to the cafeteria to eat. It was  
4 only returned upon the intervention of his attorney.

5 78. Plaintiff Ruben Darío Mencías Soto challenges Defendants' failure to  
6 ensure constitutionally adequate medical care and failure to ensure compliance with  
7 Section 504 at Detention Facilities.

8 **M. Plaintiff Alex Hernandez**

9 79. Plaintiff Alex Hernandez is 48 years old and currently detained at  
10 Etowah County Detention Center ("Etowah"). He has a torn rotator cuff in his right  
11 shoulder, as well as persistent pain and inflammation in his back, right hip, legs,  
12 and both feet, which limit his mobility, range of motion, and ability to engage in  
13 activities of daily living. He is also diagnosed with Barrett's esophagus,  
14 hypertension, and PTSD, and he has some vision loss. Mr. Hernandez is a qualified  
15 individual with a disability as defined in the Rehabilitation Act.

16 80. Mr. Hernandez has been in the United States for most of his life. He  
17 was previously a resident of Los Angeles, California.

18 81. Prior to his transfer to Etowah on December 20, 2018, ICE detained  
19 Mr. Hernandez at the Alexandria Staging Facility ("Alexandria"), Otay Mesa  
20 Detention Center ("Otay Mesa"), LaSalle, and Mesa Verde. Mr. Hernandez has  
21 been in ICE custody since October 2016.

22 82. Mr. Hernandez has seen three different orthopedic surgeons who have  
23 recommended surgery to repair his torn rotator cuff, but ICE has not provided the  
24 surgery. He experiences severe pain on a daily basis due to his torn rotator cuff.

25 83. Mr. Hernandez also has chronic and severe pain in both feet, his right  
26 hip, legs, and his lower back, which makes it painful for him to stay standing up for  
27 more than twenty minutes at a time.  
28

1           84. Mr. Hernandez has been placed in segregation and denied access to  
2 recreation spaces, the law library, and a telephone to contact his family and  
3 attorney.

4           85. Plaintiff Alex Hernandez challenges Defendants’ failure to ensure  
5 constitutionally adequate medical and mental health care, failure to ensure proper  
6 administration of segregation, and failure to ensure compliance with Section 504 at  
7 Detention Facilities.

8           **N. Plaintiff Aristoteles Sanchez Martinez**

9           86. Plaintiff Aristoteles Sanchez Martinez is 46 years old and currently  
10 detained at Stewart. He is diagnosed with diabetes, neuropathy, hypertension, bone  
11 spur on left foot, Charcot foot, avascular necrosis, non-palpable pulses in lower  
12 extremities, and venous insufficiency, and is a qualified individual with a disability  
13 as defined in the Rehabilitation Act. Mr. Sanchez Martinez also has a large right  
14 flank hernia on his abdomen that causes severe pain.

15           87. Since being in ICE custody, Mr. Sanchez Martinez’s health has  
16 worsened. He uses a wheelchair because he is unable to walk due to his right flank  
17 hernia, Charcot foot, avascular necrosis, and non-palpable pulse and venous  
18 insufficiency in his lower extremities.

19           88. Mr. Sanchez Martinez has been in ICE custody since September 11,  
20 2018. Prior to arriving at Stewart on October 3, 2018, Mr. Sanchez Martinez was  
21 confined at the Folkston ICE Processing Center (“Folkston”).

22           89. Mr. Sanchez Martinez has been in the United States over half his life,  
23 and he formerly resided in Queens, New York.

24           90. Plaintiff Aristoteles Sanchez Martinez challenges Defendants’ failure  
25 to provide constitutionally adequate medical and mental health care and failure to  
26 ensure compliance with Section 504 in Detention Facilities.  
27  
28

1           **O. Plaintiff Sergio Salazar Artaga**

2           91. Mr. Salazar Artaga is 25 years old and currently detained at Florence  
3 Correctional Center (“Florence”). Mr. Salazar Artaga has been in the United States  
4 since the age of one. Before entering ICE custody, he was living in Phoenix,  
5 Arizona.

6           92. Mr. Salazar Artaga has cerebral palsy and is a qualified individual with  
7 a disability as defined in the Rehabilitation Act. He has chronic pain in his back and  
8 knees, for which he has not received appropriate, consistent pain medication for  
9 pain management

10          93. Mr. Salazar Artaga uses a cane and is awaiting leg and knee braces for  
11 stability as he walks around. Without these braces, he has fallen three times already  
12 since coming to Florence.

13          94. In addition, Mr. Salazar Artaga was unable to see a mental health care  
14 provider for an evaluation and anti-psychotic medications until after a month of  
15 detention, after he had been put on suicide watch twice for self-harming behavior  
16 and hallucinations. Florence has since diagnosed him with anxiety disorder  
17 and atypical psychosis.

18          95. He has been detained by ICE at Florence since March 2019.

19          96. Plaintiff Sergio Salazar Artaga challenges Defendants’ failure to  
20 ensure constitutionally adequate medical and mental health care and failure to  
21 ensure compliance with Section 504 at Detention Facilities.

22           **P. Plaintiff Inland Coalition for Immigrant Justice**

23          97. Plaintiff Inland Coalition for Immigrant Justice (“ICIJ”) is a nonprofit,  
24 nonpartisan organization established in 2008 in California. ICIJ has a nonprofit  
25 fiscal sponsor also incorporated in California and is working towards nonprofit  
26 incorporation.

27          98. ICIJ is an immigrant-led community-based coalition organization that  
28 promotes justice for immigrants in the Inland Empire region of California,

1 headquartered in Ontario, California. ICIJ's mission is convening organizations to  
2 collectively advocate and work to improve the lives of immigrant communities  
3 while working toward a just solution to the immigration system.

4 99. ICIJ engages in capacity building, community forums, and community  
5 engagement, carrying out such activities as public advocacy, providing community  
6 resources, educating the immigrant community, and ensuring that immigrant voices  
7 are part of substantial public discussions. As the result of substandard conditions,  
8 ICIJ has been forced to devote a growing portion of its work is to support people  
9 detained in ICE custody at Adelanto Detention Center, which is less than an hour  
10 away from ICIJ's main office, diverting its resources from other organizational  
11 activities.

12 100. Defendants' constitutionally inadequate policies regarding conditions  
13 of confinement and failure to provide disability accommodations have frustrated  
14 Plaintiff ICIJ's mission, as well as ICIJ's organizational interest in empowering  
15 immigrants with disabilities. Defendants' policies and practices have forced ICIJ to  
16 divert significant resources away from its other programs and its assistance of other  
17 migrants, refugees, asylum seekers, and Inland Empire immigrant communities.

18 101. Because of Defendants' failure to provide and ensure constitutionally  
19 adequate medical care and mental health care, and to ensure disability  
20 accommodations and other measures required by Section 504 of the Rehabilitation  
21 Act to detained individuals in immigration detention, ICIJ has been forced to  
22 expend additional, significant resources on organizing work in support of  
23 immigrants in ICE custody in Adelanto. Since November 2018, ICIJ has had a staff  
24 member who works full-time to support people at Adelanto, including those who  
25 are vulnerable in detention due to medical conditions, mental health disabilities, and  
26 other disabilities. Along with several partner organizations, the staff member  
27 organizes a network of volunteer visitors to detained people at Adelanto. She  
28 provides training to the volunteers. She supports families of detained people who



1 have medical issues by helping gather medical records, drafting letters of support,  
2 and communicating with ICE regarding the medical needs. She coordinates with  
3 doctors for medical opinions and other support. Further, ICIJ is in the process of  
4 hiring a coordinator to do medical referrals full-time.

5 102. A second ICIJ staff member works to secure legal representation to  
6 defend from deportation Inland Empire residents and asylum seekers who are  
7 detained at Adelanto. She also coordinates a rapid response network to try to  
8 prevent more detentions at Adelanto.

9 103. A third ICIJ staff member splits his time between organizing on behalf  
10 of detained individuals at Adelanto and coordinating deportation defense for people  
11 at Adelanto. He particularly focuses on support for people who are getting released  
12 from Adelanto, including housing and immediate medical attention.

13 104. ICIJ has developed a protocol to advocate on behalf of people at  
14 Adelanto who are experiencing medical emergencies, a time-intensive process that  
15 involves coordinating with family members and previous medical providers;  
16 referring individuals to a collaborating social worker when the emergency has a  
17 mental health component; and intensely advocating with ICE at Adelanto to try to  
18 ensure that the emergency is addressed. By way of example, ICIJ activated the  
19 protocol on behalf of a man who was receiving experimental treatment for a serious  
20 medical condition, whose immune system had been weakened by the treatment, and  
21 who was at risk of missing necessary doses of the treatment because Adelanto  
22 would not accept any information about it.

23 105. Most recently, in June 2019, ICIJ spent significant resources to open  
24 an office in Adelanto. This office will serve as the headquarters for the staffer who  
25 organizes at Adelanto, as well as a location for visitation volunteers and family  
26 members visiting loved ones detained at Adelanto to rest, prepare for their visits,  
27 and share information with ICIJ staff.

28

1           106. If ICIJ were not forced to divert so many resources to addressing  
2 Defendants' unlawful practices at Adelanto, the organization would have more  
3 capacity to conduct advocacy on behalf of immigrants in San Bernardino County  
4 and throughout the state of California; to provide more legal services for affirming  
5 the rights of immigrants, not defending them from deportation; and working to  
6 promote the rights of and justice for immigrant communities in Southern California.

7           107. ICIJ has also dedicated staff time and fundraising efforts to paying  
8 bonds for people detained at Adelanto. ICIJ prioritizes paying bonds for immigrants  
9 whose mental or physical health has deteriorated while being detained. For  
10 example, the largest bond they have raised money for was \$21,000 for a young man  
11 whose mental health deteriorated over the course of his prolonged detention and for  
12 his brother.

13           108. Moreover, ICIJ diverts significant resources to situating its work at  
14 Adelanto and throughout the Inland Empire in the national landscape of  
15 immigration trends, including federal detention policies and practices and  
16 organizing efforts around them. For example, ICIJ is a paying member of a national  
17 network that coordinates support for detained immigrants. ICIJ also tracks  
18 information and provides it to national organizations who are looking for on-the-  
19 ground, up-to-date information about Adelanto. ICIJ spends resources to send staff  
20 members to conferences throughout the country and spends staff time preparing  
21 presentations and information to be shared.

22           109. Plaintiff Inland Coalition for Immigrant Justice challenges Defendants'  
23 failure to ensure constitutionally adequate medical and mental health care, failure to  
24 ensure proper administration of segregation, and failure to ensure compliance with  
25 Section 504 at Detention Facilities.

1           **Q. Plaintiff Al Otro Lado**

2           110. Plaintiff Al Otro Lado is a nonprofit, nonpartisan organization  
3 established in 2014 and incorporated in California.

4           111. Al Otro Lado is a legal services organization that serves indigent  
5 migrants, refugees, deportees, and their families, and operates primarily in Los  
6 Angeles, California; San Diego, California; and Tijuana, Mexico; although it  
7 provides referrals and assistance to indigent migrants and refugees across the  
8 United States. Al Otro Lado's mission is to coordinate and provide screening,  
9 advocacy, and legal representation for individuals in immigration proceedings; to  
10 seek redress for civil rights violations, including disability rights violations; and to  
11 provide assistance with other legal and social service needs.

12           112. Defendants' constitutionally inadequate policies regarding conditions  
13 of confinement and failure to provide disability accommodations have frustrated  
14 Plaintiff Al Otro Lado's mission, as well as Al Otro Lado's organizational interest  
15 in supporting and empowering migrants, refugees, and deportees with disabilities.  
16 Defendants' policies and practices have forced Al Otro Lado to divert significant  
17 resources away from its other programs and its assistance of other migrants,  
18 refugees, asylum-seekers, and deportees, and have made it much harder and more  
19 resource-intensive for Al Otro Lado to represent many of its existing detained  
20 clients in their immigration proceedings.

21           113. Because of Defendants' failure to provide and ensure constitutionally  
22 adequate physical medical care and disability accommodations to detained  
23 individuals in immigration detention, Al Otro Lado has been forced to expend  
24 additional, significant resources when assisting detained clients with  
25 unaccommodated, untreated, and poorly treated medical conditions that it is not  
26 required to expend for its other clients. In such situations, Al Otro Lado must  
27 conduct additional and often lengthy in-detention visits, advocacy, investigation,  
28 medical record requests, and medical expert review to advocate for its clients' right

1 to medical treatment and accommodations, while also representing its clients in  
2 immigration proceedings. If Al Otro Lado's clients were provided with appropriate  
3 medical care and accommodations, it would be able to take on additional cases with  
4 the extra time and resources it currently spends on its detained clients with  
5 unaccommodated disabilities and poorly treated medical problems.

6 114. Al Otro Lado has and has had many detained clients with medical  
7 conditions requiring additional advocacy, most of whom are or were detained at  
8 Otay Mesa and Adelanto. Al Otro Lado's management estimates that staff must  
9 spend at least one-third more staff resources to represent its clients with untreated  
10 or unaccommodated medical conditions in immigration proceedings as a result of  
11 Defendants' policies.

12 115. For example, an Al Otro Lado staff attorney spent several days  
13 investigating and advocating for a client with HIV to get the medicine they needed  
14 to be safe in immigration detention, such that the client would be healthy and stable  
15 enough to proceed on their immigration case for which Al Otro Lado was originally  
16 retained.

17 116. As another example, Al Otro Lado has had two clients lose  
18 pregnancies in custody due to a detention facility's failure to provide timely  
19 medical intervention. Consequently, Al Otro Lado staff have had to expend  
20 significant additional time to prepare pregnant asylum seekers to enter custody,  
21 including counseling asylum seekers regarding the potential risk of miscarriage and  
22 coordinating with medical providers to obtain documentation of pregnancy.

23 117. Further, because of Defendants' failure to provide constitutionally  
24 adequate conditions and mental health care, Al Otro Lado has been forced to  
25 expend additional resources to represent its detained clients with serious mental  
26 health conditions in their immigration proceedings. When Defendants do not  
27 properly treat Al Otro Lado's clients' mental health conditions, or improperly place  
28 such clients in segregation and thus worsen their mental health conditions, it is

1 more challenging for Al Otro Lado to visit and communicate with, and thus  
2 advocate for and defend, its clients. Al Otro Lado staff have to spend additional  
3 time and resources to develop the cases of its clients with poorly treated mental  
4 health conditions that, if those conditions were properly treated, could instead be  
5 spent on representing a larger number of clients and on pursuing other programs.

6 118. Almost all of Al Otro Lado's detained clients have mental health  
7 conditions, many of which require additional advocacy. Staff must regularly go to  
8 meet with clients with serious mental health conditions more times than they would  
9 otherwise need to for other clients they are representing in immigration  
10 proceedings, solely due to Defendants' failure to provide constitutionally adequate  
11 mental health care.

12 119. For example, Al Otro Lado's detained clients with schizophrenia and  
13 other serious mental health conditions are often unnecessarily taken off medications  
14 that previously provided those clients with mental health stability out of detention.  
15 When that happens, Al Otro Lado attorneys are often unable to communicate with  
16 these clients, and thus must either visit their clients more often in the hope of  
17 visiting with them on a day when communication with the client is possible; visit  
18 them in an off-site hospital setting where it is impossible to see the client in a  
19 private setting, and where staff may be required to spend a great deal of time to  
20 even seek permission to visit their clients; or take other additional efforts to  
21 investigate their clients' cases to be able to adequately and ethically present those  
22 cases in immigration court.

23 120. In addition, in response to Defendants' failure to provide  
24 constitutionally adequate conditions and disability accommodations, Al Otro Lado  
25 often diverts staff time and other resources to represent detained individuals in need  
26 of an urgent change in circumstances—including provision of essential medical  
27 care, accommodations, or other constitutionally adequate conditions of  
28 confinement—solely on bond or parole.

1           121. As one of many examples, upon learning that a detained client who  
2 was HIV-positive was in a dire medical condition that was largely going untreated,  
3 an Al Otro Lado attorney expedited his medical parole application due to the  
4 severity of his condition. The attorney was unable to complete a variety of other  
5 work for other clients during that emergency period, and instead spent additional  
6 time coordinating with doctors, finding the client adequate shelter that could  
7 support the client's condition, and pursuing parole, among other things.

8           122. Several of Defendants' failures to provide constitutionally adequate  
9 conditions and accommodations overlap for the same Al Otro Lado clients. For  
10 example, a number of Al Otro Lado's detained clients are both trans and HIV-  
11 positive. Staff often are required to expend extra resources to advocate for adequate  
12 medical and mental health treatment for these clients, ranging from advocating in  
13 the face of the provision of inappropriate retro-viral medication or no medication,  
14 inappropriate mental health treatment, placement in housing units with people with  
15 infectious diseases that uniquely threaten people with HIV, and prolonged isolation  
16 and solitary confinement nominally because of potential exposure to infection  
17 diseases like mumps and the chicken pox, among other issues.

18           123. Because of Defendants' known failure to provide adequate medical  
19 and mental health care and appropriate health screenings, Al Otro Lado has also  
20 had to divert resources in Tijuana, Mexico, to coordinate and in some instances pay  
21 for medical examinations and treatment for asylum-seekers and migrants who may  
22 be detained upon their entry into the United States, as well as to otherwise  
23 coordinate documentation of their medication condition so that they may advocate  
24 for their need for medical treatment upon entering custody. If asylum-seekers and  
25 migrants were able to receive appropriate health screenings upon entry into  
26 Defendants' custody, and to receive appropriate treatment upon entry into their  
27 custody, Al Otro Lado could instead coordinate its resources to support asylum-  
28 seekers and migrants in other ways aligned with its mission.

1           124. In addition, in part as a result of Defendants' failure to provide  
2 adequate medical care and appropriate health screenings, the detention facilities in  
3 which Al Otro Lado visits clients have had numerous outbreaks of mumps and  
4 chicken pox to which large populations of people in detention may have been  
5 exposed. These outbreaks result in lengthy quarantines affecting many more of Al  
6 Otro Lado's clients than would otherwise be affected if Defendants had quickly  
7 identified and adequately addressed such infectious diseases. When clients are  
8 quarantined due to such failures, Al Otro Lado staff are unable to visit with clients  
9 about their immigration cases, and thus must put additional time into attempting  
10 more client visits, rescheduling visits, and rescheduling court dates.

11           125. Al Otro Lado also operates a pro bono referral service for migrants and  
12 asylum-seekers in detention across the country. Because of Defendants' failure to  
13 provide constitutionally adequate care and disability accommodations to people in  
14 its custody, Al Otro Lado has had to divert its very limited resources for providing  
15 referrals and seeking representation toward referrals for detained individuals at  
16 imminent risk of physical harm because of these policies, and thus away from other  
17 programs and services in line with its mission.

18           126. Plaintiff Al Otro Lado challenges Defendants' failure to ensure  
19 constitutionally adequate medical and mental health care, failure to ensure proper  
20 administration of segregation, and failure to ensure compliance with Section 504 at  
21 Detention Facilities.

## 22           **II. Defendants**

### 23           **A. Defendant U.S. Immigration Customs and Enforcement**

24           127. Defendant U.S. Immigration and Customs Enforcement is a  
25 component of DHS. As the principal investigative arm of DHS, ICE is charged with  
26 enforcement of immigration laws. ICE's primary duties include the investigation of  
27 persons suspected to have violated immigration laws, and the apprehension,  
28

1 detention, and removal of noncitizens who are unlawfully present in the United  
2 States.

3 **B. Defendant U.S. Department of Homeland Security**

4 128. Defendant U.S. Department of Homeland Security is a federal  
5 executive agency responsible for, among other things, enforcing federal  
6 immigration laws and overseeing lawful immigration to the United States.

7 **C. Defendant Kevin McAleenan, Acting Secretary of DHS**

8 129. Defendant Kevin McAleenan is the Acting Secretary of DHS, charged  
9 with enforcing and administering federal immigration laws. He oversees each of the  
10 agencies within DHS, including ICE. He has ultimate authority over all policies,  
11 procedures, and practices as applied to ICE Detention Facilities. Defendant  
12 McAleenan is sued in his official capacity.

13 **D. Defendant Matthew T. Albence, Acting Director of ICE**

14 130. Defendant Matthew T. Albence is the Acting Director of ICE, charged  
15 with enforcing federal immigration laws by detaining and removing noncitizens. He  
16 is charged with oversight and monitoring of all policies, procedures, and practices  
17 as applied to ICE Detention Facilities. Defendant Albence is sued in his official  
18 capacity.

19 **E. Defendant Derek N. Brenner, Deputy Director of ICE**

20 131. Defendant Derek N. Benner is the Deputy Director of ICE. In this  
21 capacity, Benner executes oversight of ICE's day-to-day operations and oversees a  
22 workforce of more than 20,000 employees assigned to more than 400 domestic and  
23 international offices. Defendant Benner is sued in his official capacity.

24 **F. Defendant Timothy S. Robbins, Acting Executive Associate Director of  
25 ERO**

26 132. Defendant Timothy S. Robbins is the Acting Executive Associate  
27 Director of Enforcement and Removal Operations ("ERO"). ERO enforces the  
28



1 nation's immigration laws, identifies and apprehends removable noncitizens, and  
2 detains and removes these individuals from the United States when necessary. In  
3 this capacity, Robbins manages 24 field offices nationwide. Defendant Robbins is  
4 sued in his official capacity.

5 **G. Defendant Tae Johnson, Assistant Director of Custody Management of**  
6 **ERO**

7 133. Defendant Tae Johnson is the Assistant Director of Custody  
8 Management, ERO. Johnson is responsible for policy and oversight of the  
9 administrative custody of detained immigrants. In this capacity, Johnson oversees  
10 and monitors detention operations, including those at local and state facilities  
11 operating under an Intergovernmental Service Agreement ("IGSA"), contract  
12 Detention Facilities, ICE-owned facilities, and facilities operated by the Bureau of  
13 Prisons ("BOP"). Defendant Johnson is sued in his official capacity.

14 **H. Defendant Dr. Stewart D. Smith, Assistant Director of ICE Health**  
15 **Service Corps**

16 134. Defendant Dr. Stewart D. Smith is the Assistant Director for ICE  
17 Health Service Corps, which provides medical, dental, and mental healthcare  
18 services at 21 facilities nationwide and manages off-site medical care for detained  
19 individuals housed in 240 additional IGSA facilities. Smith oversees, monitors, and  
20 is charged with ensuring adequate healthcare for all ICE detainees nationwide.  
21 Defendant Smith is sued in his official capacity.

22 **I. Defendant Jacki Becker Klopp, Assistant Director of Operations**  
23 **Support of ERO**

24 135. Defendant Jacki Becker Klopp is the Assistant Director of Operations  
25 Support, ERO. In this capacity, Klopp is responsible for formulation and execution  
26 of the overall budget of ICE detention, financial management, facilities  
27 management, and hiring and human resources management. Klopp also provides  
28

1 planning and oversight of ERO facilities and construction. Defendant Klopp is sued  
2 in her official capacity.

3 **J. Defendant David P. Pecoske, Senior Official Performing Duties of the**  
4 **Deputy Secretary of DHS**

5 136. Defendant David P. Pecoske is the Senior Official Performing the  
6 Duties of the Deputy Secretary of DHS. Upon information and belief, until the  
7 Deputy Secretary position is filled, Defendant Pecoske is the senior official charged  
8 with overseeing the day-to-day operations of DHS. Defendant Pecoske is sued in  
9 his official capacity.

10 **JURISDICTION**

11 137. Jurisdiction is proper pursuant to 28 U.S.C. §§ 1331 and 1343. This  
12 action seeks declaratory and injunctive relief under 28 U.S.C. §§ 1343, 2201, and  
13 2202, and 29 U.S.C. § 794a.

14 **VENUE**

15 138. Venue is properly in this district pursuant to 28 U.S.C. § 1391(e)(1),  
16 because at least one plaintiff resides in this district  
17

18 **FACTUAL ALLEGATIONS**

19 **III. Defendants Subject Thousands of Civil Detainees to Punitive Conditions**  
20 **Despite the Availability of Alternatives.**

21 139. Many detained individuals are recently arrived asylum seekers. These  
22 individuals have often fled traumatic violence, persecution, and severe deprivation  
23 in their home countries only to experience violence and further trauma on their  
24 journeys to this country. For example, according to some reports, approximately  
25  
26  
27  
28

1 one-third of asylum-seeking women experience sexual or gender-based violence on  
2 their journey to the U.S.<sup>14</sup>

3 140. Other detained individuals are individuals apprehended in the United  
4 States, who often have deep roots and family in this country and are dealing with  
5 the trauma of forced separation from their children and spouses and the prospect of  
6 that separation becoming permanent. For example, in 2017, Defendants deported  
7 approximately 27,080 individuals who had U.S. citizen children.<sup>15</sup> Based on data  
8 from 2016, nearly a third of unauthorized individuals live with a U.S. citizen child,  
9 and about 12% are married to a U.S. citizen.<sup>16</sup>

10 141. The majority of those detained by ICE have no experience with the  
11 prison system in this country or their country of origin. Most of the individuals in  
12 ICE custody have not been convicted of any crime. As of June 30, 2018, 58% of the  
13 individuals in ICE custody had no criminal convictions.<sup>17</sup> An even larger  
14

15 \_\_\_\_\_  
16 <sup>14</sup> *Forced to Flee Central America's Northern Triangle: A Neglected Humanitarian*  
17 *Crisis*, Doctors Without Borders, at 5 (May 2017),  
[https://www.doctorswithoutborders.org/sites/default/files/2018-06/msf\\_forced-to-flee-central-americas-northern-triangle.pdf](https://www.doctorswithoutborders.org/sites/default/files/2018-06/msf_forced-to-flee-central-americas-northern-triangle.pdf).

18 <sup>15</sup> See U.S. Immigration & Customs Enf't, Dep't of Homeland Sec., *Deportation of*  
19 *Aliens Claiming U.S.-Born Children*, at 6 (Oct. 12, 2017),  
20 <https://www.dhs.gov/sites/default/files/publications/ICE%20-%20Deportation%20of%20Aliens%20Claiming%20U.S.%20-%20Born%20Children%20-%20First%20Half%2C%20CY%202017.pdf>; U.S.  
21 Immigration & Customs Enf't, Dep't of Homeland Sec., *Deportation of Aliens*  
22 *Claiming U.S.-Born Children*, at 6 (June 26, 2018),  
23 <https://www.dhs.gov/sites/default/files/publications/ICE%20-%20Deportation%20of%20Aliens%20Claiming%20U.S.%20-%20Born%20Children%20-%20Second%20Half%2C%20CY%202017.pdf>.

24 <sup>16</sup> *Profile of the Unauthorized Population: United States*, Migration Policy Institute  
25 [https://www.migrationpolicy.org/data/unauthorized-immigrant-](https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/US#yearsresidence)  
26 [population/state/US#yearsresidence](https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/US#yearsresidence).

27 <sup>17</sup> Profiling Who ICE Detains—Few Committed Any Crime, TRAC Immigration  
28 (Oct. 9, 2018), <https://trac.syr.edu/immigration/reports/530/>.

1 proportion—four out of five—either had no record or had only committed a minor  
2 offense such as a traffic violation.<sup>18</sup>

3 142. Most individuals in ICE custody also do not speak English and  
4 therefore require interpreters, translators, or related technology to ensure that they  
5 can communicate with facility staff—including medical providers—and their  
6 immigration attorneys. Yet, ICE’s systemic failure to ensure that Detention  
7 Facilities consistently provide adequate interpretation services means that detained  
8 individuals are routinely unable to communicate with facility staff and their  
9 attorneys.<sup>19</sup>

10 143. It is estimated that between October 2010 and February 2013, the U.S.  
11 detained approximately 6,000 survivors of torture that were seeking asylum.<sup>20</sup>  
12 Based on the increased number of individuals who are currently being detained, it is  
13 likely that the number of survivors of torture who are detained has substantially  
14 increased since then.

15 144. Between 2013 and 2018, the United States deported at least 92  
16 veterans of the U.S. armed services.<sup>21</sup> From the data available, the U.S.  
17 Government Accountability Office (“GAO”) also identified 250 noncitizen veterans  
18 who were put in removal proceedings during this same time period.<sup>22</sup>

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20 <sup>18</sup> *Id.*

21 <sup>19</sup> *See, e.g.,* Xavier Becerra, Cal. Att’y Gen., *Immigration Detention in California*,  
22 Cal. Dep’t of Justice, at 61, 82, 123 (Feb. 2019),  
23 <https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2019.pdf>.

24 <sup>20</sup> *Tortured & Detained: Survivor Stories of U.S. Immigration Detention*, The  
25 Center for Victims of Torture et al., at 5 (Nov. 2013),  
26 [https://www.uusc.org/sites/default/files/report\\_torturedanddetained\\_nov2013.pdf](https://www.uusc.org/sites/default/files/report_torturedanddetained_nov2013.pdf).

27 <sup>21</sup> U.S. Gov’t Accountability Office, GAO-19-416, *Actions Needed to Better*  
28 *Handle, Identify, and Track Cases Involving Veterans*, at 16 (June 2019)  
<https://www.gao.gov/assets/700/699549.pdf>.

<sup>22</sup> *Id.*

1           145. Immigration proceedings are civil matters, and immigration detention  
2 is likewise civil and therefore should be “nonpunitive” in nature.<sup>23</sup> Accordingly,  
3 because neither Plaintiffs nor putative Class members are detained pursuant to  
4 criminal charges or convictions, the conditions in which they are held must reflect  
5 that distinct custody status and must not be similar to, or worse than, the conditions  
6 of confinement in jails and prisons.

7           146. In practice, however, individuals in immigration detention are held in  
8 punitive conditions that are similar to, and sometimes worse than, conditions of  
9 confinement in prisons and jails.

10           147. When the core standards governing detention in federal facilities were  
11 promulgated in January 2000, the U.S. Department of Justice allowed the core  
12 standards for immigration detention facilities to be the same as those governing the  
13 U.S. Bureau of Prisons.<sup>24</sup> Likewise, ICE’s current national standards governing  
14 immigration prisons were promulgated in cooperation with the American  
15 Correctional Association (“ACA”).<sup>25</sup>

16           148. Consistent with ICE’s history of relying upon a prison model for  
17 operating its facilities, most Detention Facilities are built and operated like  
18 correctional institutions—and many of them are, in fact, currently operative penal  
19 institutions.<sup>26</sup> They are ringed by chain link fences topped with barbed wire, and  
20 visitation is substantially restricted. Correctional officers strictly control movement

21 \_\_\_\_\_  
22 <sup>23</sup> See *Zadvydas v. Davis*, 533 U.S. 678, 690 (2001).

23 <sup>24</sup> Office of the Federal Detention Trustee, *Detention Standards & Compliance*  
24 *Division: History of the Federal Performance-Based Detention Standards*,  
<https://www.justice.gov/archive/ofdt/qap-brochure.pdf>.

25 <sup>25</sup> *Facility Inspections*, ICE, <https://www.ice.gov/facility-inspections>.

26 <sup>26</sup> See, e.g., Sarah N. Lynch et al., *Exclusive: U.S. Sending 1,600 Immigration*  
27 *Detainees to Federal Prisons*, Reuters (June 7, 2018),  
<https://www.reuters.com/article/us-usa-immigration-prisons-exclusive/exclusive-u-s-immigration-authorities-sending-1600-detainees-to-federal-prisons-idUSKCN1J32W1>; Tallahatchie County Correctional Facility, CoreCivic,  
28 <http://www.corecivic.com/facilities/tallahatchie-county-correctional-facility>.

1 within the facilities and conduct “counts” up to ten times a day, during which all  
2 movement is prohibited. Detained individuals, who are denied access to their  
3 personal clothing and most possessions, are dressed in prison garb and often held in  
4 large cells with up to 100 others for most of the day. Generally, they are allowed  
5 only a few hours of access to fresh air and sunlight each week; detained individuals  
6 in some facilities are entirely denied access to the outdoors, and pass months or  
7 years without ever feeling the sun on their faces.

8 149. When detained individuals are transported outside of the facilities,  
9 corrections officers fully shackle their ankles and wrists. While some detained  
10 individuals are offered the “opportunity” to work, they earn only about a dollar a  
11 day, and reprisals for refusal to work are also common.<sup>27</sup> Corrections officers use  
12 solitary confinement as punishment for disciplinary infractions both real and  
13 pretextual, often without processes to determine which is which.

14 150. Facility conditions make communication between detained individuals  
15 and the outside world incredibly difficult—and often effectively impossible. When  
16 visited by family and friends during limited visitation hours, detained individuals  
17 are often denied contact visitation and must communicate with their loved ones  
18 through thick plexiglass.

19 151. Detention Facilities also routinely obstruct detained individuals from  
20 meaningfully communicating with their attorneys.<sup>28</sup> Contact visitation between

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22 <sup>27</sup> See generally e.g., *Menocal v. GEO Grp., Inc.*, 882 F.3d 905 (10th Cir. 2018);  
23 *Chao Chen v. Geo Grp., Inc.*, 287 F. Supp. 3d 1158 (W.D. Wash. 2017); *Nova v.*  
24 *GEO Grp., Inc.*, No. EDCV 17-2514 JGB (SHKx), 2018 WL 4057814 (C.D. Cal.  
25 Aug. 22, 2018); *Barrientos v. CoreCivic, Inc.*, 332 F. Supp. 3d 1305 (M.D. Ga.  
26 2018); *Gonzalez v. CoreCivic, Inc.*, No. 17-CV-2573 JLS (NLS), 2018 WL  
27 1172579 (S.D. Cal. Mar. 6, 2018); *Owino v. CoreCivic, Inc.*, No. 17-CV-1112 JLS  
28 (NLS), 2018 WL 2193644 (S.D. Cal. May 14, 2018).

<sup>28</sup> See, e.g., Becerra, *supra* note 19, at 125–27; U.S. Comm’n on Civil Rights, *With Liberty and Justice for All*, at 112 (Sep. 2015),  
[https://www.usccr.gov/pubs/docs/Statutory\\_Enforcement\\_Report2015.pdf](https://www.usccr.gov/pubs/docs/Statutory_Enforcement_Report2015.pdf).

1 attorneys and clients is commonly denied, and access to confidential legal phones  
2 and interpretation services is lacking on a systemic scale. Non-confidential phone  
3 access is provided by private prison phone companies that charge exorbitant rates.<sup>29</sup>  
4 Facility staff screen detained individuals' mail<sup>30</sup> and deny them access to almost all  
5 their possessions.<sup>31</sup> Communication is made nearly impossible when Defendants  
6 fail to provide appropriate accommodations to individuals with disabilities who rely  
7 on assistive devices and other aids for effective communication.

8 152. Multiple reports have concluded that immigration detainees are subject  
9 to prison-like conditions of confinement. For example, the U.S. Commission on  
10 Civil Rights issued a report in September 2015 concluding that: (1) "it was apparent  
11 that immigration detention centers were built, house detainees, and operate like  
12 criminal penitentiaries;"<sup>32</sup> and (2) "the Commission finds evidence indicating that  
13 DHS and its component agencies and contractees detain undocumented immigrants  
14 in a manner inconsistent with civil detention and instead detain many  
15 undocumented immigrants like their criminal counterparts in violation of a detained  
16 immigrant's Fifth Amendment Rights."<sup>33</sup>

17 153. Similarly, in February 2019, the California Department of Justice  
18 published the findings of its review of all ten Detention Facilities in California.<sup>34</sup>  
19 Overall, the review found that detained individuals often face highly restrictive and  
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21 <sup>29</sup> Leticia Miranda, *Dialing with Dollars: How County Jails Profit From Immigrant*  
22 *Detainees*, The Nation (May 15, 2014), [https://www.thenation.com/article/dialing-](https://www.thenation.com/article/dialing-dollars-how-county-jails-profit-immigrant-detainees/)  
[dollars-how-county-jails-profit-immigrant-detainees/](https://www.thenation.com/article/dialing-dollars-how-county-jails-profit-immigrant-detainees/).

23 <sup>30</sup> See ICE, 2011 Performance-Based National Detention Standards (revised 2016),  
24 at § 5.1.

25 <sup>31</sup> See ICE, 2011 Performance-Based National Detention Standards (revised 2016),  
26 at § 2.5.

27 <sup>32</sup> U.S. Comm'n on Civil Rights, *With Liberty and Justice for All*, at 95–96 (Sep.  
28 2015), [https://www.usccr.gov/pubs/docs/Statutory\\_Enforcement\\_Report2015.pdf](https://www.usccr.gov/pubs/docs/Statutory_Enforcement_Report2015.pdf).

<sup>33</sup> *Id.* at 106.

<sup>34</sup> Becerra, *supra* note 19, at ii.

1 prison-like settings, including wearing prison-style clothing, spending up to 22  
2 hours a day in their cells, facing restrictions on communicating with counsel,  
3 receiving inadequate medical and mental health care, and performing work for  
4 which they are often unpaid or compensated at \$1.00 a day.<sup>35</sup>

5 154. In a March 2019 report, Disability Rights California (“DRC”) found  
6 that Adelanto holds detained individuals in punitive, prison-like conditions that  
7 harm people with disabilities, that “are obvious from the moment one enters the  
8 detention center complex,” and that “amount to the unnecessary and possibly  
9 unlawful punishment of civil detainees.”<sup>36</sup> The facility, part of which was originally  
10 constructed to be a prison and which operated as one for many years, is:

11 infused with unnecessarily harsh—and in effect, punitive—conditions,  
12 raising questions as to whether ICE and GEO Group are violating the  
13 constitutional rights of the people held there as civil detainees. Adelanto  
14 looks, feels and operates like a prison, from the extreme idleness and  
15 regimented daily schedule to the use of solitary confinement-type  
16 housing . . . . The facility’s prison-like conditions disproportionately harm  
17 people with mental illness and other disabilities.<sup>37</sup>

18 155. Denial of medical care, mental health care, and disability  
19 accommodations contributes to and exacerbates the punitive conditions in  
20 Defendants’ Detention Facilities. Indeed, as detailed herein, Plaintiffs and the Class  
21 are routinely denied access to crucial medical and mental health care, refused  
22 necessary accommodations for their disabilities, and subjected to near-constant  
23 isolation. Viewed in their totality, these brutal conditions and punitive practices  
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25 <sup>35</sup> *Id.* at iii–iv, 78, 122–27.

26 <sup>36</sup> Disability Rights Cal., *There Is No Safety Here*, at 17 (Mar. 2019),  
27 [https://www.disabilityrightsca.org/system/files/file-  
28 attachments/DRC\\_REPORT\\_ADELANTO-  
IMMIG\\_DETENTION\\_MARCH2019.pdf.](https://www.disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTION_MARCH2019.pdf)

<sup>37</sup> *Id.* at 2 (emphasis in original).



1 evince that conditions in the Detention Facilities are indistinguishable from—and  
2 often worse than—jails and prisons.

3 156. Notwithstanding ICE’s regulatory and statutory authority to release  
4 detained individuals, Defendants’ knowledge of the inadequate and inhumane  
5 conditions in Detention Facilities, and the availability of multiple cost-effective  
6 alternatives to detention, Defendants choose to detain thousands of individuals  
7 every year—knowing that they are unable to provide the minimum level of care and  
8 accommodations required by the Constitution and federal law. For example,  
9 8 C.F.R. § 212.5 gives ICE the authority to parole asylum seekers who have  
10 presented themselves at a port of entry into the U.S. during the pendency of their  
11 asylum hearings. In fact, 8 C.F.R. § 212.5(b)(1) specifically authorizes release for  
12 those with serious medical conditions. Another regulatory subdivision likewise  
13 authorizes the release of pregnant women. 8 C.F.R. § 212.5(b)(2). ICE policy  
14 directives also authorize parole for those asylum seekers who have passed the  
15 “Credible Fear Interview,” a mechanism by which DHS filters out non-meritorious  
16 asylum claims.<sup>38</sup> Despite authorization to use its parole power, ICE now does so  
17 only in a “negligible” number of cases.<sup>39</sup> To provide but one example, although  
18 approximately 90 percent of asylum seekers processed in New Orleans were  
19 previously granted parole, parole was granted in just two of 130 cases in 2018.<sup>40</sup>  
20  
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22 <sup>38</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11002.1, Parole of Arriving*  
23 *Aliens Found to Have a Credible Fear of Persecution or Torture*, at ¶ 6.2 (Jan. 4,  
24 2010), [https://www.ice.gov/doclib/dro/pdf/11002.1-hd-  
parole\\_of\\_arriving\\_alien\\_found\\_credible\\_fear.pdf](https://www.ice.gov/doclib/dro/pdf/11002.1-hd-parole_of_arriving_alien_found_credible_fear.pdf).

25 <sup>39</sup> *Damus v. Nielsen*, 313 F. Supp. 3d 317, 330 (D.D.C. 2018).

26 <sup>40</sup> Southern Poverty Law Center, *SPLC Lawsuit: ICE Illegally Denying Parole to*  
27 *Asylum Seekers in Southeast* (May 30, 2019),  
28 [https://www.splcenter.org/news/2019/05/30/splc-lawsuit-ice-illegally-denying-  
parole-asylum-seekers-southeast](https://www.splcenter.org/news/2019/05/30/splc-lawsuit-ice-illegally-denying-parole-asylum-seekers-southeast).

1 157. For many other detained individuals who have not presented  
2 themselves at a port of entry, 8 C.F.R. § 1236.1(d)(1) authorizes ICE to set a bond  
3 for those it apprehends. However, upon information and belief, ICE rarely sets bond  
4 for detained individuals and has been instructed, as of February 20, 2017, to not use  
5 its discretion to deprioritize any classes of people—even people who are pregnant,  
6 elderly, or disabled—from detention.<sup>41</sup>

7 158. ICE contends that detention is necessary to ensure appearance for  
8 court hearings, but a 2014 GAO report found that 99 percent of individuals in an  
9 intensive monitoring appearance program appeared in court.<sup>42</sup> Another study found  
10 that community-based alternatives to detention program achieved a compliance rate  
11 of 90 percent or better.<sup>43</sup> Instead of using those programs, or using its prosecutorial  
12

13 \_\_\_\_\_  
14 <sup>41</sup> *Compare* Memorandum from Jeh Charles Johnson, Sec’y of Homeland Sec., to  
15 Thomas S. Winkowski, Acting Dir., U.S. Immigration & Customs Enf’t, et al.  
16 (Nov. 20, 2014),  
17 [https://www.dhs.gov/sites/default/files/publications/14\\_1120\\_memo\\_prosecutorial](https://www.dhs.gov/sites/default/files/publications/14_1120_memo_prosecutorial_discretion.pdf)  
18 [discretion.pdf](https://www.dhs.gov/sites/default/files/publications/14_1120_memo_prosecutorial_discretion.pdf) (DHS directing that, as a general matter, ICE should not detain  
19 individuals “who are known to be suffering from serious physical or mental illness,  
20 who are disabled, elderly, pregnant, or nursing, who demonstrate that they are  
21 primary caretakers of children or an infirm person, or whose detention is otherwise  
22 not in the public interest”) *with* Memorandum from John Kelly, Sec’y of Homeland  
23 Sec., to Thomas D. Homan, Acting Dir., U.S. Immigration & Customs Enf’t, et al.  
24 (Feb. 20, 2017),  
25 [https://www.dhs.gov/sites/default/files/publications/17\\_0220\\_S1\\_Enforcement-of-](https://www.dhs.gov/sites/default/files/publications/17_0220_S1_Enforcement-of-the-Immigration-Laws-to-Serve-the-National-Interest.pdf)  
26 [the-Immigration-Laws-to-Serve-the-National-Interest.pdf](https://www.dhs.gov/sites/default/files/publications/17_0220_S1_Enforcement-of-the-Immigration-Laws-to-Serve-the-National-Interest.pdf) (explicitly rescinding  
27 November 20, 2014 Memorandum and providing that “[e]xcept as specifically  
28 provided in this memorandum, prosecutorial discretion shall not be exercised in a  
manner that exempts or excludes a specified class or category of aliens from  
enforcement of the immigration laws”).

<sup>42</sup> U.S. Gov’t Accountability Office, GAO-15-26, *Alternatives to Detention: Improved Data Collection and Analyses Needed to Better Assess Program Effectiveness*, at 2 (Nov. 2014), <https://www.gao.gov/assets/670/666911.pdf>.

<sup>43</sup> National Immigrant Justice Center, *A Better Way: Community-Based Programming as an Alternative To Immigrant Incarceration*, at 4 (Apr. 2019),

1 discretion to decline to initiate removal proceedings against vulnerable populations  
 2 as it had before February 2017, ICE insists on detaining people with serious  
 3 illnesses and disabilities despite its inability to provide them adequate care and  
 4 accommodation.

5 **IV. Defendants are Responsible for Selecting, Contracting, and Monitoring**  
 6 **Conditions in Detention Facilities.**

7 159. Defendants utilize a centralized process to identify and enter into  
 8 contracts with private and public entities to detain individuals in their custody; to  
 9 administer those contracts; and to determine what, if any, actions will be taken  
 10 against contractors who provide substandard care.

11 160. These contracts are administered and managed by ICE's Office of  
 12 Acquisitions Management via a process that ICE has centralized "in order to  
 13 aggressively enforce contract compliance and initiate new procurements."<sup>44</sup> ICE's  
 14 Office of Acquisitions Management contracting officers have signature authority to  
 15 execute and modify contracts, and they appoint Contract Officers' Representatives  
 16 ("CORs").<sup>45</sup> When facilities are found noncompliant, CORs may submit a Contract  
 17 Discrepancy Report that documents the issue and recommends financial penalties.

18 161. In procuring space in facilities for its detainees, ICE does not use any  
 19 of the three lawful procurement means available to federal agencies.<sup>46</sup> Instead, it

20 [https://www.immigrantjustice.org/sites/default/files/uploaded-files/no-content-](https://www.immigrantjustice.org/sites/default/files/uploaded-files/no-content-type/2019-04/A-Better-Way-report-April2019-FINAL-full.pdf)  
 21 [type/2019-04/A-Better-Way-report-April2019-FINAL-full.pdf](https://www.immigrantjustice.org/sites/default/files/uploaded-files/no-content-type/2019-04/A-Better-Way-report-April2019-FINAL-full.pdf).

22 <sup>44</sup> *Detention Reform*, U.S. Immigration & Customs Enf't,  
 23 <https://www.ice.gov/detention-reform#tab1> (last updated Jul. 24, 2018).

24 <sup>45</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-19-18: ICE Does*  
 25 *Not Fully Use Contracting Tools to Hold Detention Facility Contractors*  
 26 *Accountable for Failing to Meet Performance Standards*, at 5 (Jan. 29, 2019),  
 27 <https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf>.

28 <sup>46</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-55: Immigration*  
 and Customs Enforcement Did Not Follow Federal Procurement Guidelines When  
 Contracting for Detention Services, at 19 (Feb. 21, 2018),  
<https://www.oig.dhs.gov/sites/default/files/assets/2018-02/OIG-18-53-Feb18.pdf>.

1 most commonly uses Intergovernmental Service Agreements (“IGSAs”) with local  
2 entities who then contract with private prison companies to operate the facilities.<sup>47</sup>  
3 In 2018, the DHS Office of the Inspector General (“OIG”) found that “ICE has no  
4 assurance that it executed detention center contracts in the best interest of the  
5 Federal Government, taxpayers, or detainees.”<sup>48</sup> In particular, this 2018 OIG Report  
6 found that ICE had intentionally circumvented the federal procurement process to  
7 render the private prison company’s performance “effectively insulated from  
8 government scrutiny.”<sup>49</sup>

9 162. In 2019, OIG found that Defendants fail to thoroughly vet programs  
10 and services at Detention Facilities, use lax procurement requirements, and enter  
11 into vague and toothless contracts, as described below.<sup>50</sup> Thus, Defendants’ failure  
12 to properly monitor Detention Facilities begins with the very contracts intended to  
13 govern the conditions in which non-citizens are detained.

14 163. In the fall of 2016, Assistant Attorney General Sally Yates directed the  
15 U.S. Department of Justice to begin to phase out the use of private prisons for  
16 federal prisoners, based in part on a recognition that conditions in privately run  
17 facilities were substandard.<sup>51</sup>

18 164. Shortly thereafter, then-Secretary of DHS Jeh Johnson established a  
19 Subcommittee at DHS to consider whether DHS should follow suit. While  
20 acknowledging that the use of private providers and local jails was likely to  
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22 <sup>47</sup> *Id.*; see also 2 C.F.R. § 200; 48 C.F.R. § 1.

23 <sup>48</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-55*, *supra* note  
24 46, at 3.

24 <sup>49</sup> *Id.* at 6.

25 <sup>50</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-19-18*, *supra* note  
26 4546, at 15.

27 <sup>51</sup> Memorandum from Sally Yates, Deputy Att’y Gen, to the Acting Dir. of the Fed.  
28 Bureau of Prisons, at 1-2 (Aug. 18, 2016),  
<https://www.justice.gov/archives/opa/file/886311/download>

1 continue, the Subcommittee, in a report issued in December 2016, offered multiple  
2 recommendations, including that DHS expand its oversight over such facilities,  
3 improve the quality and quantity of inspections at facilities, and initiate  
4 unannounced inspections.<sup>52</sup> Significantly, the Subcommittee recommended shifting  
5 away from privately provided healthcare toward ICE-Health-Service-Corps-  
6 provided healthcare at ICE facilities for cost and quality reasons.<sup>53</sup>

7 165. On information and belief, under this Administration, DHS has heeded  
8 none of the Subcommittee's recommendations, and has instead dramatically  
9 expanded the use and scope of private and county contractors. For example, IHSC  
10 provides direct care to approximately 13,500 detained persons, the same as when  
11 DHS made its recommendation in 2016, despite a marked increase in the detained  
12 population since then.<sup>54</sup>

13 166. Instead, ICE has expanded its use of private prison corporations with  
14 histories of negligence and abuse, such as GEO and CoreCivic.<sup>55</sup>

15 167. GEO, ICE's most frequently used contractor, has repeatedly failed to  
16 provide adequate care. In 2012, 26 members of Congress requested an investigation  
17 of the GEO-operated Broward Transitional Center in Florida after receiving reports  
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19 <sup>52</sup> Homeland Security Advisory Council, U.S. Dep't of Homeland Sec., *Report of*  
20 *the Subcommittee on Privatized Immigration Detention Facilities*, at 3 (Dec. 1,  
21 2016),  
22 [https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20](https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf)  
[Final%20Report.pdf](https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf).

<sup>53</sup>*Id.* at 2.

23 <sup>54</sup> *Compare id.* at 10 with *ICE Health Service Corps*, U.S. Immigration & Customs  
24 Enf't (Last Updated: February 26, 2019), [https://www.ice.gov/features/health-](https://www.ice.gov/features/health-service-corps)  
[service-corps](https://www.ice.gov/features/health-service-corps).

25 <sup>55</sup> *The GEO Group Inc (GEO) Q1 2019 Earnings Call Transcript*, Yahoo Finance  
26 (Apr. 30, 2019), [https://finance.yahoo.com/news/geo-group-inc-geo-q1-](https://finance.yahoo.com/news/geo-group-inc-geo-q1-223554152.html)  
[223554152.html](https://finance.yahoo.com/news/geo-group-inc-geo-q1-223554152.html); Justin Rohrlich, *As US communities resist ICE, private prison*  
27 *companies are cashing in*, Quartz (Apr. 9, 2019), [https://qz.com/1586161/private-](https://qz.com/1586161/private-prisons-make-big-profits-from-ice/)  
28 [prisons-make-big-profits-from-ice/](https://qz.com/1586161/private-prisons-make-big-profits-from-ice/).

1 of inadequate medical care for detained immigrants.<sup>56</sup> The same year, the  
 2 Department of Justice found “systematic, egregious, and dangerous practices,”  
 3 including inadequate medical care, at a GEO facility in Mississippi.<sup>57</sup> At another  
 4 GEO facility in Pennsylvania, seven people died in less than two years, with several  
 5 deaths resulting in lawsuits alleging that the facility failed to provide adequate  
 6 medical care.<sup>58</sup> In 2011, GEO was held civilly liable in a wrongful death action  
 7 brought by the estate of an inmate at a GEO facility in Oklahoma.<sup>59</sup> There are  
 8 dozens more suits that have been filed against GEO, ranging from allegations of  
 9 inmate death to abuse to medical neglect, many of which were settled before trial.<sup>60</sup>  
 10 In the past year, both OIG- and state-contracted disability monitor Disability Rights  
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 12  
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14 <sup>56</sup> Letter from Christina Fialho, Co-Founder & Exec. Dir. of Cmty. Initiatives for  
 15 Visiting Immigrants in Confinement to Karen Tandy, Subcomm. Chair of  
 16 Privatized Immigration Det, Facilities Subcomm. (Oct. 3, 2016),  
 17 [https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20](https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf)  
 18 [Final%20Report.pdf](https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf).

19 <sup>57</sup> Dep’t of Justice: Civil Rights Div., *Investigation of the Walnut Grove Youth*  
 20 *Correctional Facility* at 20–33 (Mar. 20, 2012),  
 21 <http://www.justice.gov/crt/about/spl/documents/walnutgrovefl.pdf>.

22 <sup>58</sup> Alex Rose, *A changing of the guard at county prison*, Daily Times News, (Jan. 4,  
 23 2009), [http://www.delcotimes.com/general-news/20090104/a-changing-of-the-](http://www.delcotimes.com/general-news/20090104/a-changing-of-the-guard-at-county-prison)  
 24 [guard-at-county-prison](http://www.delcotimes.com/general-news/20090104/a-changing-of-the-guard-at-county-prison).

25 <sup>59</sup> The GEO Group, Inc., Annual Report (Form 10-K) (Mar. 1, 2013),  
 26 [https://www.sec.gov/Archives/edgar/data/923796/000119312513087892/d493925d](https://www.sec.gov/Archives/edgar/data/923796/000119312513087892/d493925d10k.htm#tx493925)  
 27 [10k.htm#tx493925](https://www.sec.gov/Archives/edgar/data/923796/000119312513087892/d493925d10k.htm#tx493925) 21.

28 <sup>60</sup> *Private Corrections Working Group/Private Corrections Institute: List of GEO*  
*Group Lawsuits*, PR Watch (Sep. 26, 2013)  
[https://www.prwatch.org/news/2013/09/12255/violence-abuse-and-death-profit-](https://www.prwatch.org/news/2013/09/12255/violence-abuse-and-death-profit-prisons-geo-group-rap-sheet)  
[prisons-geo-group-rap-sheet](https://www.prwatch.org/news/2013/09/12255/violence-abuse-and-death-profit-prisons-geo-group-rap-sheet); *GEO Group/GEO Care Rapsheet*, Private Corrections  
 Working Group, [https://www.privateci.org/rap\\_geo.html](https://www.privateci.org/rap_geo.html); *GEO Group*, Project on  
 Government Oversight,  
<https://www.contractormisconduct.org/contractors/253/geo-group>.

1 California reported widespread lack of medical care and disability accommodation  
2 at the GEO-run Adelanto.<sup>61</sup>

3 168. ICE's other main contractor, CoreCivic, has a similar history of  
4 refusing to provide adequate medical treatment to those it detains.<sup>62</sup> However,  
5 despite knowing the inherent risks of contracting with private prison corporations,  
6 ICE continues to entrust them with the care of an ever-growing number of detained  
7 individuals.

8 169. ICE's choice of medical service contractors is similarly disturbing. For  
9 example, ICE frequently contracts with private medical provider Correct Care  
10 Solutions ("CCS"), now rebranded as Wellpath, even though the company has been  
11 sued at least 1,395 times over the last decade. Upon information and belief,  
12 individuals in ICE custody also receive medical care from Corizon, another private  
13 prison healthcare provider. Corizon has been sued over 1,000 times in the past five  
14 years.<sup>63</sup> In June 2018, the United States District Court for the District of Arizona  
15 sanctioned the Arizona Department of Corrections nearly \$1.5 million for, among  
16 other things, continuing to contract with Corizon, "which has been unable to meet  
17 the prisoner's health care needs," and for "pa[y]ing them more and reward[ing]

18  
19 <sup>61</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-86: Management*  
20 *Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto,*  
*California*, at 9 (Sep.27, 2018),

21 <https://www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-86-Sep18.pdf>;  
22 *Disability Rights Cal.*, *supra* note 36, at 4.

23 <sup>62</sup> *See, e.g., Grae v. Corr. Corp. of Am.*, No. 3:16-CV-2267, 2019 WL 1399600, at  
24 \*2 (M.D. Tenn. Mar. 26, 2019) (shareholder class certified alleging CoreCivic's  
25 "failure to provide sufficient medical services to its inmates."); *Dodson v.*  
26 *CoreCivic*, No. 3:17-CV-00048, 2018 WL 4800836, at \*1 (M.D. Tenn. Oct. 3,  
2018) (alleging deliberate inference to prisoners medical needs); *Pierce v. D.C.*,  
128 F. Supp. 3d 250, 284 (D.D.C. 2015) (finding prisoner's ADA and Section 504  
rights violated at CoreCivic facility).

27 <sup>63</sup> *The Jail Health-Care Crisis*, *The New Yorker* (Feb. 25, 2019),  
28 <https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis>.

1 them with financial incentives while limiting the financial penalties for non-  
2 compliance.”<sup>64</sup> Further, in May 2019, Corizon entered into a consent decree to pay  
3 \$950,000 to individuals in a case in which the Equal Employment Opportunity  
4 Commission alleged that Corizon had discriminated against its disabled  
5 employees.<sup>65</sup> Despite other prison systems such as the New Mexico, Indiana,  
6 Arizona, and Nebraska Departments of Correction terminating contracts with CCS  
7 and Corizon because of safety concerns, both companies continue to provide care to  
8 ICE detainees.<sup>66</sup>

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12 <sup>64</sup> *Parsons v. Ryan*, No. CV-12-0601-PHX-DKD, 2018 WL 3239691, at \*11 (D.  
13 Ariz. June 22, 2018).

14 <sup>65</sup> *Corizon Health / Corizon LLC to Pay \$950,000 to Settle Nationwide EEOC*  
15 *Disability Discrimination Lawsuit*, U.S. Equal Opportunity Employment  
16 Commission (May 16, 2019), [https://www1.eeoc.gov/eeoc/newsroom/release/5-13-  
17 19b.cfm](https://www1.eeoc.gov/eeoc/newsroom/release/5-13-19b.cfm).

18 <sup>66</sup> *Amid safety concerns, company ending medical services contract for Tecumseh*  
19 *State Prison*, Omaha World Herald (Jun. 3, 2017),  
20 [https://www.omaha.com/news/nebraska/amid-safety-concerns-company-ending-  
21 medical-services-contract-for-tecumseh/article\\_17e8e24e-479e-11e7-95a7-  
22 af05ec215c6f.html](https://www.omaha.com/news/nebraska/amid-safety-concerns-company-ending-medical-services-contract-for-tecumseh/article_17e8e24e-479e-11e7-95a7-af05ec215c6f.html); *Numerous Lawsuits Filed Against Corizon Nationwide;*  
23 *Company Loses Contracts*, Prison Legal News (Aug. 30, 2017),  
24 [https://www.prisonlegalnews.org/news/2017/aug/30/numerous-lawsuits-filed-  
25 against-corizon-nationwide-company-loses-contracts/](https://www.prisonlegalnews.org/news/2017/aug/30/numerous-lawsuits-filed-against-corizon-nationwide-company-loses-contracts/); *Corizon, the Prison*  
26 *Healthcare Giant, Stumbles Again*, The Appeal (February 8, 2019),  
27 <https://theappeal.org/corizon-the-prison-healthcare-giant-stumbles-again/>; *City*  
28 *Officials Defend Contract to House ICE Detainees at Henderson Detention Center*,  
Las Vegas Review Journal (May 8, 2017),  
[https://www.reviewjournal.com/crime/city-officials-defend-contract-to-house-ice-  
detainees-at-henderson-detention-center/](https://www.reviewjournal.com/crime/city-officials-defend-contract-to-house-ice-detainees-at-henderson-detention-center/); *Leading For-Profit Prison and*  
*Immigration Detention Medical Company Sued At Least 1,395 Times*, Project on  
Government Oversight (Oct. 29, 2018),  
[https://www.pogo.org/investigation/2018/10/leading-for-profit-prison-and-  
immigration-detention-medical-company-sued-at-least-1-395-times/](https://www.pogo.org/investigation/2018/10/leading-for-profit-prison-and-immigration-detention-medical-company-sued-at-least-1-395-times/).



1 **V. Multiple Government Entities, Including DHS Itself, Have Concluded**  
2 **That Defendants Are Not Adequately Monitoring and Overseeing**  
3 **Detention Facilities.**

4 170. Defendants divide responsibility for monitoring Detention Facilities  
5 between government employees and private contractors. There is no independent  
6 oversight, inasmuch as all entities that conduct inspections are paid and vetted—  
7 either as contractors or as direct employees—by DHS.<sup>67</sup>

8 171. Enforcement and Removal Operations, the branch of ICE responsible  
9 for apprehending and deporting noncitizens, is responsible for overseeing  
10 confinement across its facilities. Nearly a quarter of Detention Facilities are smaller  
11 jails that were permitted to conduct their own unregulated “self-assessments.”<sup>68</sup>

12 172. ICE’s Custody Management Division (“CMD”) contracts with  
13 inspectors to conduct routine inspections of Detention Facilities, assess compliance  
14 with ICE detention standards, and develop corrective actions plans. OMD also  
15 oversees the on-site Detention Monitoring Program and operates the Detention  
16 Reporting and Information Line, which detained individuals and others can use to  
17 file complaints.<sup>69</sup>

18 173. The DHS Office of Inspector General, DHS Office of Civil Rights and  
19 Civil Liberties (“CRCL”), and ICE Office of Detention Oversight (“ODO”) are also  
20 responsible for conducting inspections to ensure compliance with detention

21 \_\_\_\_\_  
22 <sup>67</sup> *Lives In Peril: How Ineffective Inspections Make ICE Complicit In Detention*  
23 *Center Abuse*, National Immigrant Justice Center (October 22, 2015),  
24 <https://www.immigrantjustice.org/lives-peril-how-ineffective-inspections-make-ice-complicit-detention-center-abuse-0>.

25 <sup>68</sup> *Dear ICE: Congress Is Watching, And So Are We*, National Immigrant Justice  
26 Center (April 5, 2018), <https://immigrantjustice.org/staff/blog/dear-ice-congress-watching-and-so-are-we>.

27 <sup>69</sup> U.S. Gov’t Accountability Office, *GAO-16-231: Immigration Detention-*  
28 *Additional Actions Needed to Strengthen Management and Oversight of Detainee*  
*Medical Care*, at 11 (Feb. 2016), <https://www.gao.gov/assets/680/675758.pdf>.

1 standards and applicable law.<sup>70</sup> ODO and ICE’s External Reviews and Analysis  
 2 Unit are also responsible for conducting a Detainee Death Review (“DDR”) after a  
 3 detained individual dies.<sup>71</sup>

4 174. The ICE Health Service Corps oversees administration, investigates  
 5 detainee complaints related to health care, and manages medical payment  
 6 authorizations for detainee care inspection of medical care at all Detention  
 7 Facilities.<sup>72</sup> IHSC also monitors and conducts inspections at all facilities, including  
 8 those in which health care is provided by a contractor. 52

9 175. Finally, ICE has also created a Detention Monitoring Council  
 10 (“DMC”), comprised of ICE senior leadership, that is supposed to meet regularly to  
 11 review problems uncovered by the internal or external oversight entities.<sup>73</sup> In  
 12 addition, the DMC supposedly meets immediately after any detained individual’s  
 13 death or other critical incident.<sup>74</sup>

14 176. Though responsibility for conditions compliance is shared by the  
 15 above DHS offices, Defendants primarily rely on periodic detention center  
 16 inspections performed by a private company, Nakamoto, with which CMD  
 17

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 19 <sup>70</sup> *Id.*

20 <sup>71</sup> *See e.g.*, Office of Professional Responsibility, *Detainee Death Review – Sergio*  
 21 *Alonso Lopez*, at 1 (“Sergio Alonso Lopez DDR”),  
 22 <https://www.ice.gov/doclib/foia/reports/ddrLopez.pdf>; Office of Professional  
 23 Responsibility, *Detainee Death Review – Moises Tino Lopez*, at 1 (“Moises Tino  
 24 Lopez DDR”), <https://www.ice.gov/doclib/foia/reports/ddr-Tino.pdf>.

25 <sup>72</sup> U.S. Gov’t Accountability Office, *GAO-16-231*, *supra* note 69, at 11.

26 <sup>73</sup> *Holiday on ICE: The U.S. Dep’t of Homeland Sec.’s New Immigration Detention*  
 27 *Standards Before the Subcomm. on Immigration Policy & Enf’t, H. Comm. on the*  
 28 *Judiciary*, 112th Cong. 112-104 (2012) (Statement Of Kevin Landy, Assistant Dir.  
 Office of Det. Policy & Planning, U.S. Immigration And Customs Enf’t.),  
[https://archive.org/stream/gov.gpo.fdsys.CHRG-112hhr73543/CHRG-112hhr73543\\_djvu.txt](https://archive.org/stream/gov.gpo.fdsys.CHRG-112hhr73543/CHRG-112hhr73543_djvu.txt).

<sup>74</sup> *Id.*

1 contracts. Nakamoto annually or biennially inspects facilities that hold ICE  
2 detainees more than 72 hours.<sup>75</sup>

3 177. Both GAO and OIG have repeatedly expressed concern over major  
4 structural deficiencies in ICE’s contract and oversight system. In 2016, GAO found  
5 that it is unclear whether IHSC’s data tracking system “will capture all medical  
6 complaints received by DHS or facilitate analyses of complaints over time and  
7 across facilities” and that, because of a lack of resources allocated, “ICE does not  
8 utilize the data gathered . . . in a way that examines overall trends in medical care  
9 deficiencies.”<sup>76</sup> The GAO observed that under CMD’s monitoring scheme, a  
10 facility may be found deficient as to individual systemic medical provision criteria,  
11 but still be found compliant with the overall relevant medical care standard.<sup>77</sup> At  
12 smaller facilities, ICE does no systematic analysis of inspection reports.<sup>78</sup> Nor does  
13 ICE perform or have any plans to perform any type of analysis on complaints  
14 received by ODO, CRCL, and IHSC.<sup>79</sup>

15 178. Likewise, in 2018, OIG found major deficiencies in ICE’s external and  
16 internal monitoring mechanisms.<sup>80</sup> The OIG report included a telling recitation of  
17 the long-standing deficiencies in Defendants’ monitoring practices:

18 ICE’s difficulties with monitoring and enforcing compliance  
19 with detention standards stretch back many years and continue  
20 today. In 2006, [OIG] identified issues related to ICE Detention

21 \_\_\_\_\_  
22 <sup>75</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-47: ICE’s*  
23 *Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained*  
24 *Compliance or Systemic Improvements*, at 2 (Jun. 26, 2018),  
<https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>.

25 <sup>76</sup> U.S. Gov’t Accountability Office, *GAO-16-231*, *supra* note 69, at 26.

26 <sup>77</sup> *Id.* at 21–22.

27 <sup>78</sup> *Id.* at 27.

28 <sup>79</sup> *Id.* at 26–27

<sup>80</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-47*, *supra* note  
75, at 5–10.

1 Facility inspections and implementation of corrective actions. In  
2 our 2006 report, we recommended that ICE “improve the  
3 inspection process and ensure that all non-compliance  
4 deficiencies are identified and corrected.” In a December 2017  
5 report, which related to OIG’s unannounced inspections of five  
6 Detention Facilities, we identified problems in some of the same  
7 areas noted in the 2006 report.<sup>81</sup>

8 179. Specifically, OIG found the Nakamoto inspections deficient because:  
9 (1) inspections required too much work for such small teams to complete over a  
10 short period of time; (2) some inspections were not thorough; (3) instead of  
11 interviewing detained individuals privately in a confidential area, the inspectors  
12 mostly held group conversations in the presence of Detention Facility personnel,  
13 and conducted the interviews only in English without any interpreters;  
14 (4) Nakamoto’s inspection reports contained inaccuracies; and (5) ICE did not  
15 perform any quality assurance visits to assess Nakamoto’s performance.<sup>82</sup>

16 180. The 2018 OIG report also found that Nakamoto’s inspectors did not  
17 follow inspection protocols and misrepresented information in final inspection  
18 reports.<sup>83</sup> OIG detailed how some inspectors relied on brief answers from staff  
19 interviews and reviews of written policies to evaluate facility conditions, instead of  
20 conducting personal observations as required.<sup>84</sup> Nakamoto inspectors also made  
21 misrepresentations in their inspection reports that were inconsistent with OIG  
22 observations during the same visit. At one facility, Nakamoto reported that detained  
23 individuals understood how to get assistance from ICE officers and their case  
24 managers, and that detained individuals also made positive comments about access  
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26 <sup>81</sup> *Id.*

27 <sup>82</sup> *Id.*

28 <sup>83</sup> *Id.* at 5.

<sup>84</sup> *Id.* at 6–7.

1 to law library services and family visitation. In contrast, however, OIG inspectors  
2 noted that they “heard detainees tell inspectors they did not know the identity of  
3 their ICE deportation officer or how to contact the officer” and “did not observe  
4 inspectors asking any detainees about law library services or visiting  
5 opportunities.”<sup>85</sup> At another facility, inspectors reported that corrections officers  
6 “exhibited an understanding of the detention standards and civil detention” without  
7 having spoken to any such officers during the visit.<sup>86</sup>

8 181. OIG also found that “[s]everal ICE employees in the field and  
9 managers at ICE ERO headquarters commented that Nakamoto inspectors ‘breeze  
10 by the standards’ and do not ‘have enough time to see if the [facility] is actually  
11 implementing the policies.’”<sup>87</sup> These employees and managers also described  
12 Nakamoto inspections as being “very, very, very difficult to fail.”<sup>88</sup> “One ICE ERO  
13 official suggested these inspections are ‘useless.’”<sup>89</sup> Further, at least some  
14 inspectors speak only to facility staff and English-speaking detained individuals,  
15 and some do not enter all areas of the facilities.<sup>90</sup> The OIG report also found that  
16 “all Nakamoto and ODO inspections are scheduled in advance and announced to  
17 the facilities, which, according to ICE field staff, allows facility management to  
18 temporarily modify practices to ‘pass’ an inspection.”<sup>91</sup>

19 182. Additionally, a 2016 Homeland Security Advisory Council report  
20 found Nakamoto’s inspections flawed because they “focus on quantitative

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21 <sup>85</sup> *Id.* at 9.

22 <sup>86</sup> *Id.* at 10.

23 <sup>87</sup> *Id.* at 7.

24 <sup>88</sup> *Id.*

24 <sup>89</sup> *Id.* at 10.

25 <sup>90</sup> *At Immigration Detention Facilities, 'Inspectors for Hire' Miss Signs of Neglect,*  
26 *Say Critics*, Yahoo News (Mar. 12, 2019), [https://news.yahoo.com/at-immigration-](https://news.yahoo.com/at-immigration-detention-facilities-inspectors-for-hire-miss-signs-of-neglect-say-critics-090000015.html?soc_src=community&soc_trk=tw)  
27 [detention-facilities-inspectors-for-hire-miss-signs-of-neglect-say-critics-](https://news.yahoo.com/at-immigration-detention-facilities-inspectors-for-hire-miss-signs-of-neglect-say-critics-090000015.html?soc_src=community&soc_trk=tw)  
27 [090000015.html?soc\\_src=community&soc\\_trk=tw.](https://news.yahoo.com/at-immigration-detention-facilities-inspectors-for-hire-miss-signs-of-neglect-say-critics-090000015.html?soc_src=community&soc_trk=tw)

28 <sup>91</sup> *Id.*

1 measurement of inputs rather than qualitative inquiry.”<sup>92</sup> That is, Nakamoto  
2 inspections use yes/no checklists, instead of reviewing the extent to and means by  
3 which facilities can improve compliance. Notably, none of the items in Nakamoto’s  
4 checklist requires review of disability access or accommodation.<sup>93</sup>

5 183. As for inspections by ODO, the 2018 OIG report concluded that “these  
6 inspections are too infrequent to ensure the facilities implement all corrections.”<sup>94</sup>  
7 Of the approximately 158 facilities that ICE monitors, ODO inspects only  
8 approximately 30 facilities each year.<sup>95</sup>

9 184. The 2018 OIG report also identified problems with monitoring by  
10 ICE’s Detention Service Monitors (“DSMs”). First, DSMs are in place at only 52  
11 Detention Facilities. Second, “to correct instances of noncompliance, DSMs usually  
12 must rely on local ERO field office assistance”—and, in some instances, local ERO  
13 management was disengaged or reluctant to work with DSMs.”<sup>96</sup>

14 185. In 2019, OIG issued a report summarizing unannounced inspections at  
15 Adelanto, Aurora, LaSalle, and Essex County Correctional Facility (“Essex  
16 County”). These inspections “revealed violations of ICE’s detention standards and  
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18 <sup>92</sup> Homeland Sec. Advisory Council, U.S. Dep’t of Homeland Sec., *Report of the*  
19 *Subcommittee on Privatized Immigration Detention Facilities*, *supra* note 52, at 14.  
20 [https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20](https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf)  
[Final%20Report.pdf](https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf).

21 <sup>93</sup> *See, e.g.*, Letter from Lead Compliance Inspector, The Nakamoto Grp., to  
22 Assistant Dir. for Detention Mgmt. (Oct. 11, 2018),  
23 [https://www.ice.gov/doclib/facilityInspections/adelantoEastCa\\_CL\\_10\\_11\\_2018.pd](https://www.ice.gov/doclib/facilityInspections/adelantoEastCa_CL_10_11_2018.pdf)  
24 [f](https://www.ice.gov/doclib/facilityInspections/adelantoEastCa_CL_10_11_2018.pdf); Letter from Lead Compliance Inspector, The Nakamoto Grp., to Assistant Dir.  
25 for Detention Mgmt. (May 3, 2018),  
26 [https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA\\_CL\\_05\\_03\\_2018.](https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA_CL_05_03_2018.pdf)  
27 [pdf](https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA_CL_05_03_2018.pdf).

28 <sup>94</sup> Office of Inspector Gen., Dep’t of Homeland Sec., *OIG-18-47*, *supra* note 75, at  
4, <https://www.oig.dhs.gov/sites/default/files/assets/2018-06/OIG-18-67-Jun18.pdf>.

<sup>95</sup> *Id.* at 10.

<sup>96</sup> *Id.* at 14–15.

1 raised concerns about the environment in which detainees are held.”<sup>97</sup> The report  
 2 recommended that ICE improve its oversight detention facility management and  
 3 operations, and that “ICE could mitigate and resolve many of these issues through  
 4 increased engagement and interaction with the facilities and their operations.”<sup>98</sup>

5 186. ICE’s own officials have raised concerns related to monitoring. In a  
 6 memo from December 2018, an ICE supervisor notified then Acting Deputy  
 7 Director of ICE Matthew Albence that “IHSC is severely dysfunctional and  
 8 unfortunately preventable harm and death to detainees has occurred . . . [and that]  
 9 IHSC leadership is not focused on preventing horrible recurrences.”<sup>99</sup> According to  
 10 the memo, IHSC officials fail to review reports of severe mental health disabilities  
 11 representing a high risk of suicide.<sup>100</sup> The memo asserted that “many detainees have  
 12 encountered preventable harm and death [and] IHSC leadership is not focused on  
 13 preventing horrible recurrences.”<sup>101</sup> The memo then went on to detail over a dozen  
 14 cases in which detained individuals were not provided with proper medical and  
 15 mental health care, including two that resulted in fatalities.<sup>102</sup>

16 187. Nongovernmental organizations have also repeatedly identified the  
 17 systemic problems with ICE’s inspection system. For example, a January 2018  
 18 report by the Detention Watch Network and National Immigrant Justice Center  
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20 \_\_\_\_\_  
 21 <sup>97</sup> Office of Inspector General, U.S. Dep’t of Homeland Sec., *OIG-19-47: Concerns*  
 22 *About ICE Detainee Treatment and Care at Four Detention Facilities*, at 3 (Jun. 3,  
 23 2019), [https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-](https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf)  
 24 [Jun19.pdf](https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf).

25 <sup>98</sup> *Id.* at 12.

26 <sup>99</sup> Memorandum to Matthew Albence, Acting Deputy Dir., U.S. Immigr. and  
 27 Customs Enf’t (Dec. 3, 2018),  
 28 [https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu](https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h)  
 29 [7h](https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h).

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

1 concluded that these inspections are fundamentally flawed in that “they are not  
2 independent, they do not include interviews with detained people, they provide  
3 advance notice to the facilities and look for the existence of policies rather than  
4 evidence that these policies are followed, and they often misrepresent conditions  
5 inside the facility, for example counting an indoor room with a skylight as outdoor  
6 recreation.”<sup>103</sup>

7 188. Defendants’ failure to properly monitor Detention Facilities can have  
8 deadly consequences. For example, an April 2017 OIG inspection found that  
9 Stewart Detention Center suffered from major staffing issues, prompting one  
10 employee to describe the medical care situation as “a ticking time bomb.”<sup>104</sup>  
11 That May, Nakamoto’s inspection found that Stewart complied with all 39  
12 applicable standards.<sup>105</sup> The same month, Jean Carlo Jimenez Joseph, who ICE  
13 detained at Stewart, died by suicide there because of a guard’s failure to  
14 perform a required cell check.<sup>106</sup> Then, in January 2018, 33-year-old Yulio  
15 Castro-Garrido died of pneumonia while detained at Stewart.<sup>107</sup> In July 2018,

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17 <sup>103</sup> Detention Watch Network & National Immigrant Justice Center, *supra* note 13,  
at 6.

18 <sup>104</sup> Office of Inspector General, U.S. Dep’t of Homeland Sec., *OIG Freedom of*  
19 *Information Act Request No. 2018-IGFO-00059 Final Response*, at 16 (April 25,  
20 2018), [https://www.wabe.org/wp-content/uploads/2018/05/2018-IGFO-](https://www.wabe.org/wp-content/uploads/2018/05/2018-IGFO-00059-Final-Response-watermark-4.pdf)  
21 [00059-Final-Response-watermark-4.pdf](https://www.wabe.org/wp-content/uploads/2018/05/2018-IGFO-00059-Final-Response-watermark-4.pdf); *see also Investigation finds ICE detention*  
22 *center cut corners and skirted federal detention rules*, Public Radio International  
(March 15, 2018), [https://www.pri.org/stories/2018-03-15/investigation-finds-ice-](https://www.pri.org/stories/2018-03-15/investigation-finds-ice-detention-center-cuts-corners-and-skirted-federal)  
23 [detention-center-cuts-corners-and-skirted-federal](https://www.pri.org/stories/2018-03-15/investigation-finds-ice-detention-center-cuts-corners-and-skirted-federal); Katherine Hawkins, *Outsourced*  
*Oversight*, Project on Government Oversight (March 12, 2019),  
24 <https://www.pogo.org/investigation/2019/03/outsourced-oversight/>.

25 <sup>105</sup> Letter from Lead Compliance Inspector to Assistant Dir. for Detention Mgmt.,  
*supra* note 93, at 2.

26 <sup>106</sup> Investigative Summary, GA Bureau of Investigation, at 92–93 (May 19, 2017)  
(on file with Plaintiffs’ Counsel).

27 <sup>107</sup> *ICE detainee passes away*, U.S. Immigration & Customs Enf’t, (Jan. 31, 2018),  
28 <https://www.ice.gov/news/releases/ice-detainee-passes-away>.



1 Efrain De La Rosa, another person ICE was detaining at Stewart, died by  
2 suicide in circumstances almost identical to Mr. Jimenez Joseph.<sup>108</sup> In both  
3 cases, CoreCivic guards failed to perform a required check of the detained  
4 individual's cell and then falsified logs to cover for that failure.<sup>109</sup> The Nakamoto  
5 inspections failed to raise systematic failures of care at Stewart that could have  
6 prevented these deaths.

7 189. Similarly, at Adelanto, Nakamoto's 2017 and 2018 inspection reports  
8 found that the facility met all 40 applicable detentions standards.<sup>110</sup> However, in  
9 between the two reports, OIG issued a report on Adelanto finding nooses in  
10 detained individuals' cells, improper and overly restrictive segregation, and  
11 untimely and inadequate medical care.<sup>111</sup> Nakamoto's 2018 report, instead of  
12 seriously addressing OIG's findings, dismissed them and admonished that "it would  
13 be advantageous for OIG to use inspectors with detention and corrections  
14 backgrounds for future inspections to avoid this type of embarrassment to their  
15  
16

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17  
18 <sup>108</sup> Investigation Report Form, CoreCivic General Counsel Office of  
Investigation, at 10 (Aug. 6, 2018) (on file with Plaintiffs' Counsel).

19 <sup>109</sup> *Private prison giant under fire for pressuring Georgia to keep immigrant*  
20 *detainee's death report sealed*, Fast Company (Dec. 10, 2018),  
21 [https://www.fastcompany.com/90279208/private-prison-giant-under-fire-for-](https://www.fastcompany.com/90279208/private-prison-giant-under-fire-for-pressuring-georgia-to-keep-immigrant-detainees-death-report-sealed)  
22 [pressuring-georgia-to-keep-immigrant-detainees-death-report-sealed](https://www.fastcompany.com/90279208/private-prison-giant-under-fire-for-pressuring-georgia-to-keep-immigrant-detainees-death-report-sealed); *Investigation*  
23 *finds ICE detention center cut corners and skirted federal detention rules*, Public  
Radio International, (Mar. 15, 2018), [https://www.pri.org/stories/2018-03-](https://www.pri.org/stories/2018-03-15/investigation-finds-ice-detention-center-cuts-corners-and-skirted-federal)  
24 [15/investigation-finds-ice-detention-center-cuts-corners-and-skirted-federal](https://www.pri.org/stories/2018-03-15/investigation-finds-ice-detention-center-cuts-corners-and-skirted-federal).

25 <sup>110</sup> Letter from Lead Compliance Inspector to Assistant Dir. for Detention Mgmt.,  
*supra* note 93, at 2.; Letter from Lead Compliance Inspector, The Nakamoto Grp.,  
26 to Assistant Dir. for Detention Mgmt., at 2 (Oct. 11, 2018),  
[https://www.ice.gov/doclib/facilityInspections/adelantoWestCa\\_CL\\_10\\_11\\_2018.p](https://www.ice.gov/doclib/facilityInspections/adelantoWestCa_CL_10_11_2018.pdf)  
27 [df](https://www.ice.gov/doclib/facilityInspections/adelantoWestCa_CL_10_11_2018.pdf).

28 <sup>111</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-86 supra* note  
61, at 2, 7, 8.

1 office and ICE.”<sup>112</sup> A March 2019 report by Disability Rights California  
 2 subsequently confirmed and supported OIG’s findings that medical and mental  
 3 health care and segregation policies were seriously deficient at Adelanto.<sup>113</sup>

4 190. These are only a few examples of Nakamoto’s system-wide  
 5 incompetence. As stated by Scott Shuchart, Senior Advisor at CRCL for eight  
 6 years, “Nakamoto has no credibility because of the volume of problems it has  
 7 failed to uncover at multiple facilities over multiple years. . . . It is a checklist  
 8 driven, superficial inspection process.”<sup>114</sup> Similarly, in November 2018, 11 U.S.  
 9 Senators wrote to Nakamoto Group expressing concern that its inspections “are  
 10 potentially misrepresenting conditions in these facilities or underreporting  
 11 violations.”<sup>115</sup> However, despite all evidence that Nakamoto provides an  
 12 ineffective oversight mechanism, Defendants continue to contract with the  
 13 company for critical inspection services.

14 191. ODO inspections also fail to lead to systemic change. A 2016  
 15 inspection of Aurora found deficiencies related to medical notifications, including  
 16 that the Health Services Administrator (“HSA”) was not notified of detained  
 17 individuals determined to be in need of mental health services during intake, and  
 18 that 11 out of 26 medical records of chronic care patients lacked the required

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 20  
 21 <sup>112</sup> Letter from Lead Compliance Inspector to Assistant Dir. for Detention Mgmt.,  
*supra* note 93, at 2.

22 <sup>113</sup> Disability Rights Cal., *supra* note 36, at 4.

23 <sup>114</sup> Katherine Hawkins, *Outsourced Oversight*, Project on Government Oversight  
 24 (March 12, 2019), <https://www.pogo.org/investigation/2019/03/outsourced-oversight/>.

25 <sup>115</sup> Letter from Senator Elizabeth Warren *et al.* to Jennifer H. Nakamoto, President  
 26 Nakamoto Grp., at 1 (Apr. 15, 2018),  
 27 <https://www.warren.senate.gov/imo/media/doc/2018-11-16%20Letter%20to%20Nakamoto%20Group%20re%20ICE%20Detention%20Facility%20Inspections.pdf>.

1 medical or psychiatric alerts forms.<sup>116</sup> The following year, this problem at Aurora  
2 still existed, as demonstrated by the DDR for Kamyar Samimi, who died of opioid  
3 withdrawal at the facility due to intake failures.<sup>117</sup> Overall, in 2018, OIG concluded  
4 that Periodic Inspections do not “ensure consistent compliance with detention  
5 standards, nor do they promote comprehensive deficiency corrections.”<sup>118</sup> As  
6 Inspector General John V. Kelly testified in March 2019, “neither the inspections  
7 nor the onsite monitoring ensure consistent compliance with detention standards,  
8 nor do they promote comprehensive deficiency corrections.”<sup>119</sup>

9 192. Even after inspections reveal major flaws, Defendants regularly fail to  
10 take corrective action. Though ERO Field Offices are tasked to respond to  
11 inspection flaws with corrective plans, they “do not always respond”; “some  
12 respond late, submit incomplete responses, or report that facility deficiencies will  
13 continue due to local policies or conditions.”<sup>120</sup> Repeat offenses are common, as  
14 “ICE does not appear to have a comprehensive process to verify whether facilities  
15 implemented all the corrective actions until the next Nakamoto or ODO  
16 inspection.”<sup>121</sup>

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17  
18 <sup>116</sup> Office of Detention Oversight, U.S. Dep’t of Homeland Sec., *Enforcement and*  
19 *Removal Operations ERO Denver Field Office Denver Contract Detention Facility*  
20 *Aurora, CO*, at 9 (April 2016), [https://www.ice.gov/doclib/foia/odo-compliance-](https://www.ice.gov/doclib/foia/odo-compliance-inspections/denverContractDetentionFacilityAuroraCoApr_12_14_2016.pdf)  
21 [inspections/denverContractDetentionFacilityAuroraCoApr\\_12\\_14\\_2016.pdf](https://www.ice.gov/doclib/foia/odo-compliance-inspections/denverContractDetentionFacilityAuroraCoApr_12_14_2016.pdf).

22 <sup>117</sup> Office of Professional Responsibility, Detainee Death Review – Kamyar  
23 Samimi, at 2, (“Kamyar Samimi DDR”) [https://bento.cdn.pbs.org/hostedbento-](https://bento.cdn.pbs.org/hostedbento-prod/filer_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf)  
24 [prod/filer\\_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf](https://bento.cdn.pbs.org/hostedbento-prod/filer_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf).

25 <sup>118</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-47*, *supra* note  
26 75, at 4.

27 <sup>119</sup> “DHS Office of the Inspector General” *Before the Subcomm. on Homeland Sec.,*  
28 *H. Comm. on Appropriations*, 116th Cong. (2019) (Statement Of John V. Kelly,  
Acting Inspector Gen., U.S. Dep’t of Homeland Sec.),  
<https://www.oig.dhs.gov/sites/default/files/assets/TM/2019/oigtm-jvk-030619.pdf>

<sup>120</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-47*, *supra* note  
75, at 11.

<sup>121</sup> *Id.* at 12.

1           193. Likewise, Defendants often delay responding to or implementing  
2 CRCL recommendations. For example, CRCL’s 2015 report to Congress stated that  
3 it sent ICE 49 recommendations at an Arizona facility in which three individuals  
4 died between October 2012 and April 2013.<sup>122</sup> However, ICE took two years to  
5 respond, and even then, CRCL concluded that ICE did not respond appropriately to  
6 30 of the 49 recommendations.”<sup>123</sup> Similarly, CRCL provided ICE with  
7 recommendations concerning two facilities in 2012, and when ICE finally  
8 responded two and a half years later, “a large number of the responses were deemed  
9 to be either incomplete or unresponsive by CRCL.”<sup>124</sup> CRCL has no enforcement  
10 power, so ICE is free to disagree with CRCL recommendations or refuse to  
11 implement them.<sup>125</sup>

12           194. Defendants also shirk their obligations when they flout a  
13 Congressional directive to “complete and make public an initial report regarding  
14 any in-custody death within 30 days of such death, with subsequent reporting to be  
15 completed and released within 60 days of the initial report.”<sup>126</sup> Though Defendants  
16 have been releasing those reports, beginning fiscal year 2018, ICE stopped  
17 releasing detailed Detainee Death Reviews to its FOIA library, and instead now  
18 publishes cursory “detainee death reports” that recite the basic facts surrounding a  
19 death without detailing why the death happened, what standards were violated, or  
20 how processes could be improved to prevent further deaths.<sup>127</sup>

21 \_\_\_\_\_  
22 <sup>122</sup> Office for Civil Rights & Civil Liberties, U.S. Dep’t of Homeland Sec., *Fiscal*  
23 *Year 2015 Annual Report to Congress*, at 45 (Jun. 10, 2016),  
<https://www.hsdl.org/?view&did=801456>.

24 <sup>123</sup> *Id.*

25 <sup>124</sup> *Id.* at 40.

26 <sup>125</sup> See 6 U.S.C. § 345.

27 <sup>126</sup> H.R. Rep. No. 115-239 (2018).

28 <sup>127</sup> *Death Detainee Report*, Immigration & Customs Enf’t (last updated May 20,  
2019), <https://www.ice.gov/death-detainee-report>; *ICE Releases Sham Immigrant*  
*Death Reports As It Dodges Accountability And Flouts Congressional*

1 195. Defendants also attempt to evade their reporting responsibilities by  
2 interpreting Congress’s mandate to complete reports on an “in-custody death” to  
3 not include deaths in which a detained person is transferred to a hospital to die.<sup>128</sup>  
4 By releasing detained individuals to their deathbeds, ICE evades reporting  
5 requirements and artificially suppresses the number of deaths for which it is  
6 considered responsible. For example, in May 2019, ICE diagnosed Johana Medina  
7 Leon with HIV and then immediately released her to a hospital, where she died four  
8 days later.<sup>129</sup> In February 2019, ICE “released” a comatose José Luis Ibarra Bucio  
9 to a hospital in which he died shortly thereafter.<sup>130</sup> ICE did not release even a  
10 cursory “detainee death report” for either individual.<sup>131</sup>

11 196. Those few times when ICE makes adverse findings regarding  
12 conditions in Detention Facilities, they typically do not result in any  
13 consequences. A January 2019 OIG report found numerous deficiencies in  
14 ICE’s contract enforcement mechanisms.<sup>132</sup>

15 197. First, the 2019 OIG report found that ICE does not consistently use  
16 contract-based quality assurance tools or impose consequences for contract  
17 noncompliance. Only 28 of 106 contracts reviewed for the OIG report contained  
18 Quality Assurance Surveillance Plan provisions that outlined requirements for  
19 compliance with performance standards, and potential actions ICE can take when a  
20

21 Requirements, National Immigrant Justice Center (Dec. 19, 2018),  
22 <https://immigrantjustice.org/press-releases/ice-releases-sham-immigrant-death-reports-it-dodges-accountability-and-flouts>.

23 <sup>128</sup> *A Trans Asylum Seeker Dies After Pleading to ICE for Medical Care*, The  
24 Nation (June 4, 2019), <https://www.thenation.com/article/ice-otero-joa-transgender-death/>.

25 <sup>129</sup> *Id.*

26 <sup>130</sup> *Id.*

27 <sup>131</sup> *Death Detainee Report*, Immigration & Customs Enf’t, *supra* note 127.

28 <sup>132</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-19-18*, *supra* note 45, at 15.

1 contractor fails to meet those standards.<sup>133</sup> This results in confusion among  
2 contracting officers as to whether they can issue Discrepancy Reports documenting  
3 noncompliance, and whether they can seek financial penalties for  
4 noncompliance.<sup>134</sup>

5 198. Second, OIG found that ICE very rarely imposes any consequences on  
6 its contractors for noncompliance.<sup>135</sup> From October 2015 to June 2018, various  
7 inspections and DSMs found 14,003 deficiencies at the 106 contract facilities  
8 reviewed by OIG, yet ICE imposed financial penalties only twice.<sup>136</sup> One of those  
9 two fines was for underpayment of wages to contractors.<sup>137</sup> Stewart and Adelanto,  
10 for example, have never been fined, despite multiple detainee deaths and internal  
11 OIG findings of noncompliance. Further, beginning in fiscal year 2009, Congress  
12 added language to the DHS appropriations bill requiring that ICE terminate  
13 contracts for any facility that failed two consecutive inspections.<sup>138</sup> Since then, no  
14 facility has failed two consecutive inspections.<sup>139</sup>

15 199. Third, the 2019 OIG report noted that ICE uses waivers to excuse  
16 substandard conditions in Detention Facilities.<sup>140</sup> ICE frequently issues waivers of  
17 compliance to facilities with deficient conditions; however, ICE lacks a formal  
18 policy to govern the waiver process, and it has allowed ERO officials without clear  
19 authority to grant waivers.<sup>141</sup> Contract facilities may be exempt from compliance  
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21 <sup>133</sup> *Id.* at 7.

22 <sup>134</sup> *Id.*

23 <sup>135</sup> *Id.* at 7–8.

24 <sup>136</sup> *Id.*

25 <sup>137</sup> *Id.* at 9.

26 <sup>138</sup> Department of Homeland Security Appropriations Act of 2009, H.R. 6947,  
27 110th Cong. at 18 (2008).

28 <sup>139</sup> Hawkins, *supra* note 114.

<sup>140</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-19-18*, *supra* note  
45, at 7.

<sup>141</sup> *Id.*

1 indefinitely, as some waivers lack an end date and are not reviewed after  
2 approval.<sup>142</sup> Further, ICE fails to communicate about waivers to its Office of  
3 Acquisitions Management.<sup>143</sup> Thus, Acquisitions Management cannot ensure that  
4 its Contract Officers' Representatives, or CORs, know about waiver decisions,  
5 which undermines their ability to monitor their assigned contracts.

6 200. Fourth, OIG found that ICE's policies result in inadequate  
7 enforcement of contracts because (a) ICE's policy of placing CORs in ERO Field  
8 Offices inhibits their ability to enforce contracts, and (b) ICE assigns too many  
9 contracts to individual CORs to allow CORs to adequately enforce those contracts.  
10 Specifically, CORs' current placement within ERO Field Offices has resulted in  
11 pressure for CORs to break protocol, the assignment of additional duties that create  
12 unachievable workloads, and the creation of environments impeding the oversight  
13 of contracts.<sup>144</sup> For example, OIG's 2019 report found that "[t]hree Field Offices  
14 restricted CORs from traveling to Detention Facilities" to evaluate compliance.<sup>145</sup>  
15 Some CORs reported that they "were hesitant to identify instances of  
16 noncompliance or issue Discrepancy Reports . . . because they feared retaliation  
17 from Field Office management."<sup>146</sup>

18 201. Fifth, a lack of direct access to important contract files hinders CORs'  
19 and DSMs' ability to monitor detention contracts.<sup>147</sup> CORs and DSMs both monitor  
20 detention contracts, but they lack consistent access to essential contract files  
21 including contracts and modifications.<sup>148</sup> CORs and DSMs do not have electronic  
22 access to contract files, and instead must maintain their own files—but they do not

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23 <sup>142</sup> *Id.* at 10.

24 <sup>143</sup> *Id.* at 12.

25 <sup>144</sup> *Id.*

26 <sup>145</sup> *Id.* at 13.

27 <sup>146</sup> *Id.*

28 <sup>147</sup> *Id.* at 14–15.

<sup>148</sup> *Id.* at 15.

1 always receive contracts and modifications and must try to obtain these documents  
2 on their own, which can be time-consuming and inefficient.<sup>149</sup>

3 202. Ultimately, as OIG's 2019 report concluded, "[n]ot only does ICE not  
4 fully use contracting tools to hold detention facility contractors accountable for  
5 failing to meet performance standards, [OIG's] previous work has determined that  
6 ICE's inspections and onsite monitoring do not ensure consistent compliance with  
7 detention standards or promote comprehensive deficiency corrections."<sup>150</sup> By  
8 Defendants' own Inspector General's assessment, ICE has failed to meet  
9 monitoring and oversight responsibilities, leaving the tens of thousands in  
10 Defendants' custody to suffer.

11 **VI. As a Result of Defendants' Failure to Monitor and Oversee Medical and**  
12 **Mental Health Care at Detention Facilities, Conditions in Those**  
13 **Facilities Constitute Punishment and Expose Plaintiffs and Class**  
14 **Members to Substantial Risk of Serious Harm.**

15 203. All Plaintiffs and the Class challenge Defendants' failure to ensure  
16 Detention Facilities provide constitutionally adequate medical and mental health  
17 care.

18 204. Specifically, the policies, practices, and procedures include but are not  
19 limited to Defendants' failures to ensure the following: (1) adequate medical and  
20 mental health care without lengthy and dangerous delays and outright denials of  
21 care; (2) timely access to medically necessary specialty care or chronic care;  
22 (3) provision of health care by trained or qualified personnel; (4) provision of  
23 timely emergency health care; (5) adequate physical and mental health intake  
24 screening; (6) adequate staffing of medical and mental health care positions;  
25 (7) adequate mental health care; (8) adequate maintenance of medical records and  
26 documentation; and (9) location of Detention Facilities in places where specialists  
27 and community health care providers are readily available. In addition, the Class

28 <sup>149</sup> *Id.*

<sup>150</sup> *Id.* at 17.



1 challenges Defendants’ policies, practices, and procedures resulting in Defendants’  
2 failure to ensure that conditions of confinement at Detention Facilities are not  
3 similar to, or worse than, conditions found in prisons. Together, these practices will  
4 be referred to as the “Challenged Practices.”

5 205. Organizational Plaintiffs ICIJ and Al Otro Lado have had to divert  
6 resources, and have had their missions frustrated, as a result of the Challenged  
7 Practices.

8 206. All Individual Plaintiffs and members of the Class face a substantial  
9 risk of serious harm resulting from Defendants’ failure to adequately monitor and  
10 oversee the Challenged Practices at Detention Facilities.

11 207. In addition, conditions of confinement that are expressly intended to  
12 punish, that are not reasonably related to a legitimate governmental objective, or  
13 that are excessive in relation to that objective constitute punishment in violation of  
14 the Fifth Amendment due process clause.

15 208. As a result of Defendants’ failure to adequately monitor and oversee  
16 medical and mental health care practices in Detention Facilities, the Individual  
17 Plaintiffs and members of the Class are subjected to the Challenged Practices,  
18 which individually and collectively constitute punishment because they are  
19 expressly intended to punish, and are not reasonably related to a legitimate  
20 governmental objective and/or are excessive in relation to that objective.

21 **A. Defendants Systemically Fail to Ensure That Detained Individuals**  
22 **Receive Timely Medical and Mental Health Care.**

23 209. Defendants have a policy and practice of systemically failing to  
24 monitor and enforce requirements to provide timely access to medical and mental  
25 health care. Across Defendants’ network of Detention Facilities, detained  
26 individuals experience lengthy and dangerous delays, and often outright denials, in  
27 receiving medical and mental health care.

28

1           210. To seek care, detained individuals regularly must make repeated  
2 requests to staff for medical attention—and then wait for days for a response. Once  
3 they do receive a response, it is often days, weeks, or months before they can see  
4 medical staff within Detention Facilities. They are commonly given over-the-  
5 counter pain medication as the only intervention, even if the underlying medical  
6 issue—from cancer to chest pain to depression—requires more serious and  
7 immediate treatment.

8           211. Detained individuals experience harm and unnecessary pain and  
9 suffering as a result of these delays and denials. Examples of the harm include  
10 cancer that goes undiagnosed for years, severe pain that is left untreated, and  
11 detained individuals who are placed at risk of amputation and other severe medical  
12 consequences.

13           212. Moreover, Defendants are deliberately indifferent to the serious risk of  
14 substantial harm and injury to detained individuals that results from this systemic  
15 failure. Delays and denial of medical and mental health care have been cited  
16 repeatedly in government reviews documenting detained individuals' deaths, in the  
17 government's own reporting on Defendants' Detention Facility network, and in  
18 non-governmental organization reporting. Despite these reports, Defendants have  
19 taken no effective steps to eliminate or mitigate the delays and denial of care,  
20 exposing Plaintiffs and members of the Class to significant risk of serious medical  
21 harm.

22           213. These problems are systemic, as shown by the examples below of  
23 delays or denials of medical treatment at Detention Facilities across the country.

24           214. Plaintiff Jimmy Sudney has experienced numerous delays in care for  
25 his vision. In late 2015 and early 2016, while detained, he had surgeries to implant  
26 and then remove silicone and a lens from his eye. His doctors then intended to  
27 perform another surgery on December 9, 2016, to address glaucoma, a second-  
28 degree cataract, and a detaching retina. On December 7, two days before he was to

1 have surgery, he was transferred to Eloy. Mr. Sudney told the doctor at Eloy that he  
2 was supposed to have surgery, but did not have access to papers from his previous  
3 doctors to show the Eloy doctor what he needed. Mr. Sudney was hospitalized three  
4 times related to his high eye pressure while in detention at Eloy—once because the  
5 Eloy doctor gave him medicine that gave him a seizure. The month after Mr.  
6 Sudney filed a complaint regarding inadequate care for his eye, he was transferred  
7 to Adelanto.

8 215. At Adelanto, Mr. Sudney continues to experience delays in care for his  
9 eye. He saw a retina specialist in November 2018, who he did not see again until  
10 May 2019—six months later. In July 2019, an outside doctor told Mr. Sudney that  
11 he needs to have surgery as soon as possible, before he loses his vision completely.  
12 Mr. Sudney’s eye is getting worse—it is blurry when he reads, stays red, and he is  
13 losing vision and starting to see flashing light and dripping on his eye. Mr. Sudney  
14 has still not had the surgery he has needed since December 2016.

15 216. Plaintiff Melvin Murillo Hernandez endured four allergic, anaphylactic  
16 shocks in six months before facility staff ordered a blood test to determine the  
17 extent of Mr. Murillo Hernandez’s allergies. On May 1, 2019, after Mr. Murillo  
18 Hernandez had already once required hospitalization for anaphylactic shock, two  
19 independent doctors informed ICE that Mr. Murillo Hernandez required access to  
20 an EpiPen and an environment free of allergens. Staff at River did nothing, and Mr.  
21 Murillo Hernandez subsequently required hospitalization on May 5 and May 6,  
22 2019. Though medical staff did not identify any known allergens as the cause for  
23 Mr. Murillo Hernandez’s May 5 and May 6 anaphylaxis, medical staff again failed  
24 to do any additional allergy testing or provide him access to an EpiPen. As a result,  
25 Mr. Murillo Hernandez subsequently suffered at least another two hospitalizations.  
26 Though medical staff referred him to an allergist on May 8, 2019, they never took  
27 him to see any specialist until August 14, 2018. They waited until June 2019 to  
28 perform the blood test necessary to determine Mr. Murillo Hernandez’s allergies.

1           217. Likewise, on May 10, 2019, Mr. Murillo Hernandez told a nurse that  
2 his heart was beating fast and his chest was hurting. Given Mr. Murillo  
3 Hernandez's allergy history, medical staff should have closely monitored his  
4 condition. Instead, the nurse told him the he was fine and did not order any  
5 observation. The following morning, because of these failures, Mr. Murillo  
6 Hernandez once again went into severe anaphylactic shock necessitating  
7 hospitalization.

8           218. Plaintiff Alex Hernandez has experienced blurry vision and reported it  
9 to medical staff at Etowah in or around April 2019. He was previously prescribed  
10 glasses which were broken. He requested to see an optometrist. A nurse conducted  
11 his vision test and told him he did not meet ICE's requirements to see an  
12 optometrist, although the findings of the vision test are not noted in his records. He  
13 was told he would receive reading glasses, but he has not received them and cannot  
14 read his legal papers or other documents without borrowing another detainee's  
15 glasses. Mr. Hernandez also has a torn rotator cuff, loss of vision, Barrett's  
16 esophagus, and persistent pain in his hip, legs, and feet, and PTSD, for which he  
17 needs ongoing medical care.

18           219. Plaintiff Salazar Artaga experienced a delay of more than a month in  
19 receiving psychiatric care and appropriate psychotropic medication upon his arrival  
20 to Florence Correctional Center, even after requesting the medication and  
21 exhibiting symptoms of psychosis—banging his head on the walls, scratching  
22 himself to the point that he was bleeding, and auditory and visual hallucinations—  
23 because of a failure to identify his condition and suspicion of secondary gain. This  
24 delay contributed to avoidable self-harm.

25           220. The experiences of Plaintiffs are not unique. Worse yet, Defendants  
26 are on notice of, but have failed to remedy, these systemic delays and denials of  
27 care.

28

1           221. For example, a report OIG produced on Adelanto concluded that  
2 “detainees do not have timely access to proper medical care,” and that “detainees  
3 are placed on wait lists for months and, sometimes, years to receive basic dental  
4 care.”<sup>151</sup>

5           222. According to a December 2017 OIG report, detained individuals at the  
6 Stewart Detention Center in Georgia and the Santa Ana City Jail in California,  
7 which previously contracted with ICE, reported “long waits for the provision of  
8 medical care, including instances of detainees with painful conditions, such as  
9 infected teeth and a knee injury, waiting days for medical intervention.”<sup>152</sup>

10           223. Between 2011 and 2019, Detainee Death Reviews, or DDRs,  
11 documented lengthy and dangerous delays and denials of medical and mental health  
12 care at Detention Facilities across the country, including Adelanto, Albany County  
13 Correctional Facility (“Albany County”), Aurora, Brooks County Detention Center  
14 (“Brooks County”), Dodge County Detention Center (“Dodge County”), Elizabeth  
15 Detention Center (“Elizabeth”), Eloy, El Paso Processing Center (“El Paso”),  
16 Houston Contract Detention Center (“Houston”), Hudson County Correctional  
17 Facility (“Hudson County”), Immigration Centers of America—Farmville  
18 (“Farmville”), Joe Corley Detention Center (“Joe Corley”), Krome Service  
19 Processing Center (“Krome”), Rio Grande Detention Center (“Rio Grande”),  
20 Rolling Plains Correctional Facility (“Rolling Plains”), South Texas Detention  
21 Complex (“South Texas”), Stewart, Theo Lacy, and Utah County Jail (“Utah  
22 County”). These delays and denials contributed to a substantial number of the  
23 deaths reviewed.

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25 <sup>151</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-86*, *supra* note  
26 61, at 7.

27 <sup>152</sup> Office of Inspector Gen., Office of Homeland Sec., *OIG-18-32: Concerns About*  
28 *ICE Detainee Treatment and Care at Detention Facilities*, at 7 (2017),  
<https://www.oig.dhs.gov/sites/default/files/assets/2017-12/OIG-18-32-Dec17.pdf>.

1           224. A 2018 Human Rights Watch (“HRW”) report further documents  
2 detainee deaths connected to dangerous and unreasonable delays in medical care at  
3 Adelanto, El Paso, Otero County Processing Center (“Otero County”), and San  
4 Diego County Detention Facility (“San Diego County”).<sup>153</sup>

5           225. The following are just a few examples from the DDRs, HRW reports,  
6 and DRC reports that illustrate the harms caused by delays and lack of access to  
7 medical care in Detention Facilities.

8           226. On April 13, 2017, Sergio Alonso Lopez died from an upper  
9 gastrointestinal bleed while detained at Adelanto.<sup>154</sup> The DDR found that Mr.  
10 Lopez never received a response to his sick call requests within 48 hours unless he  
11 was already scheduled for a follow-up appointment.<sup>155</sup> He also waited more than  
12 four weeks to see a provider after laboratory tests showed abnormal results in  
13 February 2017.<sup>156</sup> As a result, “provider consideration of further testing and  
14 treatment was delayed.”<sup>157</sup>

15           227. On April 6, 2015 Raul Ernesto Morales-Ramos died at Adelanto of  
16 organ failure with signs of widespread gastrointestinal cancer, which went  
17 undiagnosed despite two and a half years of Mr. Morales-Ramos’ complaints about  
18 gastrointestinal issues at Theo Lacy and Adelanto.<sup>158</sup>

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20 \_\_\_\_\_  
21 <sup>153</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
22 Center & Detention Watch Network, *Code Red: The Fatal Consequences of*  
23 *Dangerously Substandard Medical Care in Immigration Detention*, at 15, 19, 25,  
46 (June 2018),  
[https://www.hrw.org/sites/default/files/report\\_pdf/us0618\\_immigration\\_web2.pdf](https://www.hrw.org/sites/default/files/report_pdf/us0618_immigration_web2.pdf).

24 <sup>154</sup> Sergio Alonso Lopez DDR, *supra* note 71, at 16.

25 <sup>155</sup> *Id.*

26 <sup>156</sup> *Id.*

27 <sup>157</sup> *Id.*

28 <sup>158</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
*Death Review – Raul Ernesto Morales-Ramos*, at 1, 4–26 (“Morales-Ramos DDR”)  
<https://www.ice.gov/doclib/foia/reports/ddr-morales.pdf>.

1           228. On October 24, 2016, Olubunmi Toyin Joshua died of hypertensive  
2 cardiovascular disease while in ICE custody at Rolling Plains.<sup>159</sup> The DDR found  
3 that Ms. Joshua experienced multiple delays or denials of treatment. Despite high  
4 blood pressure readings on ten separate occasions, nursing staff failed to notify a  
5 provider, in contravention of nursing protocol.<sup>160</sup> After she was diagnosed with  
6 anemia and anxiety, conditions that increased her risk of heart attack, she waited  
7 two months before receiving iron supplements, and she never received anxiety  
8 medication.<sup>161</sup> Additionally, it took two weeks and three requests before she was  
9 seen by a dentist on October 20, 2016, who found that she had gum abscesses and  
10 broken teeth.<sup>162</sup> These deficiencies resulted in part from inadequate staffing. An  
11 independent medical expert found that “[i]t is difficult to imagine how the poor care  
12 provided to her during her detention did not materially contribute to her death.”<sup>163</sup>

13           229. Third party reports are also replete with examples of delayed or denied  
14 medical care. For example, the 2019 DRC report found that Adelanto staff waited  
15 three months to provide the results of HIV and pregnancy tests to a woman who  
16 was raped multiple times during her journey to the United States.<sup>164</sup>

17           230. Likewise, an asylum seeker from Cameroon detained at Imperial  
18 Detention Facility (“Imperial”) waited over four months in extreme pain to have  
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21

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22 <sup>159</sup> Office of Professional Responsibility, *Detainee Death Review – Olubunmi Toyin*  
23 *Joshua* (2016) (“Olubunmi Toyin Joshua DDR”),  
24 <https://www.ice.gov/doclib/foia/reports/ddr-Joshua.pdf>.

<sup>160</sup> *Id.* at 17.

<sup>161</sup> *Id.* at 18.

<sup>162</sup> *Id.* at 19.

<sup>163</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
27 Center & Detention Watch Network, *supra* note 153161, at 33.

<sup>164</sup> Disability Rights Cal., *supra* note 36, at 33.

1 several teeth pulled.<sup>165</sup> Dental staff told her they could only remove the problematic  
2 teeth, as opposed to providing other preventative care, because their contract  
3 limited them to extractions.<sup>166</sup> Furthermore, dental care staff at both Imperial and  
4 Mesa Verde stated that no routine checkups or cleanings are provided to detained  
5 individuals until they are detained for at least one year.<sup>167</sup>

6 231. An asylum seeker from India saw the dentist at Imperial due to  
7 extreme pain in his mouth.<sup>168</sup> He was given painkillers but was not treated for the  
8 cause of pain.<sup>169</sup> He was told by dental staff that he needs additional treatment, but  
9 he has been waiting for treatment for two months. Every time he eats, his teeth hurt  
10 him.<sup>170</sup>

11 232. An asylum seeker detained at Otay Mesa was repeatedly denied  
12 treatment for severe back pain.<sup>171</sup> Facility guards forced her to walk without a  
13 mobility aid despite her continued complaints; she fell and hurt herself further, and  
14 she now must use a wheelchair.<sup>172</sup>

15 233. Another detained individual at Otay Mesa complained of  
16 hemorrhaging for over two months and was repeatedly ignored until she fainted.<sup>173</sup>  
17 She was taken to the hospital, where she had a blood transfusion in the hospital  
18 parking garage.<sup>174</sup>

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20 <sup>165</sup> Human Rights First, *Prisons and Punishment: Immigration Detention in*  
21 *California*, at 11 (Jan. 2018),  
22 [https://www.humanrightsfirst.org/sites/default/files/Prisons\\_and\\_Punishment.pdf](https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf).

23 <sup>166</sup> *Id.*

24 <sup>167</sup> *Id.*

25 <sup>168</sup> *Id.* at 12.

26 <sup>169</sup> *Id.*

27 <sup>170</sup> *Id.*

28 <sup>171</sup> *Id.*

<sup>172</sup> *Id.*

<sup>173</sup> *Id.*

<sup>174</sup> *Id.*



1           234. Yet another detained individual at Otay Mesa experienced pain in her  
2 abdominal area for five months.<sup>175</sup> She was finally taken to the hospital, in shackles,  
3 for an ultrasound.<sup>176</sup> The hospital told her she had uterine fibroids and needed to see  
4 a gynecologist.<sup>177</sup> Upon return to the detention center, she was given ibuprofen and  
5 told to wait for an appointment.<sup>178</sup> As of March 2019, she had been waiting two  
6 months, despite complaining repeatedly to facility staff about vaginal bleeding.<sup>179</sup>

7           235. Another detained individual at Adelanto reported, “I write a request to  
8 see doctor every day, but I haven’t been able to see one for six weeks[.] I’ve asked  
9 for medicine, but the only thing they have given me is ibuprofen.”<sup>180</sup> A detained  
10 individual at Imperial requested emergency help because of a severe tooth pain.<sup>181</sup>  
11 He saw a nurse who gave him some pain medication and was initially told he would  
12 see a dentist later that day, but the patient did not actually see a dentist until four  
13 days later.<sup>182</sup> He was later diagnosed with a periodontal abscess, which, according  
14 to an independent medical expert, could have spread to the rest of the body and  
15 developed into sepsis if left untreated.<sup>183</sup> The expert concluded that the detained  
16 individual should have been seen by a dentist the same day he reported severe  
17 pain.<sup>184</sup>

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18  
19 <sup>175</sup> *Id.* at 11.

20 <sup>176</sup> *Id.*

21 <sup>177</sup> *Id.*

22 <sup>178</sup> *Id.*

23 <sup>179</sup> *Id.*

24 <sup>180</sup> Ken Silverstein, *Death Valley: Profit and Despair Inside California’s Largest  
Immigration Detention Camp*, Project on Government Oversight (Dec. 22, 2018),  
[https://www.pogo.org/investigation/2018/12/death-valley-profit-and-despair-inside-  
californias-largest-immigration-detention-camp/](https://www.pogo.org/investigation/2018/12/death-valley-profit-and-despair-inside-californias-largest-immigration-detention-camp/).

25 <sup>181</sup> Human Rights Watch & CIVIC, *Systemic Indifference: Dangerous and  
Substandard Medical Care in U.S. Immigration Detention*, at 57 (May 2017),  
[https://www.hrw.org/sites/default/files/report\\_pdf/usimmigration0517\\_web\\_0.pdf](https://www.hrw.org/sites/default/files/report_pdf/usimmigration0517_web_0.pdf).

26 <sup>182</sup> *Id.*

27 <sup>183</sup> *Id.*

28 <sup>184</sup> *Id.*

1           236. The evidence set forth above and in the referenced reports show  
2 Defendants' long-standing and systemic failure to ensure that medical and mental  
3 health care is timely provided in Detention Facilities across the country. Defendants  
4 are well aware of these delays and denials of health care in their network of  
5 Detention Facilities, but they have taken no effective steps to ensure that care is  
6 timely provided to detained individuals.

7           **B. Defendants Systemically Fail to Ensure Timely Access to Medically**  
8           **Necessary Specialty and Chronic Care.**

9           237. Defendants have a policy and practice of systemically failing to  
10 monitor and enforce requirements for timely access to medically necessary  
11 specialty care, where the underlying condition requires the attention of a medical  
12 specialist, or to chronic care, where the underlying condition requires ongoing  
13 medical needs or diseases.

14           238. Defendants require ICE Health Service Corps approval of all  
15 nonemergency requests for specialty care outside of the facility. Because the  
16 Detention Facilities themselves do not employ medical specialists, this IHSC  
17 approval process often results in lengthy delays and denials of specialty care. The  
18 delays are not surprising because, according to a 2016 GAO report, Defendants  
19 have no specific written clinical guidelines on which to base decisions on requests  
20 for specialty care outside of a facility.<sup>185</sup>

21           239. Compounding the delays, on information and belief, Defendants  
22 require that facilities make an appointment with an off-site provider before  
23 receiving approval from IHSC, which risks cancellation of the appointment if IHSC  
24 does not approve the request or fails to do so in a timely manner. These  
25 appointments are particularly difficult to reschedule in many Detention Facilities in  
26 rural areas, far from any providers of specialty medical care.

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<sup>185</sup> U.S. Gov't Accountability Office, *GAO-16-23*, *supra* note 6970, at 18.

1           240. On information and belief, Defendants often do not provide specialty  
2 care for detained individuals that they believe may be deported soon. For example,  
3 Gabe Valdez, the ICE Assistant Field Office Director (“AFOD”) at Adelanto, told  
4 HRW that decisions on outside treatment can be affected by whether deportation is  
5 imminent. He stated, “[t]imelines for approval exist,”<sup>186</sup> explaining that a man who  
6 needs dentures but who will be deported in three days will not get dentures. He  
7 further stated decisions are made in consultation with ICE and with IHSC. Among  
8 other problems with this policy, Defendants cannot always predict when a person  
9 will be deported or released. Also, imminent departure dates do not obviate the  
10 need to provide medically necessary care while in ICE custody.

11           241. The California Department of Justice issued a report in March 2019  
12 finding a failure to thoroughly assess patients with chronic diseases at West County  
13 Detention Facility in California. Referrals to specialty care were delayed up to  
14 seven weeks.<sup>187</sup> Likewise, a 2017 New York Lawyers for the Public Interest report  
15 documented Hudson County staff’s frequent denials of chronic and specialty care,  
16 including failures to provide specialty care to one detained individual suffering  
17 from sickle cell anemia and to another experiencing complications from a  
18 malfunctioning pacemaker.<sup>188</sup>

19           242. Delays from these policies have in many cases resulted in unnecessary  
20 pain and suffering, permanent injuries, and death. For example, detained  
21 individuals with known heart conditions are denied treatment by specialists; a  
22 detained person with cataracts needing surgery was denied this treatment for a year,  
23

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24 <sup>186</sup> Human Rights Watch & CIVIC, *supra* note 181193, at 70.

25 <sup>187</sup> Becerra, *supra* note 19, at 115–16.

26 <sup>188</sup> New York Lawyers for the Public Interest, *Detained and Denied: Healthcare*  
27 *Access in Immigration Detention*, at 7–11 (February 2017),  
28 [https://www.nylpi.org/wp-content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report\\_2017.pdf](https://www.nylpi.org/wp-content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report_2017.pdf).

1 causing her vision to greatly deteriorate; and detained individuals with obvious  
2 mental health issues are not provided specialty care.

3 243. Defendants are deliberately indifferent to the serious risk of substantial  
4 harm and injury to Plaintiffs from this systemic failure. The deficiencies in the  
5 provision of specialty and chronic medical care at Detention Facilities have been  
6 repeatedly documented, including, without limitation, in numerous DDRs,  
7 government reports, and nonprofit reports. Nevertheless, Defendants have taken no  
8 effective steps to mitigate them, exposing Plaintiffs and members of the Class to  
9 substantial risk of serious harm.

10 244. These failures to provide timely specialty and chronic medical care are  
11 routine. Defendants have taken no action to effectively monitor or ensure that  
12 Detention Facilities provide constitutionally mandated chronic and specialty care.

13 245. These problems are systemic, occurring across Defendants' network of  
14 Detention Facilities, and are illustrated by the experiences of the Named Plaintiffs.

15 246. For example, Plaintiff Marco Montoya Amaya's medical records  
16 indicate that the Yuba County Jail intended to refer him to a neurologist for  
17 treatment of apparent end-stage neurocysticercosis on April 23, 2018. On  
18 information and belief, Mr. Montoya Amaya has still never seen a neurologist,  
19 despite worsening symptoms consistent with a brain parasite, and despite his likely  
20 need for intensive treatment for this potentially life-threatening parasite condition.  
21 Neurocysticercosis, when untreated, carries significant risks of brain damage,  
22 meningitis, seizures, inflammation of the spinal cord that can lead to paralysis,  
23 swelling of the brain that can lead to blindness, irreversible cognitive and  
24 psychiatric symptoms, and other complications that may be fatal.<sup>189</sup>

25 247. Plaintiff Jose Segovia Benitez has a heart condition that requires  
26 specialty care. Due to Defendants' failure to ensure he receives specialty care, Mr.

27 \_\_\_\_\_  
28 <sup>189</sup>*Parasites—Cysticercosis*, Centers for Disease Control and Prevention, available  
at [https://www.cdc.gov/parasites/cysticercosis/health\\_professionals/index.html](https://www.cdc.gov/parasites/cysticercosis/health_professionals/index.html).

1 Segovia Benitez was hospitalized for several days for cardiac problems that may  
2 have been avoided. Adelanto has entirely ignored several abnormal cardiology test  
3 results while he has been in detention, despite his reports of intermittent chest pains  
4 and several risk factors in his medical history. Specifically, in March 2018 and  
5 again in January 2019, Mr. Segovia Benitez had an electrocardiogram (“EKG”) that  
6 produced abnormal results; however, there was no apparent follow-up.

7 248. In April 2019, Mr. Segovia Benitez saw a doctor for chest pains, and  
8 he was finally referred to a cardiologist and prescribed medication for his high  
9 lipids. On information and belief, Mr. Segovia Benitez has not seen a cardiologist  
10 through this referral, despite the urgency of this medical issue. Instead, Mr. Segovia  
11 Benitez was seen by a cardiologist only during a cardiac emergency in July 2019;  
12 however, since he was returned to Adelanto following that emergency, he has had  
13 no follow-up cardiology care.

14 249. Plaintiff Salazar Artaga has repeatedly requested appropriate  
15 medication and medical equipment for his cerebral palsy, a musculoskeletal and  
16 developmental disorder. These included, for example, requests on March 21,  
17 March 29, and April 7, and April 16, 2019 for appropriate medications to manage  
18 back, knee, and foot pain resulting from his cerebral palsy. When the chronic  
19 medication he typically takes for pain, Gabapentin, was prescribed after a delay, it  
20 was prescribed at a much lower dose than his usual regimen and only “as needed”  
21 instead of on a scheduled basis, which contributed to poor pain control for several  
22 weeks.

23 250. Plaintiff Edilberto García Guerrero, who is detained at Aurora, has  
24 been suffering from chronic migraines for several months. He has submitted written  
25 requests for medical treatment to treat these migraines and has not had a diagnostic  
26 evaluation or received any treatment specific to these migraines.

27 251. Mr. García Guerrero has also requested medical care due to  
28 deterioration of his vision over several months. His visual acuity was noted by a

1 medical staff employee at Aurora in mid-December 2018, although visual acuity  
2 tests merely note the general performance of a person's vision and do not alone  
3 have significant medically diagnostic value. His vision was not evaluated by an  
4 optometrist until months later, in June 2019. Mr. García Guerrero still has  
5 diminished vision and has not been fitted for glasses.

6 252. In addition, Mr. García Guerrero has noted moving black spots in his  
7 left eye, as well as a burning sensation since around the time he was attacked by  
8 other detained individuals in spring 2019, diminishing his vision in his left eye. He  
9 has still not seen a specialist for a diagnostic evaluation or for treatment.

10 253. Mr. García Guerrero has diminished hearing and persistent pain in his  
11 left ear. He has been experiencing these symptoms since spring 2019 and  
12 complained to medical staff of this ongoing issue. He filed a medical request in  
13 May 2019 and previously complained about the pain and diminished hearing to  
14 facility staff. Mr. García Guerrero still has not seen a medical professional to  
15 diagnose or treat his ear issues.

16 254. Mr. García Guerrero had orthopedic surgery on his right ankle around  
17 six ago after he was injured prior to detention. At that time, hardware was placed in  
18 his bone. While in ankle shackles in ICE custody at the Aurora facility, Mr. García  
19 Guerrero fell, injuring that same right ankle. His ankle has been swollen and very  
20 painful in the several months since his fall. Mr. García Guerrero saw an orthopedic  
21 specialist at the hospital in the spring of 2019. This specialist recommended  
22 surgical intervention to fix his ankle. Mr. García Guerrero has still not had surgery,  
23 although, on information and belief, he may have very recently been scheduled for  
24 surgery. The facility provided him with a plastic ankle brace, and had long  
25 informed him that the surgery would not be scheduled because it was "elective."

26 255. Plaintiff Alex Hernandez has a torn rotator cuff in his right shoulder.  
27 He has had this injury for several years, causing Mr. Hernandez persistent and  
28 severe pain on a daily basis. When he was transferred to ICE custody, he was

1 detained at Mesa Verde. Mr. Hernandez had a magnetic resonance imaging  
2 (“MRI”) while detained at Mesa Verde, which led to diagnosis of his torn rotator  
3 cuff. An orthopedic surgeon recommended surgery to repair his shoulder. Instead of  
4 scheduling the surgery, ICE transferred him two weeks after the doctor  
5 recommended surgery.

6 256. In or around October 2017, Mr. Hernandez was transferred to Otay  
7 Mesa. His medical records, however, were not transferred, and he had to begin the  
8 process of getting treatment for his torn rotator cuff from the beginning, despite  
9 reporting the previous tests and recommendations to the medical staff at Otay Mesa.  
10 He had an MRI in late November 2017 and a CT scan in January 2018; these tests  
11 confirmed the same diagnosis he received at Mesa Verde—that Mr. Hernandez had  
12 a torn rotator cuff. He received physical therapy and received cortisone shots that  
13 temporarily helped, but the pain and limited range of motion persisted. Finally, in  
14 or around December 2018, orthopedic surgeon he saw at Otay Mesa recommended  
15 surgery.

16 257. Shortly after he was recommended for surgery a second time, Mr.  
17 Hernandez was transferred yet again—this time to Etowah on or around December  
18 12, 2018. Again, his medical records were not transferred with him and he had to  
19 sign a consent form for Etowah to receive the records, even though he was still in  
20 ICE custody. For the third time, he had to restart the diagnostic process to receive  
21 treatment for his shoulder. Yet again, he had to have another MRI, despite the two  
22 previous recommendations for surgery based on two previous MRIs. He had to wait  
23 approximately three months before he was able to see an off-site specialist for his  
24 shoulder. The orthopedic surgeon recommended surgery in late April 2019, but it  
25 has yet to be scheduled, and Mr. Hernandez has not received any information as to  
26 when he will be able to have the operation. As a result, he continues to experience  
27 severe pain in his shoulder and has a limited range of motion. He fears that his  
28 injury will worsen due to the lack of treatment.

1           258. In addition to his torn rotator cuff, Mr. Hernandez experiences  
2 persistent pain in his right hip and both legs and feet that impedes his ability to  
3 stand for more than about fifteen minutes and limits his mobility. Mr. Hernandez  
4 saw an orthopedic surgeon in Otay Mesa to treat this medical issue, and he had to  
5 restart this treatment as well when he was transferred to Etowah. Mr. Hernandez is  
6 in near constant pain due to the inflammation in his hip and his feet. He was  
7 recently told that he will not receive treatment for his hip and leg pain until after he  
8 has had surgery for his shoulder, which has yet to be scheduled, to Mr. Hernandez's  
9 knowledge.

10           259. Mr. Hernandez is also diagnosed with Barrett's Esophagus, which  
11 places him at higher risk of esophageal cancer. To monitor this condition, he was  
12 receiving regular endoscopies not more than every three years. His last endoscopy  
13 was a year before he was in ICE custody. He has reported this condition and the  
14 need for his endoscopy to monitor his condition. It has been nearly four years since  
15 he had his last endoscopy.

16           260. Plaintiff Aristoteles Sanchez Martinez has diabetes. His blood sugar  
17 levels have consistently been dangerously high since entering ICE custody. Prior to  
18 being in ICE detention, Mr. Sanchez Martinez's diabetes was being managed, but it  
19 has progressively worsened since being in ICE custody. There have been no  
20 meaningful efforts made to control his blood sugar, such as changing his diet,  
21 significantly increasing his insulin dosage, or changing the type of insulin he  
22 receives.

23           261. Mr. Sanchez Martinez has experienced delays and denials in receiving  
24 his daily insulin shots due to the lack of custody staff to escort him to medical.  
25 Twice a day, Mr. Sanchez Martinez must have his blood sugar checked and receive  
26 insulin based on his blood sugar. However, due to inadequate staffing, he rarely  
27 receives his insulin shots on time, and sometimes not at all, putting him at risk of  
28 life-threatening situations daily.



1           262. Since November 2018, Mr. Sanchez Martinez has missed at least 11  
2 insulin shots. On numerous other occasions, he was delayed in receiving his insulin,  
3 and thus at risk of missing a meal. The denials he experienced in receiving his  
4 insulin shots have contributed to his uncontrolled diabetes, which in turn has  
5 exacerbated the severity of his other medical conditions.

6           263. Additionally, staff are not well-trained as to Mr. Sanchez Martinez's  
7 medication administration; due to the high staff turnover, inexperienced and  
8 untrained staff often do not know the proper protocols for his medication. To  
9 reduce delays in medical care, Mr. Sanchez Martinez reminds staff daily to wake  
10 him up for his morning insulin. Further, due to delays between being given his  
11 insulin and being escorted to the cafeteria, Mr. Sanchez Martinez often does not  
12 receive his meals immediately after receiving insulin. Delays in receiving his meals  
13 after insulin shots leave Mr. Sanchez Martinez vulnerable to hypoglycemic events.

14           264. Further, Mr. Sanchez Martinez's history of high blood sugar levels  
15 indicates that he requires a doctor monitoring his kidneys to prevent kidney  
16 damage. His medical records contain no documentation of such monitoring.  
17 Similarly, Mr. Sanchez Martinez has not had his annually required eye examination  
18 necessary to monitor for diabetic retinopathy.

19           265. On December 26, 2018, Plaintiff Ruben Darío Mencías Soto fell in the  
20 shower at Adelanto, and he has been in immense pain ever since. The day after his  
21 fall, Mr. Mencías Soto was taken to the medical unit at Adelanto where staff did X-  
22 rays on his back; about three weeks later, Mr. Mencías Soto received an MRI scan  
23 on his back. In early February, Adelanto medical staff referred Mr. Mencías Soto  
24 for a consultation with a neurologist to discuss a possible back surgery, pending  
25 ICE approval. About two weeks later, an Adelanto doctor explained to Mr. Mencías  
26 Soto that the discs in his back were dislocated and herniated, that he should stop  
27 doing strenuous physical activities and exercising, and that he would know in two  
28 weeks when a surgery would be scheduled.

1           266. Since his fall in December 2108, Mr. Mencías Soto has been in  
2 significant pain. He cannot walk without assistance, and the pain in his back and leg  
3 is constant and severe. Though he has complained multiple times of 10 out of 10  
4 pain, medical staff have neglected to increase his pain relief medication or provide  
5 him meaningful physical therapy. He did not receive pain medication besides  
6 ibuprofen until about three months after his fall.

7           267. On May 10, 2019, more than five months after his fall, Adelanto staff  
8 brought Mr. Mencías Soto to see a neurologist for the first time. After the  
9 neurologist explained the relevant options, Mr. Mencías Soto opted for attempting  
10 physical therapy and medication before surgery. However, since that meeting, Mr.  
11 Mencías Soto has not received any physical therapy or new medication. In early  
12 July 2019, Mr. Mencías Soto asked a nurse in Adelanto about the status of his  
13 therapy or surgery, but the nurse responded that the medical staff was waiting for  
14 ICE to approve his treatment. His extreme pain persists.

15           268. Defendants have knowingly selected to detain thousands of individuals  
16 in these remote, rural locations, notwithstanding the paucity of medical providers  
17 and the acute nature of many detained individuals' medical needs. Defendants'  
18 reliance on rural Detention Facilities, through which many detained individuals are  
19 transferred and where some spend months or years, poses a substantial risk of  
20 serious harm to Plaintiffs and the Class.

21           269. This danger is known to Defendants. In 2016, the Health Services  
22 Administrator at Stewart told an OIG inspector that because of the facility's rural  
23 location, there was a lack of community health care providers, mental health  
24 treatment centers, ambulance service, and emergency care in the area around the  
25 Detention Facility.<sup>190</sup> Stewart is two hours and fifteen minutes from Atlanta, and 45  
26 minutes from Columbus, Georgia. Detention Facilities like LaSalle, Rolling Plains,

27 \_\_\_\_\_  
28 <sup>190</sup> Office of Inspector Gen., Office of Homeland Sec., *FOIA Response No. 2018-IGFO-00059*, *supra* note 104, at 35.

1 Pine Prairie ICE Processing Center, and Irwin are located even farther from major  
2 population centers and therefore, on information and belief, suffer from similar  
3 medical care scarcities.

4 270. As a result, one individual detained at Stewart in 2016 told an OIG  
5 inspector that he waited for ten weeks just to have a chest X-ray taken.<sup>191</sup>

6 271. Another detained individual complained about serious medical  
7 problems—a hernia and the inability to urinate due to some blockage—but reported  
8 that he was not seen by an outside doctor for approximately nine days.<sup>192</sup>

9 272. Defendants have long known of, but nevertheless are deliberately  
10 indifferent to, the serious risk of substantial harm and injury to plaintiffs and  
11 members of the class resulting from confinement in detention centers in locations  
12 without access to adequate medical and mental health care.

13 273. Between 2011 and 2019, DDRs documented Defendants’ failures to  
14 provide timely access to specialty or chronic care at Detention Facilities across the  
15 country, including Adelanto, Albany, Aurora, Elizabeth, Eloy, Essex County,  
16 Houston, Krome, LaSalle, Otero, Port Isabel Detention Center (“Port Isabel”), Rio  
17 Grande, South Texas, Theo Lacy, and Utah. A significant number of the death  
18 reviews implicated these failures.

19 274. Sergio Alonso Lopez died in April 2017 due in part to heroin and  
20 alcohol withdrawal, after medical staff at Adelanto failed to monitor and assess his  
21 withdrawal.<sup>193</sup> Mr. Lopez had been taking methadone for more than 17 years for  
22 heroin withdrawal.<sup>194</sup> Although a doctor diagnosed Mr. Lopez with opioid  
23 dependence with withdrawal a day after Mr. Lopez’s arrival at the facility on  
24

25 \_\_\_\_\_  
26 <sup>191</sup> *Id.* at 24.

27 <sup>192</sup> *Id.* at 75.

28 <sup>193</sup> Sergio Alonso Lopez DDR, *supra* note 71 at 16.

<sup>194</sup> *Id.* at 4.

1 February 9, 2017, the doctor did not order recommended assessments and did not  
2 order nurses to monitor Mr. Lopez during his withdrawal.<sup>195</sup>

3 275. The DDR for Mr. Lopez found numerous ways in which Adelanto  
4 failed to provide timely, medically necessary specialty care for withdrawal,  
5 including that the facility failed to act in accordance with standards governing  
6 detoxification of chemically dependent detained individuals because medical staff  
7 did not monitor and assess Mr. Lopez while he underwent withdrawal.<sup>196</sup>

8 276. On June 13, 2016, Luis Alonso Fino Martinez died while in ICE  
9 custody at Essex County.<sup>197</sup> The cause of death was listed as hypertensive and  
10 atherosclerotic cardiovascular disease with congestive heart failure.<sup>198</sup> The DDR  
11 found that though Mr. Fino Martinez had a history of high cholesterol and insulin-  
12 dependent diabetes and clinical guidelines call for the completion of an EKG for  
13 patients with diabetes, facility staff never order an EKG for Mr. Fino Martinez,  
14 despite multiple medical encounters during which one was mandated by clinical  
15 guidelines.<sup>199</sup>

16 277. On March 17, 2016, Thongchay Saengsiri died while detained at the  
17 LaSalle Detention Center in Jena, Louisiana.<sup>200</sup> His cause of death was listed as  
18 hypertensive atherosclerotic cardiovascular disease with emphysema and obesity.<sup>201</sup>  
19 Mr. Saengsiri suffered from worsening symptoms of congestive heart failure for  
20 most of the 15 months he was at the facility, including fainting, swelling, anemia, a

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21 <sup>195</sup> *Id.* at 11–12.

22 <sup>196</sup> *Id.* at 16.

23 <sup>197</sup> Office of Professional Responsibility, *Detainee Death Review – Moises Tino-*  
24 *Lopez*, at 1 (“Moises Tino-Lopez DDR”)

<https://www.ice.gov/doclib/foia/reports/ddr-Tino.pdf>.

25 <sup>198</sup> *Id.*

26 <sup>199</sup> *Id.* at 5, 6, 8, 21.

27 <sup>200</sup> Office of Professional Responsibility, *Detainee Death Review – Thongchay*  
*Saengsiri*, at 1, <https://www.ice.gov/doclib/foia/reports/ddr-Saengsiri.pdf>.

28 <sup>201</sup> *Id.*

1 nonproductive cough, and shortness of breath.<sup>202</sup> These symptoms were largely  
2 ignored by medical staff.<sup>203</sup> The DDR found that in May 2015, an EKG report  
3 indicated no assessment could be made because an artificial pacemaker prevented  
4 measurement of the detainee's heart rate and rhythm, but Mr. Saengsiri did not have  
5 a pacemaker.<sup>204</sup> In January 2016, his abnormal EKG results were never  
6 interpreted.<sup>205</sup> In February 2016, he did not receive a referral to a doctor or a re-  
7 evaluation from a provider after complaining of a cough, shortness of breath, and  
8 wheezing.<sup>206</sup> In addition, the records indicated that on several occasions, Mr.  
9 Saengsiri was supposed to be seen for follow-up visits or evaluations, but those  
10 visits and evaluations did not occur.<sup>207</sup> Two expert physicians reviewed the case on  
11 behalf of HRW, concluding that his death likely could have been prevented with  
12 appropriate care to manage his symptoms.<sup>208</sup> The experts found that Mr. Saengsiri  
13 demonstrated very clear symptoms of the new onset of congestive heart failure  
14 from the early days of his detention, and that he needed aggressive cardiac  
15 management, most likely including hospital admission.<sup>209</sup>

16 278. Raul Ernesto Morales Ramos died from gastrointestinal cancer in April  
17 2015 while detained at Adelanto.<sup>210</sup> In the two years in detention prior to his death,  
18 he suffered from symptoms of undiagnosed cancer, including weight loss, body  
19 aches, diarrhea, and rectal bleeding, but he was not seen by a specialist until a  
20 month before his death, when it was too late. In March 2015, a nurse at Adelanto

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21 <sup>202</sup> *Id.* at 18–21.

22 <sup>203</sup> *Id.*

23 <sup>204</sup> *Id.* at 19.

24 <sup>205</sup> *Id.*

25 <sup>206</sup> *Id.*

26 <sup>207</sup> *Id.*

27 <sup>208</sup> Human Rights Watch, Am. Civil Liberties Union National Immigrant Justice  
Center & Detention Watch Network, *supra* note 153161, at 19.

28 <sup>209</sup> *Id.*

<sup>210</sup> Raul Ernesto Morales-Ramos DDR, *supra* note 158, at 23.

1 noted that Mr. Morales Ramos had a distended abdomen but she “did not detect a  
2 mass or protrusion.”<sup>211</sup> Four days later, he was seen by a doctor who stated that Mr.  
3 Morales Ramos had “the largest [abdominal mass] she ha[d] ever seen in her  
4 practice,” which was “notably visible through the abdominal wall.”<sup>212</sup>

5 279. Based on the doctor’s findings and referrals, Mr. Morales Ramos was  
6 scheduled for a colonoscopy, which did not occur until about one month later.<sup>213</sup>  
7 During the colonoscopy, he began to experience abdominal bleeding after the  
8 doctor attempted to remove “a huge rectal mass.”<sup>214</sup> He was transferred to the  
9 hospital and died three days later.<sup>215</sup>

10 280. The evidence set forth above demonstrates a systemic failure to ensure  
11 that necessary chronic and specialty care is timely provided at Detention Facilities.  
12 These delays and denials persist because of Defendants’ failure to adequately  
13 monitor, oversee, and administer their facilities.

14 **C. Defendants Systemically Fail to Ensure That Care is Provided by**  
15 **Trained or Qualified Personnel.**

16 281. Defendants have a systemic policy and practice of failing to monitor  
17 and ensure that Detention Facilities provide health care from trained and qualified  
18 personnel.

19 282. Detained individuals throughout Defendants’ detention network  
20 receive inadequate healthcare from providers untrained on basic protocols, as well  
21 as from licensed practical nurses and other providers attempting to provide care  
22 well outside their scope of licensure, often without the consultation of doctors. This  
23 includes staff failing to properly respond to serious health events—like opioid  
24 withdrawal, chest pain, and seizures—because of a lack of training and inadequate

25 \_\_\_\_\_  
26 <sup>211</sup> *Id.*

27 <sup>212</sup> *Id.* at 24–25.

28 <sup>213</sup> *Id.* at 29.

<sup>214</sup> *Id.* at 30.

<sup>215</sup> *Id.* at 32.

1 protocols, staff ordering interventions that are contraindicated by individuals'  
2 symptoms, and staff not involving physicians in decision-making.

3 283. For example, an internal ICE memo identified five cases between  
4 November 2017 and March 2018 in which ICE failed to follow withdrawal  
5 guidelines for detained individuals who have alcohol or opioid withdrawal.<sup>216</sup> Four  
6 out of five cases lacked physician oversight.<sup>217</sup>

7 284. According to a 2011 OIG report entitled "Management of Mental  
8 Health Cases in Immigration Detention," OIG visited three facilities in which  
9 nurses who were not trained in psychiatric mental health care were assigned to  
10 administer psychiatric medication, communicate with mentally ill patients about  
11 their medication and participation in recreation activities, and help to manage  
12 acutely psychotic or aggressive detained individuals.<sup>218</sup>

13 285. Despite numerous government reports, non-governmental organization  
14 reports, DDRs, and other documentation of this serious problem, Defendants have  
15 taken no effective steps to ensure that health care personnel at Detention Facilities  
16 are properly trained or qualified, exposing detained individuals to significant risk of  
17 serious harm.

18 286. Detention Facilities' reliance on untrained and unqualified personnel is  
19 widespread, occurring at Detention Facilities across the country, and resulting from  
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22 <sup>216</sup> Email to Matthew Albence, Acting Deputy Dir., U.S. Immigr. and Customs  
23 Enf't, at 2 (Dec. 3, 2018),  
24 [https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu](https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h)  
25 [7h](#).

26 <sup>217</sup> *Id.*

27 <sup>218</sup> Office of Inspector Gen., Office of Homeland Sec., *OIG-11-61: Management of*  
28 *Mental Health Cases in Immigration Detention* (2011),  
<https://www.hsdl.org/?view&did=6985>.

1 systemic deficiencies in Defendants’ oversight and monitoring practices and  
2 policies.

3 287. For example, HRW’s 2017 report details substandard provision of  
4 medical care by Defendant’s healthcare providers. The report found a pervasive  
5 practice of vocational and practical nurses practicing outside of their scopes of  
6 practice, without licensed practitioner and doctor supervision, at Imperial, Yuba  
7 County, Eloy, and Laredo Detention Center (“Laredo”), causing grave injury to  
8 detained individuals there.<sup>219</sup>

9 288. Plaintiffs have suffered significant harm resulting from treatment by  
10 untrained or unqualified personnel.

11 289. On May 10, 2019, Plaintiff Melvin Murillo Hernandez told a nurse that  
12 his heart was beating fast and his chest was hurting. Given Mr. Murillo  
13 Hernandez’s allergy history, which included multiple hospitalizations while in ICE  
14 custody, medical staff should have closely monitored his condition. Instead, the  
15 nurse, who is not qualified to diagnose or treat individuals, told him the he was fine  
16 and did not order any observation or relay the complaint to a doctor or nurse  
17 practitioner. The following morning, Mr. Murillo Hernandez was found  
18 unconscious in his cell and Mr. Murillo Hernandez once again went into severe  
19 anaphylactic shock necessitating hospitalization.

20 290. Upon Plaintiff Aristoteles Sanchez Martinez’s arrival to Stewart, a  
21 nurse forced him to choose between his back brace and his hernia belt. The nurse  
22 was not qualified to discontinue his use of the back brace or hernia belt. Upon  
23 information and belief, she did not consult with a provider before discontinuing Mr.  
24 Sanchez Martinez’s use of the back brace. Both devices served different medical  
25 purposes and Mr. Sanchez Martinez has been without his back brace since his  
26 intake risking further injury to his back.

27  
28 <sup>219</sup> Human Rights Watch & CIVIC, *supra* note 181, at 25–26, 61–64, 67–68.



1           291. On March 27, 2019, Plaintiff Salazar Artaga requested Risperidone (he  
2 spelled it “Respodon”) because he had taken the medication previously and needed  
3 it for a long-standing condition. L. Boone, LPN, noted that no referral or  
4 appointment was needed, as Mr. Salazar Artaga had been seen the day before. But a  
5 licensed practical nurse is not qualified to evaluate the need for a prescription for  
6 anti-psychotic medication. Further, a denial of such medication to a patient with a  
7 history of psychosis can put the individual at risk of self-harm. As a result of the  
8 failure to escalate his request, Plaintiff Salazar Artaga developed hallucinations and  
9 suicidal ideation requiring him to be put on suicide watch repeatedly. His requests  
10 for refills of pain medication and a shower chair were similarly ignored by LPNs  
11 without documented discussions with qualified medical providers, even though  
12 such decisions are outside the scope of practice for an LPN.

13           292. After Adelanto staff caused Plaintiff Martin Muñoz to overdose by  
14 giving him triple the amount of his prescribed insulin, Mr. Muñoz was never  
15 evaluated by a doctor—despite the fact that such overdoses can lead to comas and  
16 be fatal. Although nurses checked on Mr. Muñoz a few times, guards took over the  
17 primary responsibility for checking on Mr. Muñoz’s wellbeing in the aftermath of  
18 this overdose.

19           293. Defendants are aware of these deficiencies but have failed to take any  
20 effective measures to prevent them from recurring in the future.

21           294. For example, between 2011 and 2019, DDRs documented that  
22 unqualified personnel provided health care at Detention Facilities across the  
23 country, including Aurora, Brooks, Dodge County, Eloy, El Paso, Farmville, Port  
24 Isabel, Rio Grande, San Bernardino County Detention Center (“San Bernardino  
25 County”), and Utah County. In a significant number of the reviewed deaths,  
26 unqualified personnel were involved in providing health care.

27           295. According to the DDRs, in some facilities, only half of the medical  
28 staff were trained in basic skills such as CPR and first aid. This lack of training for

1 medical staff severely increases the risk of fatalities for detained individuals in  
2 emergency situations. Moreover, the nurses at many facilities lack proper medical  
3 training for the types of medical conditions they encounter, especially for  
4 emergency situations.

5 296. The DDRs also highlighted many instances of important medical  
6 decisions being made by non-medical staff. On December 2, 2017, Kamyar Samimi  
7 died at Aurora after inadequate care for opioid withdrawal.<sup>220</sup> He was never seen by  
8 a doctor.<sup>221</sup> His DDR found that, despite Mr. Samimi’s “frequent and progressive  
9 complaints related to symptoms of withdrawal, nurses administered less than 50%  
10 of physician-ordered withdrawal medications . . . .”<sup>222</sup> Nurses also failed to  
11 consistently document signs of withdrawal or medication administration; to  
12 correctly document orders; to perform nursing assessments, obtain vital signs, or  
13 monitor Mr. Samimi’s weight loss; and to maintain Mr. Samimi’s safety through  
14 fall prevention and injury assessments during fainting episodes. Additionally,  
15 nursing notes “were brief and inadequate”<sup>223</sup> and were not in standard format. On at  
16 least two occasions, a nurse failed to call the physician “despite her observation of  
17 [Mr. Samimi’s] serious clinical symptoms.”<sup>224</sup>

18 297. Additionally, nurses were never trained in opiate withdrawal, and so  
19 never completed ordered withdrawal monitoring.<sup>225</sup>

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21 <sup>220</sup> Office of Professional Responsibility, *Detainee Death Review- Kamyar Samimi*,  
22 at 3 (2017) (“Samimi DDR”), [https://bento.cdn.pbs.org/hostedbento-  
prod/filer\\_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf](https://bento.cdn.pbs.org/hostedbento-prod/filer_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf).

23 <sup>221</sup> *Id.*

24 <sup>222</sup> Memorandum from Jennifer M. Fenton, Assistant Dir., U.S. Immigr. and  
25 Customs Enf’t, to Matthew Albence, Exec. Assoc. Dir., Enf’t and Removal  
26 Operations (May 22, 2018) at 3, available at [https://bento.cdn.pbs.org/hostedbento-  
prod/filer\\_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf](https://bento.cdn.pbs.org/hostedbento-prod/filer_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf).

27 <sup>223</sup> Samimi DDR, *supra* note 220, at 32.

28 <sup>224</sup> *Id.* at 29.

<sup>225</sup> *Id.* at 31.

1           298. Overall, nurses “demonstrated a lack of understanding of opioid  
2 withdrawal symptoms” and “failed to properly monitor [Mr. Samimi] as he  
3 withdrew from opioids and to recognize his related life-threatening symptoms.”<sup>226</sup>

4           299. Olubunmi Toyin Joshua died in October 2016 of hypertensive  
5 cardiovascular disease while detained at Rolling Plains.<sup>227</sup> The DDR found that  
6 although the facility had a hypertension protocol, the nurses did not follow that  
7 protocol, presumably because they had not received sufficient training.<sup>228</sup> One nurse  
8 stated that he set the blood pressure threshold for provider notification  
9 independently, rather than follow protocol.<sup>229</sup> Additionally, a nurse who conducted  
10 Ms. Joshua’s physical assessment lacked training to do so.<sup>230</sup>

11           300. On September 27, 2016, Moises Tino Lopez died while in ICE custody  
12 at Hall County.<sup>231</sup> The DDR found that the facility did not have a written,  
13 formalized seizure protocol in place.<sup>232</sup> Additionally, “staff reported inconsistent  
14 understanding of procedures” for placing Mr. Tino on 15-minute status checks after  
15 his first seizure on September 6.<sup>233</sup> Independent experts for HRW concluded that  
16 serious medical failures, including the fact that Mr. Tino’s repeated seizures failed  
17 to prompt a high level of concern and attention from medical staff, likely  
18 contributed to his death.<sup>234</sup>

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19  
20 <sup>226</sup> *Id.* at 31.

21 <sup>227</sup> Olubunmi Toyin Joshua DDR, *supra* note 159, at 1.

22 <sup>228</sup> *Id.* at 17.

23 <sup>229</sup> *Id.* at 17.

24 <sup>230</sup> *Id.* at 19.

25 <sup>231</sup> Office of Professional Responsibility, *Detainee Death Review – Moises Tino-  
Lopez* (“Moises Tino-Lopez”), [https://d1zbh0am38bx6v.cloudfront.net/wp-  
content/uploads/2018/07/17044550/ddr-Tino.pdf](https://d1zbh0am38bx6v.cloudfront.net/wp-content/uploads/2018/07/17044550/ddr-Tino.pdf).

26 <sup>232</sup> *Id.* at 16.

27 <sup>233</sup> *Id.* at 16.

28 <sup>234</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 153161, at 30–3.

1           301. Raul Ernesto Morales Ramos died on April 6, 2015 at Adelanto, after a  
2 doctor attempted to remove a large rectal mass that developed when Adelanto  
3 medical staff neglected to treat Mr. Morales' gastrointestinal cancer.<sup>235</sup> The DDR  
4 found that many facility medical staff cited "a high turnover rate among nurses [as]  
5 a great concern," and that "approximately 50 percent of ADF's medical staff hires  
6 are new graduates" with a "definite difference between their skills and those of  
7 more experienced nurses."<sup>236</sup> In addition, the DDR found the facility deficient in  
8 that it failed to conduct any formal skills training or require nurses to demonstrate  
9 competency prior to conducting clinical assessments, and also that it failed to  
10 provide comprehensive training and routine competency evaluations.<sup>237</sup>

11           302. On May 1, 2016, Igor Zyazin died of a heart attack while confined at  
12 Otay Mesa.<sup>238</sup> He was previously detained at the Emerald Correctional  
13 Management San Luis Regional Detention Center ("San Luis") in San Luis,  
14 Arizona. On April 29, 2016, a nurse managed Mr. Zyazin's acute chest pain by  
15 administering nitroglycerin without a doctor's order.<sup>239</sup> Independent medical  
16 experts for HRW found that this was dangerous and "a major breach of her scope of  
17 license and one which requires reporting to the state board."<sup>240</sup>

18           303. Another detained individual fell in the shower in February 2015 while  
19 detained in ICE custody at the Yuba County Jail.<sup>241</sup> He tore his ACL and may have  
20 sustained a fracture.<sup>242</sup> He requested medical care for his knee several times but

21 \_\_\_\_\_  
22 <sup>235</sup> Morales-Ramos DDR, *supra* note 158, at 1.

23 <sup>236</sup> *Id.* at 37.

24 <sup>237</sup> *Id.*

25 <sup>238</sup> Office of Professional Responsibility, *Detainee Death Review – Igor Zyazin*,  
26 <https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf>.

27 <sup>239</sup> *Id.* at 7–8.

28 <sup>240</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 155, at 27.

<sup>241</sup> Human Rights Watch & CIVIC, *supra* note 181, at 63 (internal citation omitted).

<sup>242</sup> *Id.* at 63.

1 only saw a licensed vocational nurse (“LVN”).<sup>243</sup> His medical needs were outside  
 2 the scope of the LVN’s practice, and the nurse did not refer him to a doctor until his  
 3 fifth visit.<sup>244</sup> He eventually had surgery, and collapsed two days later with shortness  
 4 of breath.<sup>245</sup> The LVN who responded to his collapse failed to measure his  
 5 respiration or blood pressure, and did not contact the physician.<sup>246</sup> He was at risk of  
 6 blood clot and pulmonary embolism, and failure to involve a physician presented a  
 7 major threat to Mr. Morales’s life.<sup>247</sup> One independent medical expert stated, “It is  
 8 clear that the health care is delivered mostly by LVNs practicing independently.  
 9 They call the MD when they think it’s necessary, but unfortunately, they do not  
 10 have sufficient training and licensure to know when that is.”<sup>248</sup>

11 304. Regarding a woman who was detained at Eloy, independent medical  
 12 experts for HRW found multiple examples of her receiving inadequate care from  
 13 nurses when her symptoms required care from a nurse practitioner, a general  
 14 practice doctor, or a gynecologist.<sup>249</sup> According to one expert, “There was a repeat  
 15 pattern of nurses making decisions they’re not qualified to make and little to no  
 16 oversight by nurse-practitioners or physicians, which is dangerous.”<sup>250</sup>

17 305. Marjorie Annmarie Bell complained of chest pain multiple times at  
 18 CoreCivic’s San Diego facility in California before dying of a heart attack in  
 19 February 2014.<sup>251</sup> The DDR found that a nurse failed to follow the facility’s chest  
 20 pain guidelines on the day of her death by not calling 911 after Ms. Bell requested

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21 <sup>243</sup> *Id.* at 63.

22 <sup>244</sup> *Id.* at 63.

23 <sup>245</sup> *Id.* at 64.

24 <sup>246</sup> *Id.* at 64.

24 <sup>247</sup> *Id.* at 64.

25 <sup>248</sup> *Id.* at 63.

26 <sup>249</sup> *Id.* at 67–68.

26 <sup>250</sup> *Id.* at 68.

27 <sup>251</sup> Office of Professional Responsibility, *Detainee Death Review – Marjorie*  
 28 *Annmarie Bell*, <https://www.ice.gov/doclib/foia/reports/ddr-bell.pdf>.

1 morphine for pain that would not go away.<sup>252</sup> Several other nurses indicated that  
2 they were unsure whether the facility had chest pain guidelines, or were unsure of  
3 the guidelines' contents.<sup>253</sup> The DDR stated that it is critical that nurses receive  
4 training and adhere to established guidelines.<sup>254</sup> According to one expert who  
5 reviewed this case on behalf of HRW, "on six separate occasions she informed  
6 nurses that she was having chest pain, and on none of those occasions did a nurse  
7 contact a physician or call an ambulance."<sup>255</sup>

8 306. The examples set forth above reflect a systemic failure to ensure that  
9 qualified and trained personnel provide health care at Detention Facilities, to which  
10 Defendants are deliberately indifferent, resulting in a significant risk of substantial  
11 harm to detained individuals.

12 **D. Defendants Systemically Fail to Ensure Detained Individuals Receive**  
13 **Timely Emergency Health Care.**

14 307. Defendants have a systemic policy and practice of failing to monitor  
15 and ensure that Detention Facilities provide detained individuals with timely and  
16 competent emergency healthcare.

17 308. Detention Facilities repeatedly fail to treat medical emergencies with  
18 urgency by not timely calling 911, calling a correctional van rather than an  
19 ambulance to transport the detained individual to the emergency room, or refusing  
20 to take an individual to the hospital at all. Other deficiencies include refusals to  
21 administer emergency care and inability to administer emergency care because of  
22 missing equipment.

23  
24  
25 \_\_\_\_\_  
26 <sup>252</sup> *Id.* at 22.

27 <sup>253</sup> *Id.*

28 <sup>254</sup> *Id.*

<sup>255</sup> Human Rights Watch & CIVIC, *supra* note 181, at 36.

1           309. Detained individuals experience harm and unnecessary pain and  
2 suffering as a result of these delays in emergency care. In a number of cases, these  
3 delays have proven fatal.

4           310. Defendants are deliberately indifferent to the risk of harm and injury to  
5 detained individuals from this systemic failure. Delays in providing emergency  
6 treatment have been repeatedly documented, including without limitation in DDRs,  
7 government reports, and reports by non-governmental organizations. Nonetheless,  
8 Defendants fail to adequately administer, monitor, or oversee conditions in their  
9 facilities—or institute meaningful changes to address the often-fatal delays in  
10 emergency care that occur throughout their detention network—exposing Plaintiffs  
11 and members of the Class to significant risk of serious harm.

12           311. Indeed, Defendants’ inadequate monitoring and oversight have  
13 resulted in the placement of Detention Facilities in areas where emergency care is  
14 essentially unavailable. According to OIG’s 2016 interview of a Health Services  
15 Administrator, or HSA, at Stewart in Georgia, because of Stewart’s rural location,  
16 “if there is a serious medical emergency, only a few community resources are  
17 available; he recently had two local hospitals refuse to take a detainee with a  
18 urology issue.” In addition, “there is an extreme shortage of ambulance services.”

19           312. Failure to ensure that competent and timely emergency care is  
20 provided is a systemic problem that flows from Defendants’ deficient monitoring  
21 and oversight. These failures place detained individuals at substantial risk of  
22 serious harm in Detention Facilities throughout the country, as evidenced by the  
23 following examples.

24           313. In September 2017, Plaintiff Martin Muñoz had an insulin overdose  
25 when Adelanto staff administered more than triple his regular dose. An insulin  
26 overdose can lead to a hypoglycemic coma—essentially a low-blood-sugar coma—  
27 which can sometimes be fatal. Mr. Muñoz was taken to medical observation when  
28

1 Adelanto staff realized the mistake, and Adelanto staff wrote him a letter admitting  
2 fault.

3 314. Mr. Muñoz has gone without insulin twice while at Adelanto. The first  
4 time, in February 2019, his medications ran out and, because his doctor had not  
5 timely refilled his medication, he went without insulin for six days. During that  
6 time, he had no energy, his vision was blurry, and he experienced headaches. The  
7 second time, in summer 2019, he did not receive insulin for ten days because staff  
8 said it was not in the system for him. In spring 2019, Adelanto informed Mr.  
9 Muñoz that it had run out of his blood pressure medication, and he did not receive it  
10 for approximately two weeks.

11 315. While at Adelanto, on information and belief Mr. Muñoz has not  
12 received a modified diet to accommodate his diabetes, and his front tooth has fallen  
13 out due to the progression of his diabetes.

14 316. Plaintiff Jose Segovia Benitez, for whom Adelanto had a documented  
15 history of abnormal EKG results, reported significant chest pain at around 4 PM on  
16 July 3, 2019. He was first evaluated for potential medical care nearly seven hours  
17 later, at around 11 PM; over an hour later, Adelanto staff recognized Mr. Segovia  
18 Benitez required emergency care and called 911 to have him transported to a nearby  
19 hospital. Mr. Segovia Benitez ultimately spent several days in the hospital.

20 317. Defendants are on notice of, but have failed to remedy, the substantial  
21 risk of serious harm posed by the failure to ensure competent and timely emergency  
22 care. For example, between 2011 and 2019, DDRs documented failures in the  
23 provision of emergency medical care at Detention Facilities across the country,  
24 including Adelanto, Aurora, Elizabeth, Eloy, Essex County, Houston, Farmville,  
25 Port Isabel, Krome, Rio Grande, San Bernardino, South Texas, Stewart, Theo Lacy,  
26 Utah, and York County Detention Center (“York County”). In a substantial number  
27 of the reviewed deaths, Detention Facilities provided Defendants with untimely or  
28 inadequate emergency care. Several of these DDRs state explicitly that detained



1 individuals could have survived if they had been provided with timely access to  
2 emergency care.

3 318. The DDRs describe staff's failure to treat detained individuals  
4 experiencing medical emergencies with a sense of urgency. This is, in part, because  
5 medical staff commonly fail even to recognize signs and symptoms of serious  
6 medical conditions, resulting in deaths of detained people. Specific examples  
7 include the following:

8 319. On July 10, 2018, Efrain De la Rosa died by suicide at Stewart.<sup>256</sup>  
9 Earlier that day, Mr. De la Rosa told a social worker that he would die soon, yet he  
10 was not placed on observation or given a higher level of care.<sup>257</sup> Additionally,  
11 responding nurses discovered that their medical bag was missing a defibrillator and  
12 a working oxygen tank, which delayed attempts to revive Mr. De la Rosa.<sup>258</sup> The  
13 detention officer assigned to the medical unit did not hear the emergency call for  
14 assistance.<sup>259</sup>

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16 <sup>256</sup> Office of Professional Responsibility, *Detainee Death Review – Efrain Romero*  
17 *De La Rosa*,  
18 <https://www.ice.gov/doclib/foia/reports/ddrDeLaRosaEfrainRomero.pdf>.

19 <sup>257</sup> Robin Urevich, National Immigrant Solidarity Network, *Reports: Lies, Chaos*  
20 *and Abuse at ICE Contractor Lockup*, Capital & Main (Jan. 28, 2019),  
21 <https://capitalandmain.com/reports-lies-chaos-and-abuse-at-ice-contractor-lockup>;  
22 Letter from Lead Compliance Inspector, The Nakamoto Grp., to Assistant Dir. for  
23 Detention Mgmt. (May 3, 2018),  
24 [https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA\\_CL\\_05\\_03\\_2018](https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA_CL_05_03_2018.pdf).  
25 pdf.

26 <sup>258</sup> See, e.g., Robin Urevich, *Newly Released Documents Reveal Mounting Chaos*  
27 *and Abuse at a Troubled ICE Detention Center*, Fast Company (Jan. 29, 2019),  
28 [https://www.fastcompany.com/90298739/newly-released-documents-reveal-](https://www.fastcompany.com/90298739/newly-released-documents-reveal-mounting-chaos-and-abuse-at-a-troubled-ice-detention-center)  
29 [mounting-chaos-and-abuse-at-a-troubled-ice-detention-center](https://www.fastcompany.com/90298739/newly-released-documents-reveal-mounting-chaos-and-abuse-at-a-troubled-ice-detention-center); Memorandum from  
30 Investigator, Camille Baptiste-Lowers, to Warden, Charlie Peterson (Aug. 6, 2018),  
31 CoreCivic General Counsel Office of Investigations Investigation Report Form (on  
32 file with Plaintiffs' counsel).

<sup>259</sup> *Id.*

1           320. On December 2, 2017, Kamyar Samimi died while in custody at  
2 Aurora after his withdrawal symptoms progressively worsened to the point that a  
3 nurse observed that he likely had liver failure. In separate encounter, a nurse stated:  
4 “He’s dying.”<sup>260</sup> Yet, rather than calling 911, medical staff assumed he was faking  
5 his symptoms.<sup>261</sup>

6           321. On November 24, 2017, Mr. Samimi waited up to eleven hours to be  
7 seen by a nurse, during which time he lost consciousness, vomited, and had  
8 abnormally low oxygen saturation and an elevated heart rate.

9           322. On at least two occasions, nurses discovered that Mr. Samimi had not  
10 eaten in days due to nausea; in the latter instance, he had collapsed in the hallway.  
11 Their only response was to “educate” him on the importance of nutrition.

12           323. On November 30, Mr. Samimi appeared to have blood coming from  
13 his mouth. The responding nurse ordered that Mr. Samimi be monitored and given  
14 water, but the nurse did not notify a doctor that Mr. Samimi was bleeding, “which  
15 was significant given his compromised condition.”<sup>262</sup>

16           324. On December 1, it took ten minutes for a nurse to respond to reports of  
17 Mr. Samimi’s bizarre behavior and weakness, causing an officer to wonder “when  
18 medical staff were going to come check on [Mr. Samimi].”<sup>263</sup> When the nurse lifted  
19 Mr. Samimi’s arm to take his blood pressure, he screamed and said it hurt so bad “I  
20 just want to die.”<sup>264</sup> The nurse told him to stop being difficult.<sup>265</sup> Later, a nurse did  
21 not respond until 75 minutes after Mr. Samimi was observed spitting up blood.<sup>266</sup>

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23  
24 <sup>260</sup> Samimi DDR, *supra* note at 220, at 47.

25 <sup>261</sup> *Id.*

26 <sup>262</sup> *Id.*

27 <sup>263</sup> *Id.* at 43.

28 <sup>264</sup> *Id.*

<sup>265</sup> *Id.*

<sup>266</sup> *Id.*

1           325. When an officer asked why 911 was not being called, “neither nurse  
2 responded.”<sup>267</sup> Only after Mr. Samimi vomited blood and officers acted on their  
3 concern did a Lieutenant order a call to 911. The nurse had not called 911 himself  
4 because he did not think Mr. Samimi’s condition was a “super emergency.”<sup>268</sup>

5           326. The DDR found problems with the intake process for Mr. Samimi and,  
6 specifically, the fact that the facility “failed to transfer [Mr. Samimi] to an  
7 [emergency room] though he exhibited life threatening withdrawal symptoms in the  
8 week following his intake.”<sup>269</sup> Additionally, the facility doctor failed to answer or  
9 return two phone calls during Mr. Samimi’s medical emergency. Overall, “[a]ll  
10 officers were troubled by what they perceived was a lack of concern and care for  
11 [Mr. Samimi] on the part of medical staff.”<sup>270</sup>

12           327. On November 25, 2016, Wenceslau Esmerio Campos died of  
13 myocardial infarction with atherosclerotic cardiovascular disease after an officer  
14 refused to call for emergency help, even at request of another officer.<sup>271</sup> Mr.  
15 Campos was detained at the South Texas facility.<sup>272</sup> On November 23, he was  
16 found vomiting, pale, sweating, experiencing chest pains, and holding his chest.<sup>273</sup>  
17 The DDR describes the initial response on behalf of detention security personnel:

18           Officer [REDACTED] approached CAMPOS in his bunk, located towards  
19 the front of the dorm near the officer’s station, and observed he was pale and  
20 sweating, and held his hands to his chest. Officer [REDACTED] immediately  
21 asked Officer [REDACTED] to call a medical emergency on his radio,  
22

23 <sup>267</sup> *Id.* at 47.

24 <sup>268</sup> *Id.* at 52.

25 <sup>269</sup> *Id.* at 3.

26 <sup>270</sup> *Id.* at 60.

27 <sup>271</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
*Death Review – Wenesclau Esmerio Campos*, at 1 (“Esmerio-Campos DDR”),  
<https://www.ice.gov/doclib/foia/reports/ddr-Campos.pdf>.

28 <sup>272</sup> *Id.*

<sup>273</sup> *Id.* at 9.

1 telling him CAMPOS was having a heart attack, but Officer [REDACTED]  
 2 refused, stating the detainee was fine because he could walk around. Officer  
 3 [REDACTED] asked a second time, and Officer [REDACTED] again  
 4 refused, so Officer [REDACTED] asked for the radio to call the emergency  
 5 herself, but Officer [REDACTED] refused to give it to her. Officer  
 6 [REDACTED] completed two incident reports following CAMPOS' death,  
 7 wherein he stated he did not call a medical emergency or provide the radio to  
 8 Officer [REDACTED] because he did not believe CAMPOS required  
 9 emergency attention.<sup>274</sup>

10 328. Due to the officer's refusal to recognize Mr. Campos' medical  
 11 emergency, an hour elapsed before he was taken to the hospital.<sup>275</sup> Mr. Campos fell  
 12 into cardiac arrest during transport.<sup>276</sup> Despite attempts to revive him and an  
 13 emergency surgery, Mr. Campos was pronounced dead two days later.<sup>277</sup>

14 329. On May 1, 2016, Igor Zyazin died of a heart attack while confined at  
 15 Otay Mesa after being transferred from San Luis in Arizona.<sup>278</sup> The cause of death  
 16 was listed as hypertensive and atherosclerotic cardiovascular disease.<sup>279</sup> The DDR  
 17 notes that, while at San Luis, Mr. Zyazin informed staff that he had a significant  
 18 medical history of heart disease and that he was experiencing symptoms of a heart  
 19 attack.<sup>280</sup> Instead of sending him to the emergency room, an ICE officer decided to  
 20 transfer him to Otay Mesa, several hours away.<sup>281</sup> Upon arrival at Otay Mesa on  
 21 April 29, Mr. Zyazin told a nurse that he was experiencing chest pain, but no  
 22

23 <sup>274</sup> *Id.*

24 <sup>275</sup> *Id.* at 12.

25 <sup>276</sup> *Id.*

26 <sup>277</sup> *Id.* at 14.

27 <sup>278</sup> Zyazin DDR, *supra* note 238.

28 <sup>279</sup> *Id.*

<sup>280</sup> *Id.* at 6.

<sup>281</sup> *Id.* at 8.

1 follow-up occurred.<sup>282</sup> The next day he was seen by a doctor, who failed to  
2 recognize that Mr. Zyazin had an event that may have been a heart attack.<sup>283</sup> That  
3 evening he was found unresponsive and attempts to resuscitate him failed.<sup>284</sup>

4 330. Two medical experts who reviewed Mr. Zyazin's case on behalf of  
5 HRW found that his death was likely preventable. On April 29, the San Luis  
6 nurse's management of Mr. Zyazin at each step was severely deficient, including  
7 failing to inform a doctor or call 911. Further, by filling out a transfer note, the  
8 nurse was erroneously stating that the patient was stable enough for transfer,  
9 whereas sending him to the hospital for appropriate care could have saved his life.

10 331. On April 7, 2016, Rafael Barcenas Padilla died of bronchopneumonia  
11 while in ICE custody at Otero County.<sup>285</sup> On March 13, Mr. Barcenas was taken to  
12 the medical unit with a fever of 104 degrees, a high pulse, and diminished oxygen  
13 saturation in his blood.<sup>286</sup> A key medication, albuterol, was ordered to help his  
14 breathing, but the facility lacked the equipment to administer it due to depleted  
15 medical supplies.<sup>287</sup> Mr. Barcenas did not see a doctor for two days.<sup>288</sup> When he  
16 was finally seen by a doctor, the doctor decided to send him to the hospital.<sup>289</sup>  
17 Instead of being sent by ambulance, Mr. Barcenas waited for two hours to be  
18 transferred by correctional van.<sup>290</sup> He was taken to the hospital, where his condition  
19 declined until his death.<sup>291</sup>

20 \_\_\_\_\_  
21 <sup>282</sup> *Id.* at 7.

22 <sup>283</sup> *Id.* at 8.

23 <sup>284</sup> *Id.*

24 <sup>285</sup> Office of Professional Responsibility, *Office of Detention Oversight, Detainee*  
*Death Review – Rafael Barcenas Padilla*, at 1 (“Barcenas Padilla DDR”).

25 <sup>286</sup> *Id.* at 3–4.

26 <sup>287</sup> *Id.* at 4.

27 <sup>288</sup> *Id.* at 6–8.

28 <sup>289</sup> *Id.* at 8.

<sup>290</sup> *Id.* at 8–9.

<sup>291</sup> *Id.* at 9–12.

1           332. The DDR found the lack of necessary equipment in Mr. Barcena’s  
2 case to be deficient medical care.<sup>292</sup> Independent medical experts found  
3 fundamental errors in Mr. Barcena’s medical treatment, concluding that proper care  
4 may well have saved his life.<sup>293</sup> The experts agreed that his low recorded oxygen  
5 levels should have prompted immediate evacuation to a hospital.<sup>294</sup> They also raised  
6 concerns that he was sent to the hospital in a van instead of an ambulance.<sup>295</sup>

7           333. On December 24, 2015, Jose Manuel Azurdia-Hernandez died at  
8 Adelanto. His cause of death was listed as cardiogenic shock, massive right  
9 ventricular infarction, and severe ischemic heart disease. When he was found  
10 vomiting in his cell on December 19, 2015, a nurse refused to treat him because she  
11 “did not want to get sick.”<sup>296</sup> Medical staff did not return to check on his welfare,  
12 and officers had difficulty reaching the medical unit when they tried multiple times  
13 to alert medical staff to his worsening condition. When Mr. Azurdia-Hernandez was  
14 finally taken to the hospital, arriving two hours after others in the housing unit first  
15 tried to alert facility staff to his condition, his heart was too damaged to be repaired.

16           334. The DDR found that facility staff failed to triage Mr. Azurdia-  
17 Hernandez. Medical experts for HRW concluded that proper, timely care could  
18 have saved Mr. Azurdia-Hernandez’s life, stating that “[t]ime is absolutely critical”,  
19 and “[d]uring a heart attack, every minute counts.”<sup>297</sup> Additionally, they found the  
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21 <sup>292</sup> *Id.* at 13.

22 <sup>293</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
23 Center & Detention Watch Network, *supra* note 153, at 19–22.

24 <sup>294</sup> *Id.* at 21.

25 <sup>295</sup> *Id.* at 20–21.

26 <sup>296</sup> Professional Responsibility, Office of Detention Oversight, *Detainee Death*  
27 *Review- Jose Manuel Azurdia-Hernandez* at 6–7 (2016) (“Azurdia-Hernandez  
28 DDR”), <https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.pdf>.

<sup>297</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 153161, at 17.

1 nurse's refusal to see Mr. Azurdia-Hernandez to be "an egregious nursing  
2 decision."<sup>298</sup>

3 335. In sum, Plaintiffs and the Class have suffered—and Plaintiffs and the  
4 Class continue to be at substantial risk of serious harm—as a result of Defendants'  
5 failure to provide adequate and timely emergency care. Despite multiple reports  
6 documenting these deaths and the deficient emergency care involved, Defendants  
7 persist in their systemic failure to monitor or oversee the provision of emergency  
8 care to those in their custody.

9 **E. Defendants Systemically Fail to Ensure Adequate Physical and Mental**  
10 **Health Intake Screening.**

11 336. At Detention Facilities across the country, Defendants fail to  
12 adequately assess the physical and mental health needs of detained individuals  
13 during intake, which leads to failure to identify and properly treat detained  
14 individuals with such needs. Despite numerous reports documenting this failure at  
15 multiple facilities, Defendants have taken no effective steps to ensure that detained  
16 individuals receive appropriate health screening, exposing them to a significant risk  
17 of serious harm. These problems continue to recur due to systemic deficiencies in  
18 Defendants' oversight and monitoring practices and policies.

19 337. For example, when Plaintiff Jimmy Sudney arrived at Adelanto, it took  
20 over a week to see a doctor for an intake meeting, and that doctor asked only about  
21 his mental health. When he arrived at Eloy, it took almost a month to have an intake  
22 screening. Meanwhile, he went without medication that he requires daily to  
23 stabilize his medical and mental health needs.

24 338. Despite Plaintiff Luis Manuel Rodriguez Delgadillo's inability to self-  
25 report serious mental health conditions upon intake at Adelanto, medical staff did  
26 not make any efforts to secure his records or treatment plan from his treating  
27

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28 <sup>298</sup> *Id.* at 15.

1 psychiatrist, even though she is located nearby in California. Even when Mr.  
2 Rodriguez Delgadillo's parents brought a letter from his prior psychiatrist to the  
3 facility with a list of his medications, that list did not make it into his medical  
4 records and, on information and belief, the letter was not conveyed to mental health  
5 staff at Adelanto. Only recently, after Mr. Rodriguez Delgadillo wrote down his  
6 medications with the help of his mother and took the list to mental health staff, did  
7 he begin to receive his prior medications. He has had multiple acute psychiatric  
8 episodes during this gap in continuity of care.

9 339. When Plaintiff Melvin Murillo Hernandez was transferred from  
10 Tallahatchie to River, he informed intake staff at River that he was allergic to  
11 peanuts, chocolate, and jam. Though the intake nurse at River noted the allergy,  
12 medical staff did not ensure that he would receive food free of the allergens. As a  
13 result, Mr. Murillo Hernandez went into life-threatening anaphylactic shock  
14 requiring hospitalization three separate times over three months while at River. On  
15 April 7, 2019, Mr. Murillo Hernandez was given a peanut butter and jelly  
16 sandwich. As a result, his throat closed, he lost consciousness, and he was taken to  
17 the local hospital emergency room. He was also hospitalized on May 5 and 6, 2019,  
18 in response to anaphylaxis from his food allergies, and Mr. Murillo Hernandez  
19 subsequently experienced at least two additional hospitalizations for anaphylaxis.  
20 This failure to properly screen his medical issues and ensure appropriate referral  
21 related to his severe food allergies put him Mr. Murillo Hernandez at risk of death.

22 340. Plaintiff Edilberto García Guerrero has a complex medical history. Yet  
23 Aurora never requested Mr. García Guerrero's previous medical records regarding  
24 his right ankle, for which he received orthopedic surgery about six years ago,  
25 despite him experiencing a new injury to this ankle while in ICE custody.

26 341. Plaintiff Salazar Artaga's initial screenings at Florence, performed by  
27 a nurse and social worker, detected no mental health issues. Two weeks later, on  
28 March 26, 2019, he made a request for Risperidone, an anti-psychotic medication



1 he received previously. Mr. Salazar Artaga did not timely receive the medication,  
2 and he ended up on suicide watch twice over the next month for banging his head  
3 on the wall and auditory and visual hallucinations. He went without the medication  
4 until he finally had a mental health evaluation on April 17, 2019. As a result, he did  
5 not receive needed medication for over a month after he arrived at the facility.

6 342. The intake screening failures experienced by Plaintiffs are typical and  
7 are known to Defendants.

8 343. For example, in 2009, DHS released a report entitled “Immigration  
9 detention overview and recommendations,” which concluded that “[t]he current  
10 mental health intake assessment is quite brief and does not lend itself to early  
11 identification and intervention.”<sup>299</sup>

12 344. The report also concluded that, because ICE assigns detained  
13 individuals to facilities prior to completing medical screening, detained individuals  
14 with mental health disabilities are not always assigned to facilities where the  
15 staffing, proximity to emergency care, and physical space are most conducive to  
16 their conditions.<sup>300</sup>

17 345. Two years later, OIG published a report entitled “Management of  
18 Mental Health Cases in Immigration Detention.”<sup>301</sup> OIG reviewed intake forms for  
19 85 detained individuals with mental health disabilities and found that only ten of  
20 those forms included any notes relating to mental health observations during the  
21 intake process.<sup>302</sup>

22 \_\_\_\_\_  
23 <sup>299</sup> U.S. Immigration & Customs Enforcement, Dep’t of Homeland Sec.,  
24 *Immigration Detention Overview and Recommendations*, at 25 (Oct. 6, 2009),  
<https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf>.

25 <sup>300</sup> *Id.* at 27.

26 <sup>301</sup> Office of Inspector Gen., Dep’t of Homeland Sec., *OIG-11-62: Management of*  
*Mental Health Cases in Immigration Detention*, at 22 (Mar. 2011),  
27 <https://www.hsdl.org/?abstract&did=6985>.

28 <sup>302</sup> *Id.*

1           346. A 2016 GAO report found that, although detention standards require  
2 facilities to conduct in-depth medical examinations within 14 days of arrival at a  
3 facility, approximately a third of detained individuals surveyed stated that they had  
4 not received those examinations.<sup>303</sup>

5           347. In 2016, a DHS OIG inspection of Stewart found staff shortages forced  
6 the facility to operate against intake staffing policy.<sup>304</sup> Staff also reported that  
7 delays in getting transfer paperwork interfered with the timeliness of intake  
8 screenings and classification.<sup>305</sup>

9           348. As a result of the systemic deficiencies in the intake screening process,  
10 and Defendants' failure to properly monitor, oversee, and respond to those  
11 deficiencies, individuals in Detention Facilities across the country have been  
12 subjected to inadequate medical and mental health intake screenings.

13           349. DDRs illustrate the ongoing harms of these deficiencies in the intake  
14 screening process.

15           350. During Sergio Alonso Lopez's intake interview at Adelanto on  
16 February 10, 2017, a nurse noted that Mr. Lopez had hand tremors and fidgeted  
17 during the screening, and the nurse determined that he was likely in withdrawal.  
18 Although the intake screening form instructed that she should immediately notify a  
19 provider and initiate an alcohol withdrawal assessment, she did not initiate the  
20 assessment. Later that day, a doctor performed a physical examination of Mr. Lopez  
21

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22 <sup>303</sup> U.S. Gov't Accountability Office, *GAO-16-231, Additional Actions Needed to*  
23 *Strengthen Management and Oversight of Detainee Medical Care*, at 50 (Feb.  
24 2016), <https://www.gao.gov/assets/680/675484.pdf>.

25 <sup>304</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., OIG-18-32, *supra* note  
26 152, at 3-4; *see also* Office of Inspector, Gen., U.S. Dep't of Homeland Sec., *Adult*  
27 *Detention Oversight 16-047-ISP-ICE*,  
[https://www.oig.dhs.gov/sites/default/files/assets/FOIA/OIG\\_FOIA\\_Stewart-](https://www.oig.dhs.gov/sites/default/files/assets/FOIA/OIG_FOIA_Stewart-Detention-Center-Work-Papers.pdf)  
28 [Detention-Center-Work-Papers.pdf](https://www.oig.dhs.gov/sites/default/files/assets/FOIA/OIG_FOIA_Stewart-Detention-Center-Work-Papers.pdf).

<sup>305</sup> *Id.*

1 without reviewing his previous medical records first. The DDR noted that this  
 2 “hinder[ed] the physician’s ability to ensure continuity of treatment.” As such, his  
 3 withdrawal from methadone was never listed on his “problem list,” which  
 4 hampered the ability of nurses to subsequently treat his withdrawal.<sup>306</sup> On April 13,  
 5 2017, after a string of incorrect treatments, he died of internal bleeding.<sup>307</sup>

6 351. On June 2, 2016, Juan Luis Boch-Paniagua, while detained at LaSalle,  
 7 died of a gastrointestinal hemorrhage.<sup>308</sup> Mr. Boch-Paniagua’s DDR found that he  
 8 received his intake health screening from an officer via an intake medical  
 9 questionnaire, but there was no documentation showing that the intake officer had  
 10 received necessary training to conduct a health screening. The intake officers also  
 11 failed to use interpreters at Mr. Boch-Paniagua’s intake and classification.<sup>309</sup>  
 12 Though Mr. Boch-Panigua reported his acetaminophen and ibuprofen allergy to  
 13 medical staff, his “problem list” was left blank, causing medical staff to  
 14 dangerously prescribe him 17 doses of acetaminophen and 50 doses of ibuprofen.<sup>310</sup>

15 352. On April 28, 2016, José Leonardo Lemus Rajo died of acute alcohol  
 16 withdrawal syndrome soon after being detained at Krome.<sup>311</sup> His DDR identified  
 17 numerous deficiencies in the intake process. First, though Mr. Lemus Rajo reported  
 18 a history of daily heavy alcohol use, and that he was experiencing tremors as a  
 19 symptom of withdrawal, a nurse documented that he “did not observe tremors,  
 20 agitation, excessive sweating, bizarre or unusual behavior, or disorientation during  
 21

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22 <sup>306</sup> *Id.* at 17.

23 <sup>307</sup> *Id.*

24 <sup>308</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
*Death Review- - Juan Luis Boch-Paniagua* at 18 (2016) (“Boch-Paniagua DDR”).

25 <sup>309</sup> *Id.* at 29.

26 <sup>310</sup> *Id.* at 28.

27 <sup>311</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
*Death Review- - José Leonardo Lemus Rajo* at 1 (2016) (“Lemus Rajo DDR”),  
 28 <https://www.ice.gov/doclib/foia/reports/ddr-Lemus.pdf>.

1 the encounter.”<sup>312</sup> Second, a doctor consulted over the phone ordered vitamins and a  
2 withdrawal assessment to be administered to Mr. Lemus Rajo, but the vitamins  
3 were never given to Mr. Lemus Rajo, even though they “may have counteracted the  
4 effects of malnutrition and slowed or arrested withdrawal aggression.”<sup>313</sup> Third, Mr.  
5 Lemus Rajo was kept in the intake area for over five hours, during which time “his  
6 alcohol withdrawal symptoms progressed rapidly” and he did not receive any  
7 medical monitoring,<sup>314</sup> which the DDR called “highly risky.”<sup>315</sup> A withdrawal  
8 assessment was not conducted until approximately five and a half hours after Mr.  
9 Lemus Rajo’s intake screening, and when it was finally administered, it showed  
10 that he was experiencing severe tremors, anxiety, agitation, and hallucinations.

11 353. The DDR concluded that the facility “delayed [Mr. Lemus Rajo’s]  
12 access to care by failing to conduct a baseline [withdrawal assessment] upon the  
13 detainee’s acknowledged heavy alcohol use and report of experiencing tremors,  
14 maintaining him in the intake area for a protracted period without medical  
15 monitoring, and failing to give him vitamins immediately.”<sup>316</sup>

16 354. Two independent medical experts reviewing this case concluded that  
17 the DDR raised serious unresolved concerns about the quality of care given to Mr.  
18 Lemus Rajo during the intake process.<sup>317</sup> One of those doctors stated, “They had  
19 hours and hours to treat him. He was not treated until he got to the hospital.  
20 Delaying treatment for over seven hours with someone with serious alcohol  
21 withdrawal is a problem.” The other found, “Mr. Lemus reported very heavy  
22  
23

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24 <sup>312</sup> *Id.* at 8.

25 <sup>313</sup> *Id.* at 18.

26 <sup>314</sup> *Id.* at 6.

27 <sup>315</sup> *Id.* at 17.

28 <sup>316</sup> *Id.*

<sup>317</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153, at 22–25.

1 alcohol use which—very predictably—led to alcohol withdrawal.<sup>318</sup> The failure of  
2 the facility to administer medications to him promptly was significant.”<sup>319</sup>

3 355. Jose de Jesus Deniz-Sahagun died by suicide on May 20, 2015, at  
4 Eloy.<sup>320</sup> The agents who transported Mr. Deniz to the facility on May 18 notified a  
5 nurse that he had attempted suicide the day prior and that he had behaved erratically  
6 earlier in the day, including banging his head, but these behaviors were not  
7 documented in Mr. Deniz-Sahagun’s medical record.<sup>321</sup> During intake, Mr. Deniz-  
8 Sahagun acknowledged his suicide attempt to the nurse.<sup>322</sup> Yet, because the intake  
9 nurse wrote that Mr. Deniz-Sahagun “reported no mental health history and  
10 appeared stable,”<sup>323</sup> the nurse referred him for a routine, rather than urgent, mental  
11 health evaluation the next day. Before receiving a full mental health screening, Mr.  
12 Deniz-Sahagun got into an altercation with facility staff, who placed him in  
13 segregation without medical clearance.<sup>324</sup> Mr. Deniz-Sahagun died by suicide the  
14 next day.<sup>325</sup>

15 356. In short, intake procedures in Detention Facilities are slapdash,  
16 incomplete, and omit critical details like pain assessments, medication regimes, and  
17 gathering of medical records. The deficiencies with the intake procedures have been  
18 repeatedly documented, including without limitation in government and nonprofit  
19 reports and DDRs. Nevertheless defendants, with deliberate indifference, have  
20 failed to take effective measures to address these deficiencies.

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22 <sup>318</sup> *Id.* at 24.

23 <sup>319</sup> *Id.*

24 <sup>320</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
25 *Death Review- - Jose de Jesus Deniz-Sahagun* at 1 (2016) (“Deniz-Sahagun  
26 DDR”).

27 <sup>321</sup> *Id.* at 2.

28 <sup>322</sup> *Id.*

<sup>323</sup> *Id.* at 31.

<sup>324</sup> *Id.* at 32.

<sup>325</sup> *Id.* at 24.

1           **F. Defendants Systemically Fail to Ensure Adequate Staffing of Medical**  
2           **and Mental Health Care.**

3           357. Detention Facilities across the country are chronically and consistently  
4 understaffed with medical and mental health care personnel. Despite numerous  
5 reports documenting this, Defendants have taken no effective steps to ensure that  
6 Detention Facilities have appropriate medical and mental health care staffing,  
7 exposing detained individuals to significant risk of serious harm.

8           358. The staffing shortages are systemic and cause dangerous delays in the  
9 provision of medical care, as well as treatment by unqualified personnel. The  
10 shortages have been documented by Defendants' own entities repeatedly, with one  
11 DDR concluding that "[a]dequate staffing by medical professionals of appropriate  
12 levels is critical to ensuring the healthcare needs of detainees are met in a timely  
13 manner."<sup>326</sup> Nevertheless, this systemic practice of dangerous short-staffing  
14 persists.

15           359. For example, at Adelanto, nursing staff are sometimes required to act  
16 beyond their scope because of the unavailability of an attending physician. Plaintiff  
17 Faour Abdallah Fraihat has twice experienced emergency episodes including sharp  
18 chest pain, difficulty breathing, and an elevated heart rate. Both times, an Adelanto  
19 physician assistant called a "code blue" and called for an ambulance because no  
20 attending physician was available. Both times, Mr. Fraihat was admitted to the  
21 hospital for several weeks.

22           360. When Mr. Fraihat meets with a doctor at Adelanto, the doctor sets a  
23 timer for five to ten minutes. The doctor tells Mr. Fraihat that she is setting a timer  
24 because "we have a lot of people in here."

25           361. Plaintiff Luis Manuel Rodriguez Delgadillo sees a constantly shifting  
26 cast of characters among the mental health providers at Adelanto and has not

27 \_\_\_\_\_  
28 <sup>326</sup> Office of Professional Responsibility, *Detainee Death Review – Lelis Rodriguez*,  
at 12, <https://www.ice.gov/doclib/foia/reports/ddr-rodriguez.pdf>.

1 formed a trusting treating relationship with any of them. For a concrete thinker like  
2 Mr. Rodriguez Delgadillo, seeing a rotating series of providers in person and  
3 through tele-psychiatry has profound implications for his ability to communicate  
4 his mental health state and receive proper treatment.

5 362. Plaintiff García Guerrero has experienced the effects of short-staffing  
6 at Aurora, where there is only one doctor on staff, despite a new contract in April  
7 2019 increasing the facility's capacity from approximately 900 to more than 1,400  
8 beds. Plaintiff García Guerrero's requests for medical attention have received even  
9 slower responses since the expansion.

10 363. Defendants are well aware of the long-standing, systemic staffing  
11 shortages at their facilities.

12 364. For example, in July 2019, four Colorado politicians visited Aurora  
13 and reported that, in addition to a psychologist vacancy, senior positions in the  
14 health unit, including the top two positions of Health Services Administrator and  
15 deputy HSA, were vacant.<sup>327</sup>

16 365. On November 27, 2016, Raquel Calderon de Hidalgo became the  
17 fifteenth person to die while in custody at Eloy in Arizona.<sup>328</sup> Her cause of death  
18 was a pulmonary embolism due to deep vein thrombosis.<sup>329</sup> On November 23,  
19 2016, an intake nurse recommended that Ms. Calderon de Hidalgo be seen by a  
20 provider that same day, as she had recently suffered a leg injury and was still  
21

22  
23 <sup>327</sup> Blair Miller & Russell Haythorn, *Colorado's Congressional Democrats Tour*  
24 *Aurora ICE Facility, Call for Changes*, The Denver Channel (July 22, 2019)  
25 [https://www.thedenverchannel.com/news/politics/colorados-congressional-](https://www.thedenverchannel.com/news/politics/colorados-congressional-democrats-tour-aurora-ice-facility-call-for-changes-and-its-closure)  
[democrats-tour-aurora-ice-facility-call-for-changes-and-its-closure](https://www.thedenverchannel.com/news/politics/colorados-congressional-democrats-tour-aurora-ice-facility-call-for-changes-and-its-closure).

26 <sup>328</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 153161, at 36.

27 <sup>329</sup> Office of Professional Responsibility, *Detainee Death Review – Raquel*  
28 *Calderon De-Hidalgo*, <https://www.ice.gov/doclib/foia/reports/ddr-Calderon.pdf>.

1 experiencing pain.<sup>330</sup> The appointment was delayed until November 25, at which  
2 point the scheduled physical exam did not occur, because Ms. Calderon de Hidalgo  
3 had recently been quarantined for potential exposure to varicella and the nurse  
4 practitioner was too busy to leave the clinic.<sup>331</sup> Her physical exam was never  
5 rescheduled.<sup>332</sup> On November 26, Ms. Calderon de Hidalgo waited approximately  
6 five hours at the clinic to see a provider for related issues, yet she was sent back to  
7 her unit by an officer who erroneously believed she had been seen already.<sup>333</sup> The  
8 next day, Ms. Calderon de Hidalgo collapsed and had a seizure.<sup>334</sup> She later died of  
9 a blood clot that had developed from her leg injury.<sup>335</sup>

10 366. The DDR found that the facility failed to provide timely and  
11 appropriate medical care and medical assessment to Ms. Calderon de Hidalgo, and  
12 that although a registered nurse “identified [Ms. Calderon de Hidalgo] as a patient  
13 requiring expedited provider attention . . . [Ms. Calderon de Hidalgo’s] first and  
14 only contact with a provider was during her medical emergency, four days after her  
15 arrival.”<sup>336</sup> Two independent experts concluded that if a doctor had actually seen  
16 Ms. Calderon de Hidalgo when she requested a visit several days before her death,  
17 there may have been a different outcome, and that failure of a health provider to  
18 examine her when she was referred as a high priority patient constituted a  
19 dangerous and potentially fatal medical care practice.<sup>337</sup>

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22 <sup>330</sup> *Id.* at 3.

23 <sup>331</sup> *Id.* at 5.

24 <sup>332</sup> *Id.* at 5.

25 <sup>333</sup> *Id.* at 6–7.

26 <sup>334</sup> *Id.* at 7.

27 <sup>335</sup> *Id.* at 11.

28 <sup>336</sup> *Id.* at 11.

<sup>337</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 37.



1           367. In June 2019, the American Immigration Council (“AIC”) and  
2 American Immigration Lawyers Association (“AILA”) issued a complaint  
3 regarding inadequate medical and mental health care at Aurora.<sup>338</sup> Reiterating  
4 concerns expressed in a 2018 complaint, which had yet to be addressed by ICE, this  
5 complaint illustrated the ongoing problem of inadequate care given to detained  
6 individuals.<sup>339</sup> Specifically, the AIC and AILA complaint emphasized that the  
7 recent expansion of Aurora has made conditions there measurably worse, with 432  
8 beds added to the facility without sufficient staffing to manage the growing  
9 population.<sup>340</sup>

10           368. According to a March 2019 complaint filed by Project South,  
11 CoreCivic’s staffing levels were so low that immigrants at Stewart were forced to  
12 request medical attention at four in the morning or receive none at all.<sup>341</sup>

13           369. In a communication signed by an ICE official on January 25, 2017,<sup>342</sup>  
14 ICE noted it “urgently requires” on-site medical staffing support services at Stewart  
15 and Berks County, and that the facilities were in “critical need of RN staffing to  
16 sustain operations at each site.”<sup>343</sup> The document also stated that Public Health  
17 Service positions at Stewart were staffed at only 20% of the fill rate, and that  
18 “ICE’s failure to sustain minimum RN staffing levels will require healthcare  
19  
20

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21 <sup>338</sup> Email from Am. Immigration Council & Am. Immigration Lawyers Ass’n, to  
22 Stewart D. Smith, Assistant Dir., ICE Health Servs. Corps., et al. (June 11, 2019)  
(on file with Plaintiffs’ Counsel).

23 <sup>339</sup> *Id.* at 1.

24 <sup>340</sup> *Id.* at 1–2.

25 <sup>341</sup> Compl. For Declaratory and Inj. Relief at 5, Project South v. U.S. Immigr. and  
26 Customs Enf’t, No. 1:19-cv-895-APM (D.C. Mar. 29, 2019) ECF No. 3-1.

27 <sup>342</sup> Justification for Other than Full and Open Competition, Ex. A to Compl. For  
28 Declaratory and Inj. Relief, Project South v. U.S. Immigr. and Customs Enf’t, No.  
1:19-cv-00895 (ECF No. 1-4).

<sup>343</sup> *Id.* at 1–2.

1 services to be reduced at each facility; endangering detainee and non-detainee  
2 safety . . . .”<sup>344</sup>

3 370. In 2016 and 2017, researchers for the Women’s Refugee Commission  
4 visited seven detention facilities in Texas, California, Arizona, and New Mexico.<sup>345</sup>  
5 They found that the staffing for medical and mental health was inadequate.<sup>346</sup> At  
6 best, the research team observed a staffing ratio of roughly one mid-level provider  
7 per 100 detained individuals, at Hutto Detention Center (“Hutto”).<sup>347</sup> At worst, the  
8 Joe Corley facility had one full-time physician and one full-time nurse practitioner  
9 for over 1,500 people.<sup>348</sup> In addition, all seven facilities had insufficient levels of  
10 mental health care staffing.<sup>349</sup> At Laredo, there was no full-time mental health  
11 service provider.<sup>350</sup>

12 371. In 2011, OIG issued a report entitled “Management of Mental Health  
13 Cases in Immigration Detention,”<sup>351</sup> which followed a 2009 DHS report  
14 documenting systemic issues related to mental health care, including inadequate  
15 staffing. Focusing on 18 facilities staffed by the ICE Health Service Corps, the  
16 report made the following relevant findings: (1) IHSC has “experienced persistent  
17 vacancies in mental health positions which have raised concerns about the  
18 effectiveness of provider care”; (2) vacancy rates in mental health positions at 11 of

19 \_\_\_\_\_  
20 <sup>344</sup> *Id.* at 2.

21 <sup>345</sup> Women’s Refugee Comm’n, *Prison for Survivors, the Detention of Women*  
22 *Seeking Asylum in the United States*. (Oct. 2017),  
[file:///C:/Users/ADiaz/Downloads/Prison-for-Survivors-REPORT-  
FINAL%20\(3\).pdf](file:///C:/Users/ADiaz/Downloads/Prison-for-Survivors-REPORT-FINAL%20(3).pdf).

23 <sup>346</sup> *Id.* at 30, 31.

24 <sup>347</sup> *Id.* at 30.

25 <sup>348</sup> *Id.* at 31.

26 <sup>349</sup> *Id.*

27 <sup>350</sup> *Id.*

28 <sup>351</sup> Office of Inspector Gen., Office of Homeland Sec., *OIG-11-62: Management of*  
*Mental Health Cases in Immigration Detention* (2011),  
[https://www.oig.dhs.gov/assets/Mgmt/OIG\\_11-62\\_Mar11.pdf](https://www.oig.dhs.gov/assets/Mgmt/OIG_11-62_Mar11.pdf).

1 the 18 facilities staffed with IHSC employees were 50% or more; (3) ICE failed to  
2 allocate mental health staff in accordance with the needs of facilities—for example,  
3 the only mental health staff allocated at two facilities was one social worker, even  
4 though those facilities housed 76 and 59 detained individuals with mental health  
5 disabilities; (4) to compensate for short-staffing, “facilities without a psychiatrist  
6 must rely on other medical professionals qualified to prescribe any medications,  
7 even though they may not be knowledgeable of specific psychiatric medications”;  
8 and (5) some facilities were located in remote locations without access to third-  
9 party providers of mental health care.<sup>352</sup>

10 372. According to that same report, “IHSC officials from headquarters and  
11 field locations cited staffing shortages as a critical challenge. In addition, health  
12 service administrators and clinical directors throughout IHSC expressed the need  
13 for more mental health providers.”<sup>353</sup>

14 373. In 2016, OIG issued another Mental Health Staffing Report,  
15 concluding that ICE continued to fail to attract and retain adequate qualified mental  
16 health care providers, at least in part due to the “rural and remote” areas where  
17 Defendants have elected to detain individuals.<sup>354</sup>

18 374. That same year, the HSA at Stewart told an OIG inspector that the  
19 facility had “chronic shortages of almost all medical staff positions.”<sup>355</sup>  
20 Specifically, Stewart at the time was staffed with only “18 of 25 Registered Nurses;  
21  
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23 <sup>352</sup> *Id.* at 1, 8, 11, 16,

24 <sup>353</sup> *Id.* at 8.

25 <sup>354</sup> Office of Inspector Gen., Office of Homeland Sec., OIG-16-113-VR: ICE Still  
26 Struggles to Hire and Retain Staff for Mental Health Cases in Immigration  
27 Detention, at 2 (2016), [https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-  
28 Jul16.pdf](https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf).

<sup>355</sup> Office of Inspector Gen., Office of Homeland Sec., *FOIA Response No. 2018-  
IGFO-00059*, *supra* note 104, at 34.

1 8 of 11 Licensed Practical Nurses; 2 of 3 License Clinical Social Workers; no  
2 Psychiatrists; and 1 of 2 Medical Doctors.”<sup>356</sup>

3 375. A 2017 report by HRW<sup>357</sup> described the experience of Dr. John Rubel,  
4 a clinical psychologist with decades of experience in the federal Bureau of Prisons,  
5 who spent two years providing mental health services at Hutto Detention Center in  
6 Texas. Dr. Rubel found a tremendous need for mental health care, but trying to  
7 provide it at Hutto eventually posed an “ethical and moral dilemma”<sup>358</sup> that led him  
8 to leave. Dr. Rubel described the prevalence of trauma in the facility, which housed  
9 more than 500 women, as “extremely high,” saying, “it’s not just a single event [for  
10 these women], but multiple episodes of trauma.”<sup>359</sup> Despite the great need, mental  
11 health staff at the facility consisted of one to two full-time staff members and one  
12 half-time staff member. Without more mental health staff, he said, it was  
13 impossible to provide the comprehensive mental health services required under  
14 IHSC policy.<sup>360</sup>

15 376. A 2017 Penn State Law report also found understaffing issues at Irwin  
16 County Detention Center (“Irwin”). Although the facility’s website<sup>361</sup> lists a  
17 capacity of 1,201 individuals, the report found that these individuals had infrequent  
18 access to only one doctor, who worked at the facility part-time.<sup>362</sup> At Victorville  
19 Federal Correctional Complex, ICE detained 1,000 individuals despite protestations  
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21 <sup>356</sup> *Id.*

22 <sup>357</sup> Human Rights Watch & CIVIC, *supra* note 181.

23 <sup>358</sup> *Id.* at 72.

24 <sup>359</sup> *Id.* (internal citation omitted).

25 <sup>360</sup> *Id.*

26 <sup>361</sup> *Our Locations*, LaSalle Corrections,  
27 <http://www.lasallecorrections.com/locations/georgia/irwin-county-detention-center/?back=locations>.

28 <sup>362</sup> *Imprisoned Justice: Inside Two Georgia Immigrant Detention Centers*, Penn State Law, at 47–48 (May 2017) [https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned\\_Justice\\_Report-1.pdf](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf).

1 by the local facility employee union there that an existing medical staffing shortage  
 2 would cause some detained individuals to go without treatment.<sup>363</sup> In 2018, a  
 3 former CoreCivic training officer at Otay Mesa testified in a wrongful death suit  
 4 brought by the estate of a former detained individual there that short-staffing  
 5 hindered officers' ability to notice when detained individuals required medical care  
 6 and a referral to the medical unit.<sup>364</sup>

7 377. The systemic deficiencies in staffing at Detention Facilities, and  
 8 Defendants' failure to address those deficiencies, have put detained individuals  
 9 across the country at significant risk of serious harm.

10 378. On December 2, 2017, Kamyar Samimi died of methadone withdrawal  
 11 at Aurora.<sup>365</sup> His DDR found that the facility had vacancies in key medical  
 12 personnel, including a Director of Nursing and a mid-level provider, for longer than  
 13 six months.<sup>366</sup> The DDR also found a high turnover of staff and slow hiring  
 14 processes.<sup>367</sup>

15 379. Additionally, the absence of a midlevel provider contributed to the  
 16 facility's failure to provide a complete initial physical assessment of Mr. Samimi.<sup>368</sup>  
 17 A doctor interviewed for the Medical and Security Compliance Analysis portion of  
 18 the DDR<sup>369</sup> stated that, due to the vacancies, it was likely there were other detained

19 \_\_\_\_\_  
 20 <sup>363</sup> Samantha Michaels, *Understaffed Federal Prison Is Taking in 1,000*  
 21 *Noncriminal Immigrants, and Even the Guards Are Protesting*, Mother Jones, (June  
 22 15, 2018) <https://www.motherjones.com/crime-justice/2018/06/understaffed-federal-prison-is-taking-in-1000-noncriminal-immigrants-and-even-the-guards-are-protesting/>.

23 <sup>364</sup> McGinnis Dep. at 162:24-164:7, *Estate of Cruz-Sanchez by & through Rivera v.*  
 24 *United States*, No. 317-cv--00569-AJB--NLS, 2017 WL 9853749, ECF No. 67-1  
 (S.D. Cal. Oct. 4, 2017).

25 <sup>365</sup> Samimi DDR, *supra* note 220.

26 <sup>366</sup> *Id.* at 25.

27 <sup>367</sup> *Id.* at 59.

28 <sup>368</sup> *Id.* at 26.

<sup>369</sup> *Id.*

1 individuals with significant medical problems whose initial examinations were  
2 conducted by registered nurses.<sup>370</sup> In addition, as a result of the facility’s lack of a  
3 Director of Nursing or other nurse supervisor, “clinical supervision was inadequate  
4 to assure adherence to provider orders and necessary and appropriate care.”<sup>371</sup>

5 380. Moises Tino Lopez died in September 2016 while detained at Hall  
6 County Jail in Nebraska.<sup>372</sup> The DDR identified a number of serious staffing  
7 problems, including that the facility’s mid-level provider, a nurse practitioner, only  
8 provided one to three hours of coverage per week, making it “a challenge to  
9 conduct patient encounters and review telephone orders and diagnostic reports  
10 . . . .”<sup>373</sup> The facility physician “is located in Peoria, Illinois [and] provides no on-  
11 site services or supervision of the [nurse practitioner] beyond remotely reviewing  
12 her orders every three months.”<sup>374</sup> The facility also lacked any on-site registered  
13 nurses to provide administrative oversight of health care operations or clinical  
14 supervision of licensed practical nurses.<sup>375</sup> This staffing shortage likely led to  
15 delays in evaluation and medical staff doing jobs for which they were not qualified,  
16 as the facility improperly had a licensed nurse practitioner assess Mr. Tino  
17 Lopez.<sup>376</sup>

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21 <sup>370</sup> *Id.* at 7.

22 <sup>371</sup> *Id.* at 63.

23 <sup>372</sup> Office of Professional Responsibility, *Detainee Death Review – Moises Tino-*  
24 *Lopez*, [https://d1zbh0am38bx6v.cloudfront.net/wp-](https://d1zbh0am38bx6v.cloudfront.net/wp-content/uploads/2018/07/17044550/ddr-Tino.pdf)  
25 [content/uploads/2018/07/17044550/ddr-Tino.pdf](https://d1zbh0am38bx6v.cloudfront.net/wp-content/uploads/2018/07/17044550/ddr-Tino.pdf).

26 <sup>373</sup> *Id.* at 14–15.

27 <sup>374</sup> *Id.* at 14.

28 <sup>375</sup> *Id.* at 15.

<sup>376</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 153161, at 31.

1           381. Igor Zyazin died in May 2016 while detained at Otay Mesa.<sup>377</sup> He was  
2 previously detained at the San Luis Detention Center. The DDR found that,  
3 notwithstanding that “oversight of clinical decision making, and care is critical in a  
4 correctional health care operation,” San Luis did not have a designated clinical  
5 medical authority or physician coverage.<sup>378</sup>

6           382. Jose Manuel Azurdia-Hernandez died in December 2015 while  
7 detained at Adelanto in California.<sup>379</sup> The DDR found the facility had an ongoing  
8 shortage of medical personnel, including leadership vacancies in the director of  
9 nurses and the assistant HSA positions, five registered nurse vacancies, and a “high  
10 turnover rate among nursing staff, which impacts delivery and quality of care.”<sup>380</sup> It  
11 also found that the facility had had two different HSAs since October 2014, the first  
12 of whom moved to the assistant HSA position and was on administrative leave at  
13 the time of the DDR.<sup>381</sup>

14           383. Raul Ernesto Morales-Ramos died in April 2015 while detained at  
15 Adelanto.<sup>382</sup> According to the DDR, “many members of [Adelanto’s] medical staff  
16 [stated] that a high turnover rate among nurses is of great concern, particularly  
17 given an increasing population of detainees with chronic health care needs.”<sup>383</sup> The  
18 facility has difficulty recruiting and retaining nurses, which necessitates hiring new  
19 graduates with minimal experience; approximately 50 percent of Adelanto’s  
20 medical staff are new graduates, with “a definite difference between their skills and  
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22 <sup>377</sup> Office of Professional Responsibility, *Detainee Death Review – Igor Zyazin*,  
23 <https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf>.

24 <sup>378</sup> *Id.* at 11.

25 <sup>379</sup> Office of Professional Responsibility, *Detainee Death Review – Jose Manuel*  
*Azurdia-Hernandez*, <https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.pdf>.

26 <sup>380</sup> *Id.* at 16.

27 <sup>381</sup> *Id.* at 16.

28 <sup>382</sup> Raul Ernesto Morales-Ramos DDR, *supra* note 158.

<sup>383</sup> *Id.* at 37.

1 those of more experienced nurses.”<sup>384</sup> Additionally, two doctors at Adelanto  
2 reported that there is a great variation in nursing skills among current nursing  
3 staff.<sup>385</sup>

4 384. Lelis Rodriguez died in July 2013, shortly after being transferred from  
5 the Brooks County Detention Facility to the Rio Grande Detention Facility, both in  
6 Texas.<sup>386</sup> The DDR determined that the Brooks County facility had significant  
7 staffing problems, including that medical staff consisted of mostly low-level  
8 medical personnel without appropriate clinical oversight, that a physician was  
9 present only two hours per week, and that the facility lacked mental health staff,  
10 physicians assistants, and nurse practitioners.<sup>387</sup> The DDR noted that “[a]dequate  
11 staffing by medical professionals of appropriate levels is critical to ensuring the  
12 healthcare needs of detainees are met in a timely manner.”<sup>388</sup>

13 385. Another detainee, Federico Mendez Hernandez, died at this same  
14 facility just one month earlier, in June 2013.<sup>389</sup> The DDR determined that, although  
15 there were more than 25,000 detainee admissions to Brooks County during 2013,  
16 and although the facility had 63 chronic care patients, a physician was present at the  
17 facility for only two hours each week.<sup>390</sup> There were no physician assistants, nurse  
18 practitioners, or mental health staff at the facility. Most medical care was provided  
19 by low-level medical professionals, and oversight and clinical supervision of onsite  
20 medical staff was limited to services that could be provided by the physician and

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21 <sup>384</sup> *Id.*

22 <sup>385</sup> *Id.*

23 <sup>386</sup> Office of Professional Responsibility, *Detainee Death Review – Lelis Rodriguez*,  
24 <https://www.ice.gov/doclib/foia/reports/ddr-rodriguez.pdf>.

24 <sup>387</sup> *Id.* at 12.

25 <sup>388</sup> *Id.*

26 <sup>389</sup> Office of Professional Responsibility, *Detainee Death Review – Federico*  
27 *Mendez-Hernandez*, [https://www.ice.gov/doclib/foia/reports/ddr-](https://www.ice.gov/doclib/foia/reports/ddr-mendezhernandez.pdf)  
27 [mendezhernandez.pdf](https://www.ice.gov/doclib/foia/reports/ddr-mendezhernandez.pdf).

28 <sup>390</sup> *Id.* at 12.



1 the HSA, who was a registered nurse.<sup>391</sup> According to the DDR, “Nursing staff  
 2 reported they believe demanding work schedules and the heavy workload  
 3 contributed to the abbreviated clinical assessments and inadequate documentation  
 4 in the medical record of [Mr. Mendez Hernandez].”<sup>392</sup>

5 386. Pablo Gracida-Conte, held at Eloy in Arizona, died in October 2011.<sup>393</sup>  
 6 Many detained individuals at Eloy had extensive medical needs. For example, the  
 7 HSA stated that a quarter of the facility’s population had chronic care issues, and  
 8 that the number of detained individuals requiring higher levels of care was  
 9 increasing.<sup>394</sup> According to a facility nurse, there were up to 110 sick call  
 10 encounters per day, and the facility was grossly understaffed to handle these  
 11 needs.<sup>395</sup> A facility doctor reported that “she badly needs help.”<sup>396</sup> Further, at the  
 12 time of Mr. Gracida-Conte’s death, mid-level practitioners were understaffed by  
 13 17%, nursing was understaffed by 25%, physicians were understaffed by 50%, and  
 14 the facility had no clinical director for four of the five years it had been open.<sup>397</sup>  
 15 ICE was fully aware of this problem; the Assistant Field Office Director, an  
 16 employee of ICE, stated that she had been aware of the staffing issues since  
 17 assuming her post in April 2011.<sup>398</sup>

18 387. Staffing shortages are persistent, systemic, and dangerous to detained  
 19 individuals throughout Defendants’ network of Detention Facilities. Despite being  
 20 on notice for years of these staffing shortages and the risks that they pose to people  
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22 <sup>391</sup> *Id.*

23 <sup>392</sup> *Id.*

24 <sup>393</sup> Office of Professional Responsibility, *Detainee Death Review – Pablo Gracida-*  
 25 *Conte*, [https://www.documentcloud.org/documents/2695513-Gracida-Conte-](https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p1/a272669)  
 25 [Pablo.html#document/p1/a272669](https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p1/a272669).

26 <sup>394</sup> *Id.* at 13.

27 <sup>395</sup> *Id.* at 14.

28 <sup>396</sup> *Id.* at 13.

<sup>397</sup> *Id.* at 13–14.

<sup>398</sup> *Id.* at 14.

1 in their custody, Defendants with deliberate indifference have failed to effectively  
2 monitor or oversee this issue or take measures to eliminate it.

3 **G. Defendants Systemically Fail to Ensure Adequate Mental Health Care.**

4 388. At Detention Facilities across the country, detained individuals receive  
5 substandard mental health care. Despite numerous reports documenting this fact,  
6 and litigation substantiating it, Defendants have taken no effective steps to ensure  
7 that detained individuals receive appropriate mental health care, exposing Plaintiffs  
8 and the Class to significant risk of serious harm.

9 389. The problem of substandard mental health care is systemic, occurring  
10 at Detention Facilities across the country, and continuing to occur due to systemic  
11 deficiencies in Defendants' oversight and monitoring practices and policies.

12 390. Plaintiff Jimmy Sudney has mental health disabilities including PTSD  
13 from the earthquake in Haiti. Though he arrived at Eloy with a thirty-day supply of  
14 medication which had stabilized him while he was in prison, he was told he could  
15 not continue with that medication because "ICE has a different standard." While  
16 detained at Eloy, Mr. Sudney had only one 30 to 60-minute session per month. At  
17 Adelanto, therapy further decreased to once every month or two, for five to fifteen  
18 minutes each session. He now has difficulty sleeping and regularly experiences  
19 flashbacks to violence and the earthquake in Haiti, especially after the recent  
20 Southern California earthquakes, after which his requests for mental health care  
21 went unanswered.

22 391. Plaintiff Hamida Ali had a history of schizophrenia and suicidal  
23 ideation prior to coming into ICE custody, but she was nonetheless housed in  
24 Aurora alone in a dormitory designed for dozens of people, leaving her completely  
25 isolated for approximately nine months. Her mental health symptoms grew worse,  
26 yet no steps were taken to move her or otherwise mitigate her symptoms. Upon  
27 information and belief, ICE made no attempt to obtain her prior treatment or  
28

1 custodial records. When she was transferred within ICE custody from Aurora to  
2 Teller, medical staff at Teller did not receive any of her medical records from  
3 Aurora.

4 392. Plaintiff Luis Manuel Rodriguez Delgadillo, who has had diagnoses of  
5 schizophrenia and bipolar disorder for years, and who was taking medication and  
6 feeling stable prior to his detention, has noticed his mental health significantly  
7 decline since his detention at Adelanto in March 2019. He has been repeatedly  
8 placed in medical observation after expressing suicidal and other harmful ideation,  
9 and he has not received the same medication he was taking prior to his detention,  
10 nor any of the therapy or other support services he had in place.

11 393. Plaintiff Alex Hernandez is diagnosed with PTSD, for which he was  
12 receiving treatment prior to his placement in ICE custody. While detained at Mesa  
13 Verde and Otay Mesa, he received psychotropic medication to treat his PTSD.  
14 When Mr. Hernandez was transferred to Etowah in December 2018, his medication  
15 to treat his PTSD was abruptly stopped without explanation. As a result, he  
16 experienced night sweats, irritable and aggressive behavior, hypervigilance,  
17 difficulty sleeping, feelings of hopelessness, and emotional numbness.

18 394. Mr. Hernandez did not meet with a psychiatrist until February 2019, at  
19 least two months after he arrived at Etowah. He was then diagnosed with anti-social  
20 personality disorder, without any basis for that diagnosis in his medical records. He  
21 was not prescribed any medication to treat his mental health needs until on or  
22 around July 9, 2019, and he did not begin receiving the medication until on or  
23 around July 22, 2019. He has not received any therapy or counseling in Etowah.

24 395. Prior to detention, Plaintiff Jose Segovia Benitez received mental  
25 health care through the Veteran's Administration to manage his combat PTSD and  
26 other mental health diagnoses. However, since being detained at Adelanto, his  
27 combat PTSD has become unmanageable in a way that affects his ability to control  
28 his emotions and anger.

1           396. Plaintiff Marco Montoya Amaya has also had inconsistent mental  
2 health treatment, often at odds with the recommendations of the mental health  
3 providers at the facilities in which he was detained. For example, when he was first  
4 transferred to Mesa Verde in March 2019, a therapist indicated that he should  
5 receive follow-up talk therapy in two weeks; however, despite his prior diagnoses  
6 of Major Depressive Disorder and severe PTSD, he did not have another talk  
7 therapy appointment until two months later, in May 2019. Rather than provide  
8 assistance for his mental health conditions, a therapist repeatedly told Mr. Montoya  
9 Amaya that she thought he would and should be deported.

10           397. Plaintiff Salazar Artaga has been hearing voices, experiencing visual  
11 hallucinations, and grappling with suicidal ideation from the time he was a  
12 teenager. He also suffers from severe anxiety that has manifested as panic attacks  
13 in his time in detention. He requested mental health care early in his time at  
14 Florence. He has been put on suicide watch at least two times for banging his head  
15 against the wall and picking at his wounds in the midst of panic attacks. However,  
16 the psychologist he saw did not refer him to a psychiatric provider until weeks later,  
17 apparently suspecting that Mr. Salazar Artaga was seeking secondary gain. Even  
18 now, when Mr. Salazar Artaga tells officers he is having a panic attack and hearing  
19 voices, they often ridicule or ignore him and refuse to call for medical assistance.

20           398. These problems are not unique to Plaintiffs but are pervasive  
21 throughout Defendants' Detention Facilities.

22           399. For example, Disability Rights California's 2019 report concerning  
23 Adelanto<sup>399</sup> identified many people at the facility with serious mental health needs  
24 who received deficient mental health treatment. DRC found that the facility  
25 responds harshly and in non-therapeutic ways to people in psychiatric crisis, such  
26 as with the use of pepper spray or extreme isolation.<sup>400</sup>

27 \_\_\_\_\_  
28 <sup>399</sup> Disability Rights Cal., *supra* note 36.

<sup>400</sup> *Id.* at 20.

1           400. Further, the “treatments” prescribed to detained individuals—even as  
2 their mental health conditions declined—often consist only of breathing exercises,  
3 physical exercise, and religious coping.<sup>401</sup>

4           401. DRC identified key deficiencies, including (1) cursory clinical contacts  
5 and non-individualized treatment, (2) a lack of structured programming and  
6 activities, (3) harmful institutional responses to patients in psychiatric crisis, and (4)  
7 deficient medication management practices.<sup>402</sup>

8           402. Overall, the DRC report found that “Adelanto’s mental health care  
9 system does not meet the needs of the detainee population, and facility conditions  
10 are counter-therapeutic, all of which places people with mental health disabilities at  
11 a significant risk of harm. We found that the conditions and practices at Adelanto  
12 result in the abuse and neglect of detainees with mental health disabilities as  
13 defined in federal law.”<sup>403</sup>

14           403. Defendants’ own reports and DDRs also substantiate these problems.

15           404. On March 28, 2017, Osmar Epifanio Gonzalez-Gadba died by suicide  
16 after a three-month detention at Adelanto.<sup>404</sup> He was evaluated by a doctor on  
17 March 20 and 22, but the doctor was unaware that Mr. Gonzalez-Gadba had been  
18 refusing psychiatric medications.<sup>405</sup> Mr. Gonzalez-Gadba killed himself on March  
19 22. The DDR found that Mr. Gonzalez-Gadba’s medical record did not contain a  
20 consent form for psychotropic medications; that nurses did not use the Spanish  
21 version of refusal forms for eight doses of psychotropic medications refused by Mr.  
22 Gonzalez-Gadba, and did not document whether Mr. Gonzalez-Gadba was  
23 counseled about the risks of refusing medication or whether efforts were made to

24 <sup>401</sup> *Id.* at 20–21.

25 <sup>402</sup> *Id.* at 20.

26 <sup>403</sup> *Id.* at 20 (internal citation omitted).

27 <sup>404</sup> Office of Professional Responsibility, *Detainee Death Review – Osmar Epifanio  
Gonzalez-Gadba*, <https://www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf>.

28 <sup>405</sup> *Id.* at 15.

1 encourage medication compliance; and that nurses did not notify a physician or a  
2 mental health provider after Mr. Gonzalez-Gadba's medication refusals.<sup>406</sup>

3 405. On May 15, 2017, Jean Carlos Jimenez-Joseph died by suicide while  
4 detained at Stewart.<sup>407</sup> The Georgia Bureau of Investigation reported that Mr.  
5 Jimenez-Joseph had been prescribed medication at a mental health facility before he  
6 was detained by ICE, but facility staff did not give him the full dosage.<sup>408</sup> On the  
7 night of his death, Mr. Jimenez was seen jumping rope with his bedsheets and had  
8 written "Hallelujah the Grave Cometh" in large dark letters on his cell wall.<sup>409</sup>  
9 Despite being identified as a suicide risk, he was never placed on suicide watch, nor  
10 was he provided the upward adjustment of his anti-psychotic medication he begged  
11 for days before his death.<sup>410</sup>

12 406. Jose de Jesus Deniz-Sahagun died by suicide in May 2015 at Eloy.<sup>411</sup>  
13 The DDR documents that, upon his arrival at the facility on May 18, 2015, a nurse  
14 became aware that he had attempted suicide the day before and that he was still  
15 fearful, but because Mr. Deniz-Sahagun did not express suicidal ideation to the  
16 nurse, he was referred for a routine, rather than urgent, mental health evaluation.<sup>412</sup>

17 407. On May 19, a doctor diagnosed Mr. Deniz-Sahagun with delusional  
18 disorder and placed him on suicide watch until May 26.<sup>413</sup> The doctor also ordered  
19 anti-psychotic and anti-anxiety medications; medical staff later decided not to  
20 administer these medications, but this decision was not documented, and the doctor

21 \_\_\_\_\_  
22 <sup>406</sup> *Id.* at 19–20, 22.

23 <sup>407</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 153161.

24 <sup>408</sup> *Id.* at 40.

25 <sup>409</sup> *Id.* at 53 (internal citation omitted).

26 <sup>410</sup> *Id.* at 53.

27 <sup>411</sup> Office of Professional Responsibility, *Detainee Death Review – Jose De Jesus*  
*Deniz-Sahagun*, <https://www.ice.gov/doclib/foia/reports/ddr-denizshagun.pdf>.

28 <sup>412</sup> *Id.* at 2–4.

<sup>413</sup> *Id.* at 88.

1 was not notified.<sup>414</sup> On May 20, a doctor removed Mr. Deniz-Sahagun from suicide  
2 watch early because he believed that Mr. Deniz-Sahagun was no longer a danger to  
3 himself.<sup>415</sup> Less than 12 hours later, Mr. Deniz-Sahagun was found unresponsive in  
4 his cell due to suicide.<sup>416</sup>

5 408. Overall, the DDR found that the mental health care and treatment  
6 provided to Mr. Deniz-Sahagun was deficient for a number of reasons, including  
7 the facts that the decision not to administer ordered medication to Mr. Deniz-  
8 Sahagun was not documented, his doctor was not notified, and the doctor did not  
9 perform a suicide risk assessment addressing all required factors before removing  
10 Mr. Deniz from suicide watch.<sup>417</sup> In addition, the facility had not developed a  
11 suicide prevention plan, even though this was the third suicide at Eloy since April  
12 2013, and the fifth since 2005.<sup>418</sup> The DDR noted that the facility did not have any  
13 on-call mental health providers.<sup>419</sup>

14 409. Two experts reviewed this case on behalf of HRW. One expert noted  
15 that Mr. Deniz-Sahagun should have been thoroughly evaluated by a psychiatrist  
16 and strongly considered for hospitalization.<sup>420</sup> In addition, the experts had serious  
17 concerns about the appropriateness of the doctor's decision to downgrade Mr.  
18 Deniz from suicide watch.<sup>421</sup>

19 410. On October 23, 2013, Tiombe Kimana Carlos died while detained at  
20 the York County Prison in Pennsylvania. Ms. Carlos was diagnosed with  
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23 <sup>414</sup> *Id.* at 14, 15.

24 <sup>415</sup> *Id.* at 17.

25 <sup>416</sup> *Id.* at 20, 24–25.

26 <sup>417</sup> *Id.* at 27, 28, 32.

27 <sup>418</sup> *Id.* at 30.

28 <sup>419</sup> *Id.* at 29.

<sup>420</sup> Human Rights Watch & CIVIC, *supra* note 181, at 44.

<sup>421</sup> *Id.*

1 schizophrenia that, before her death, manifested in suicide attempts, behavioral  
2 issues and mental health concerns, and extended stays in segregation.<sup>422</sup>

3 411. The DDR found that Ms. Carlos’s record lacked “documentation of a  
4 treatment plan with measurable goals and objectives . . . to guide mental health  
5 interventions over the period of detention.”<sup>423</sup> The DDR also noted that, because  
6 Ms. Carlos was a mental health chronic care patient for the duration of her  
7 detention, and because she attempted suicide in August 2013, “a psychiatric alert  
8 was appropriate for her, but none was generated.”<sup>424</sup>

9 412. Two independent experts for HRW reviewed her case and found that  
10 subpar mental health care likely contributed to Ms. Carlos’ death.<sup>425</sup> One expert  
11 concluded that the mental health evaluation and treatment she received was  
12 “woefully inadequate.”<sup>426</sup>

13 413. These examples illustrate Defendants’ systemic failure to ensure that  
14 adequate mental health care is provided to people in their network of Detention  
15 Facilities. Defendants with deliberate indifference have failed to properly monitor  
16 and oversee this sad excuse of a system, leaving detained people experiencing  
17 mental health issues exposed to substantial risk of harm, including death.

18 **H. Defendants Systemically Fail to Ensure the Adequacy of Medical**  
19 **Records and Documentation.**

20 414. Defendants have a policy and practice of failing to monitor and ensure  
21 that Detention Facilities adequately maintain medical records.

22 415. Detention Facilities commonly fail to properly document information  
23 gleaned in medical visits by detained individuals, sometimes failing to document  
24

25 <sup>422</sup> Office of Professional Responsibility, *Detainee Death Review – Tiombe Kimana*  
26 *Carlos*, [ice.gov/doclib/foia/reports/ddr-carlos.pdf](https://ice.gov/doclib/foia/reports/ddr-carlos.pdf).

26 <sup>423</sup> *Id.* 27.

27 <sup>424</sup> *Id.* at 28.

27 <sup>425</sup> Human Rights Watch & CIVIC, *supra* note 181, at 34.

28 <sup>426</sup> *Id.*



1 that visits happened at all. Further, when detained individuals are transferred  
2 between Detention Facilities, their medical records and medications often do not  
3 travel with them, preventing timely continuity of care.

4 416. Detained individuals experience harm and unnecessary pain and  
5 suffering from interruptions of care resulting from inadequate medical  
6 recordkeeping. Examples of the harm include suicide by individuals whose anti-  
7 psychotic medications were not administered after transfer, as well as delayed  
8 diagnosis of serious conditions like cancer.

9 417. Defendants are deliberately indifferent to the risk of harm and injury to  
10 detained individuals that results from this systemic failure. Inadequate medical  
11 records have been cited repeatedly, including without limitation in government  
12 reports, DDRs, and nonprofit reports. Despite these reports, Defendants have failed  
13 to effectively eliminate or mitigate inadequacies in the maintenance of medical  
14 records, exposing Plaintiffs and members of the Class to significant risk of serious  
15 medical harm.

16 418. The inadequate maintenance of medical records is ubiquitous in  
17 Detention Facilities across the country.

18 419. Plaintiff Alex Hernandez was incarcerated prior to his transfer to ICE  
19 custody. Upon information and belief, ICE did not request his medical records,  
20 which delayed his ability to receive appropriate treatment for his torn rotator cuff,  
21 PTSD, and his hip, leg, and foot pain. Each time Mr. Hernandez was transferred  
22 from one ICE facility to another, his medical records were not transferred with him,  
23 which delayed his access to treatment and disrupted his care. For instance, upon his  
24 transfer from Otay Mesa to Etowah, his medication for PTSD was discontinued  
25 without reason and he had to restart the process to request treatment for his PTSD;  
26 it took several months before his medication was resumed.

27 420. Mr. Hernandez had an eye exam on June 2, 2019, that was  
28 administered by a nurse. His medical records, however, contain no documentation

1 of a complete eye exam or the actual results of the vision test. He was told the  
2 vision exam did not meet ICE requirements for him to see an optometrist, but there  
3 is no way for medical staff or a doctor to review the exam because it is not in his  
4 records. Given Mr. Hernandez's other medical conditions, his blurry vision could  
5 indicate other serious medical issues, but he has not been evaluated by a doctor.  
6 Because of the lack of documentation, there is no recorded reason why Mr.  
7 Hernandez's vision exam did not meet ICE requirements to see an optometrist. He  
8 was given a diagnosis of anti-social personality disorder, but there is no mention of  
9 his previous PTSD diagnosis, and his medical records lack the basis for the  
10 diagnosis of a personality disorder.

11 421. Very few of Plaintiff Marco Montoya Amaya's records were  
12 transferred with him when he transferred, while in ICE custody, from the Yuba  
13 County Jail to the Mesa Verde ICE Processing Center. For example, on information  
14 and belief, most of Mr. Montoya Amaya's extensive mental health records from  
15 Yuba County Jail were not sent to Mesa Verde, and that fact contributed to the over  
16 two-month lapse in treatment for his mental health conditions once he arrived in  
17 Mesa Verde.

18 422. Similarly, when Plaintiff Salazar Artaga was transferred to Florence  
19 from the Maricopa County Jail, it does not appear that Florence request his medical  
20 records. Because of that, the initial Florence screening did not detect any symptoms  
21 of psychosis. Mr. Salazar Artaga noted in subsequent sick calls that he had been  
22 previously diagnosed with schizophrenia in jail. Although the medical records  
23 indicate that Florence staff planned to seek his jail medical records from the  
24 Maricopa County Jail to confirm the diagnosis, it is unclear whether they ever  
25 asked for or received these records.

26 423. These deficiencies are known by Defendants, but Defendants have not  
27 rectified them, leaving Plaintiffs and the Class at substantial risk of serious harm.  
28

1           424. For example, DDRs document inadequate maintenance of medical  
2 records at a number of facilities, including Adelanto, Albany, Dodge, El Paso, Hall,  
3 Houston, Hudson, Joe Corley, Otay Mesa, Otero, Rolling Plains, Theo Lacy, and  
4 Utah. Experts concluded that these inadequate medical records contributed to a  
5 substantial number of the deaths reviewed.

6           425. These DDRs demonstrate that many Detention Facilities fail to request  
7 or receive records from other facilities that the detained individual may have cycled  
8 through, including hospitals, off-site medical providers, and other Detention  
9 Facilities, resulting in a lack of communication among medical providers.

10           426. Jose de Jesus Deniz-Sahagun died by suicide on May 20, 2015, at  
11 Eloy.<sup>427</sup> Even though Mr. Deniz-Sahagun was prescribed anti-psychotic and anti-  
12 anxiety medications, medical staff opted not to administer these medications  
13 without documenting their decision or contacting the physician.<sup>428</sup> The DDR  
14 concluded that several actions by staff were deficient, including this failure of  
15 documentation.<sup>429</sup>

16           427. Similarly, Petra Albrecht, who had, among other conditions, fluid on  
17 her heart and a gastrointestinal perforation, was transferred to Adelanto from Otay  
18 Mesa, where she had an appointment to see a specialist.<sup>430</sup> The Adelanto staff told  
19 her that because she had moved to a new facility, they would “start over” with tests  
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23 <sup>427</sup> Office of Professional Responsibility, *Detainee Death Review – Jose de Jesus*  
24 *Deniz-Sahagun*, <https://www.ice.gov/doclib/foia/reports/ddr-denizshagun.pdf>.

24 <sup>428</sup> *Id.* at 15.

25 <sup>429</sup> *Id.* at 27.

26 <sup>430</sup> CIVIC & Detention Watch Network, *Abuse in Adelanto: An Investigation Into a*  
27 *California Town’s Immigration Jail*, at 15 (Oct. 2015),  
28 [http://www.endisolation.org/wp-content/uploads/2015/11/CIVIC\\_DWN-Adelanto-Report\\_old.pdf](http://www.endisolation.org/wp-content/uploads/2015/11/CIVIC_DWN-Adelanto-Report_old.pdf).

1 and medical care.<sup>431</sup> Albrecht later became unconscious during a presumed heart  
2 attack.<sup>432</sup>

3 428. Similarly, the 2017 HRW report documents significant gaps in  
4 detained individuals' health care records while in detention, including with one  
5 individual detained at Etowah, diagnosed with stomach cancer after over a year of  
6 medical complaints and spotty medical record-keeping.<sup>433</sup> One medical expert  
7 found opined the missing records might show a failure to timely address the  
8 problems, leading to a delay of diagnosis for a likely fatal condition.<sup>434</sup>

9 429. These examples illustrate Defendants' systemic failure to ensure that  
10 adequate medical records are kept as to people in their network of Detention  
11 Facilities. Defendants are aware that their network of Detention Facilities fails to  
12 adequately maintain medical records but have not corrected this issue through  
13 monitoring and oversight, resulting in detained individuals suffering substantial  
14 harm and even death.

15 **VII. As a Result of Defendants' Failure to Monitor and Oversee Segregation**  
16 **Practices at Detention Facilities, Conditions in Those Facilities**  
17 **Constitute Punishment and Subject Plaintiffs in Segregation and**  
18 **Members of the Segregation Subclass to Violations of the Fifth**  
19 **Amendment.**

20 430. Plaintiffs Alex Hernandez, Jimmy Sudney, Hamida Ali, and Marco  
21 Montoya Amaya (collectively the "Segregation Plaintiffs") and the Segregation  
22 Subclass challenge ICE's systemic failure to ensure that Detention Facilities do not  
23 improperly subject the Subclass to segregation in violation of the Fifth Amendment.

24 431. As with medical and mental health care, Defendants have sole  
25 authority to select and contract with the facilities in which Segregation Subclass  
26 members are detained. Defendants maintain centralized control of the standards,

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26 <sup>431</sup> *Id.*

27 <sup>432</sup> *Id.*

28 <sup>433</sup> Human Rights Watch & CIVIC, *supra* note 181, at 56, 67, 77.

<sup>434</sup> *Id.* at 77.

1 policies, practices, and procedures applicable to segregation. Defendants likewise  
2 have ultimate authority—and the legal obligation—to monitor those facilities and to  
3 ensure that policies and practices concerning segregation satisfy constitutional  
4 dictates. Yet, as detailed below, Defendants have systemically abdicated their duty  
5 to ensure that segregation practices throughout the nationwide detention system  
6 comply with the minimal requirements of substantive and procedural due process  
7 under the Fifth Amendment. Indeed, despite numerous internal and external reports  
8 alerting Defendants to systemic failures in ICE’s segregation system, Defendants  
9 have refused to take any effective steps to remediate the improper use of  
10 segregation throughout the country’s Detention Facilities. Accordingly, absent  
11 intervention by this Court, individuals in the Segregation Subclass will continue to  
12 be subjected to punitive conditions of confinement and face an ongoing and  
13 substantial risk of serious harm.

14 432. Specifically, as a result of ICE’s failure to monitor and oversee  
15 segregation in Detention Facilities, detained individuals in segregation are  
16 subjected to unconstitutional policies, practices, and omissions, including but not  
17 limited to: (1) confinement in conditions that are punitive, (2) exposure to a  
18 substantial risk of serious harm, and (3) inadequate procedural protections  
19 (collectively, the “Segregation Practices”). Both alone and in their totality, these  
20 conditions violate the Segregation Subclass’s Fifth Amendment rights.

21 433. Organizational Plaintiffs ICIJ and Al Otro Lado have had to divert  
22 resources, and have had their missions frustrated, as a result of the Segregation  
23 Practices.

24 434. Plaintiffs Alex Hernandez, Jimmy Sudney, Hamida Ali, and Marco  
25 Montoya Amaya have all been harmed and subjected to, and face the ongoing  
26 possibility of being harmed and subjected to, constitutionally deficient segregation  
27 as a result of Defendants’ failure to properly monitor and oversee Segregation  
28 Practices at Detention Facilities.

1           **A. Defendants Violate the Fifth Amendment by Failing to Ensure**  
2           **That Civil Detainees in Segregation Are Not Subjected to Punitive**  
3           **Conditions of Confinement.**

4           435. Under the Fifth Amendment, segregation conditions in civil Detention  
5           Facilities may not rise to the level of punishment.

6           436. As set forth in detail below, Defendants fail to adequately monitor and  
7           oversee segregation practices in Detention Facilities.

8           437. As a result, detained individuals are subjected to the Segregation  
9           Practices, which individually and collectively constitute punishment because they  
10          are expressly intended to punish, are not reasonably related to a legitimate  
11          governmental objective, and/or are excessive in relation to that objective.

12          438. In addition, segregation conditions in civil Detention Facilities cannot  
13          be the same as or worse than those in a prison. As the Ninth Circuit explained,  
14          “purgatory cannot be worse than hell.”<sup>435</sup>

15          439. Nevertheless, Defendants maintain a policy and practice of failing to  
16          ensure that detained immigrants in segregation are not subjected to punitive  
17          conditions. As a result, conditions in segregation throughout Detention Facilities  
18          are indistinguishable from—and in some cases worse than—those in prison. Indeed,  
19          detained individuals confined in segregation “are typically locked down for at least  
20          22 hours a day, with limited access to recreation or contact with other human  
21          beings. Depending on the restrictions, individuals in solitary can be limited or  
22          outright denied access to phone calls, visitation, books or personal items, such as  
23          photographs of loved ones.”<sup>436</sup>

24 \_\_\_\_\_  
25 <sup>435</sup> *Jones v. Blanas*, 393 F.3d 918, 933 (9th Cir. 2004).

26 <sup>436</sup> Hannah Rappleye, *Thousands of immigrants suffer in solitary confinement in*  
27 *U.S. detention centers*, NBC News (May 20, 2019),  
28 <https://www.nbcnews.com/politics/immigration/thousands-immigrants-suffer-solitary-confinement-u-s-detention-centers-n1007881>.

1 440. ICE’s Directive 11065.1, “Review of the Use of Segregation for ICE  
2 Detainees” (the “Segregation Directive”), characterizes disciplinary segregation as  
3 punitive and administrative detention as nonpunitive.<sup>437</sup>

4 441. Yet ICE’s characterization draws a distinction without a difference.  
5 Throughout the Detention Facilities, the conditions in both disciplinary segregation  
6 and administrative detention are punitive in nature, and those punitive conditions  
7 are materially the same throughout the Detention Facilities. Indeed, regardless of  
8 the underlying basis for isolation, individuals subjected to both forms of  
9 segregation are subjected to near constant isolation—for 22 or 23 hours per day—in  
10 a closed cell; overwhelmingly denied outdoor recreation; restricted from  
11 communicating with counsel, their families, and friends; frequently shackled when  
12 they are outside their cell, regardless of disciplinary infractions; and denied access  
13 to programming, telephones, commissary, personal effects, and law libraries,  
14 among other restrictions.

15 442. The similarly punitive conditions in all forms of ICE segregation are  
16 well-documented. For example, Penn State Law’s 2017 report found that at Stewart  
17 and Irwin, “Detained immigrants report no difference between administrative or  
18 disciplinary segregation; both are considered to be equally severe,” and both subject  
19 individuals to the same draconian deprivations of liberty.<sup>438</sup>

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24 <sup>437</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use*  
25 *of Segregation for ICE Detainees*, at ¶ 3.1-3.2 (Sep. 4, 2013),  
26 [https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

27 <sup>438</sup> Penn State Law, *Imprisoned Justice: Inside Two Georgia Immigrant Detention*  
28 *Centers*, at 36 (May 2017) [https://projectsouth.org/wp-](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf)  
[content/uploads/2017/06/Imprisoned\\_Justice\\_Report-1.pdf](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf).

1 443. Human Rights First’s 2019 report found that staff at three New Jersey  
2 facilities confined individuals to their cells for at least 23 hours per day for  
3 disciplinary segregation, as compared to 22 hours in administrative segregation.<sup>439</sup>

4 444. Likewise, a 2019 report on conditions at Adelanto concluded that  
5 “[d]etainees are subject to prison-like solitary confinement, whether for disciplinary  
6 or administrative reasons.”<sup>440</sup>

7 445. In fact, those confined to administrative segregation do not receive  
8 greater protections from prolonged isolated confinement. For example, a 2017 DHS  
9 OIG report “identified detainees who were held in administrative segregation for  
10 extended periods of time without documented, periodic reviews that are required to  
11 justify continued segregation.”<sup>441</sup>

12 446. For example, Plaintiff Alex Hernandez was placed in segregation for  
13 over two weeks while he was detained at Mesa Verde for safety reasons. While he  
14 was in isolation, he was not allowed out of his cell for any recreation. He did not  
15 receive an opportunity to visit the law library or use the telephone to contact his  
16 family or attorney. He was allowed out of his cell only to shower three times a  
17 week. This isolation exacerbated Mr. Hernandez’s PTSD; he experienced  
18 nightmares and was paranoid and hypervigilant while in isolation. He did not see a  
19 mental health professional while in segregation.

20 447. Plaintiff Hamida Ali was placed in effective segregation for  
21 approximately nine months when security staff at Aurora placed her alone in a  
22 dorm designed for dozens of women. Ms. Ali has a documented history of  
23 schizophrenia and suicidal ideation and attempts, all of which were exacerbated by

24 \_\_\_\_\_  
25 <sup>439</sup> Human Rights First, *Ailing Justice: New Jersey Inadequate Healthcare,*  
26 *Indifference, and Indefinite Confinement in Immigration Detention*, at 5 (Feb.  
27 2018), <https://www.humanrightsfirst.org/sites/default/files/Ailing-Justice-NJ.pdf>.

28 <sup>440</sup> Disability Rights Cal., *supra* note 36, at 18.

<sup>441</sup> Office of Inspector Gen., U.S. Dep’t of Homeland Sec., *OIG-18-32*, *supra* note  
152, at 6.



1 this placement. No steps were taken to ensure that this placement was appropriate  
2 for someone with her mental health disability, and both mental health staff and ICE  
3 officers informed Ms. Ali that there was nothing they could do about it, even after  
4 she had attempted suicide.

5 448. Defendants' abdication of any meaningful oversight of segregation  
6 practices has allowed the operators of Detention Facilities to act with impunity in  
7 imposing segregation. For example, the June 2019, DHS OIG report found that at  
8 Adelanto and Essex, "detainees are placed in disciplinary segregation before the  
9 disciplinary hearing panel finds the detainee guilty of the charged offense," and that  
10 the facilities erroneously recorded those placements as administrative segregation  
11 placements.<sup>442</sup>

12 449. In a 2019 report detailing unannounced inspections at four detention  
13 facilities, OIG raised concerns about overly restrictive segregation practices.<sup>443</sup> At  
14 Adelanto, Essex, and Aurora, individuals in disciplinary segregation were placed in  
15 restraints when they were outside of their cells, despite ICE standards stating that  
16 disciplinary segregation alone does not constitute a valid basis for the use of  
17 restraints.<sup>444</sup> At Essex, segregated individuals were strip-searched without  
18 documented justification and without reasonable suspicion.<sup>445</sup> Both Adelanto and  
19 Essex failed to give segregated individuals proper recreation or out-of-cell time,  
20 and individuals in disciplinary segregation at Adelanto were not permitted to  
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24 <sup>442</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG 19-47*, *supra* note  
25 97, at 5–6; Performance-Based National Detention Standards: Special Management  
26 Units, Section 2.12.II (U.S. Immigr. & Customs Enf't 2011) (Revised Dec. 2016).

26 <sup>443</sup> Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG 19-47*, *supra* note  
27 97, at 3.

27 <sup>444</sup> *Id.* at 5.

28 <sup>445</sup> *Id.* at 5–6.

1 shower.<sup>446</sup> Overall, OIG concluded that these practices “violated standards and  
2 infringed on detainee rights.”<sup>447</sup>

3 450. DRC’s 2019 Adelanto report found that female disciplinary  
4 segregation cells are located in the same physical unit as the administrative  
5 segregation cells, and that Adelanto staff placed one detained individual who had  
6 been sent from suicide watch to disciplinary segregation because administrative  
7 segregation was full.<sup>448</sup>

8 451. Defendants are on notice of, but have failed to address, the use of  
9 punitive conditions in segregation.

10 452. Far from anomalous, such punitive conditions in both forms of  
11 segregation exist throughout the Detention Facilities. For example, a Penn State  
12 Law School study of Stewart and Irwin<sup>449</sup> found that detained immigrants in  
13 segregation at Stewart “cannot tell if it is day or night. There is no access to  
14 commissary or showers, and limited or prohibited access to phones, medical  
15 attention, and recreation.”<sup>450</sup> At Irwin, individuals in the “segregated unit spend  
16 twenty-three hours in their cells, with limited recreation, shower, and phone access,  
17 and no access to the law library or commissary.”<sup>451</sup> As at Essex, staff at Stewart  
18 shackle detained individuals in segregation whenever they leave their cells and  
19 allow them only one hour a day of non-lockdown time, during which detained  
20 individuals must choose between recreation or phone use.<sup>452</sup>

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23 <sup>446</sup> *Id.* at 6.

24 <sup>447</sup> *Id.* at 3.

25 <sup>448</sup> Disability Rights Cal., *supra* note 36, at 30.

26 <sup>449</sup> Penn State Law, *Imprisoned Justice: Inside Two Georgia Immigrant Detention*  
*Centers*, at 36 (May 2017) [https://projectsouth.org/wp-](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf)  
[content/uploads/2017/06/Imprisoned Justice Report-1.pdf](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf).

27 <sup>450</sup> *Id.* at 36.

28 <sup>451</sup> *Id.* at 49.

<sup>452</sup> *Id.* at 36–37.

1 453. Similarly, OIG’s 2017 unannounced inspection report of Theo Lacy in  
2 California documented several violations of ICE detention standards for  
3 disciplinary segregation, including that:

4 [D]isciplinary segregation at [Theo Lacy] means a person is isolated for 24  
5 hours a day in a cell with no access to visitors, recreation, or group religious  
6 services. The detainees are released briefly every other day to shower. In  
7 contrast, ICE detention standards require that detainees placed in disciplinary  
8 segregation receive a minimum of 1 hour of recreation five times per week,  
9 opportunities for general visitation, religious guidance, and limited access to  
10 telephones and reading material. However, through observation and  
11 interviews, we determined that detainees are not allowed any recreation time,  
12 visitation, religious guidance, or telephone access. They were permitted to  
13 access one book from the library for the duration of their stay in solitary,  
14 lasting up to 30 days.<sup>453</sup>

15 454. The California Department of Justice’s 2019 report on immigration  
16 detention in California also found “multiple facilities that fail to follow national  
17 standards that require one hour of recreation five days a week for detainees in  
18 disciplinary segregation.”<sup>454</sup>

19 455. It is not necessary for ICE to subject detained individuals to such  
20 horrors. Indeed, the 2011 Performance Based National Detention Standards  
21 (“PBNDS”)—standards developed and approved by ICE—require that facilities  
22 provide a host of protections that are not implemented in practice.  
23

24  
25 <sup>453</sup> Office of Inspector Gen., Office of Homeland Sec., OIG-17-43-MA:  
26 Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility  
27 in Orange, California (2017),  
<https://www.oig.dhs.gov/sites/default/files/assets/2017/OIG-mga-030617.pdf>.

28 <sup>454</sup> Becerra, *supra* note 19, at 123.

1 456. Moreover, Defendants can proffer no legitimate rationale for imposing  
 2 conditions in segregation that so closely mirror the conditions of segregation in  
 3 prison. Defendants' failure in this regard reflects their systemic overreliance on  
 4 punitive models to effectuate civil detention. Yet, as explained above, the Fifth  
 5 Amendment prohibits imposition of such punitive conditions in civil detention.<sup>455</sup>

6 **1. Defendants Subject Plaintiffs to a Substantial Risk of Serious Harm**  
 7 **Through Their Failure to Monitor and Prevent Needless and Arbitrary**  
 8 **Segregation.**

9 457. Defendants' failure to monitor and oversee segregation practices in  
 10 Detention Facilities results in a serious risk of substantial harm to members of the  
 11 Segregation Subclass.

12 458. Confining a person to a cell alone for 22 or more hours a day has an  
 13 extremely negative effect on psychological health. Segregation places those with  
 14 preexisting medical or mental health conditions at elevated risk for exacerbating  
 15 those conditions and those without conditions at elevated risk for developing  
 16 them.<sup>456</sup> Psychological effects of the isolation brought about by segregation include  
 17 anxiety, depression, insomnia, confusion, withdrawal, emotional flatness, cognitive  
 18 dysfunction, hallucinations, paranoia, and suicidality.<sup>457</sup> Approximately fifty  
 19 percent of all prison suicides happen among the two to eight percent of incarcerated  
 20 individuals held in solitary confinement.<sup>458</sup> According to a 2014 report, detained

21 <sup>455</sup> *Jones*, 393 F.3d at 933.

22 <sup>456</sup> Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. &  
 23 Pol'y 325, 333–38 (2006),  
 24 [https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law\\_journal\\_law\\_policy](https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law_journal_law_policy).

25 <sup>457</sup> Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax"*  
 26 *Confinement*, 49 Crime & Delinq. 124, 130–31, 133–34 (2003),  
 27 <https://www.gwern.net/docs/psychology/2003-haney.pdf>.

28 <sup>458</sup> Stuart Grassian & Terry Kupers, *The Colorado Study vs. the Reality of Supermax Confinement*, 13 Corr. Mental Health Report 1, 11 (2011),  
<https://www.probono.net/prisoners/stopsol->

1 individuals held in segregation in New York City jails were nearly seven times  
2 more likely to harm themselves than were those in the general population.<sup>459</sup>

3 459. ICE has been on notice for years of the deleterious health effects of  
4 segregation.

5 460. For example, the 2011 OIG Mental Health Management Report recited  
6 mental health care providers at Detention Facilities as stating that: “[s]egregation is  
7 never an appropriate setting for long-term placement of mentally ill detainees”;  
8 “[s]egregation often exacerbates mental illness and is counterproductive to the goal  
9 of stabilizing a detainee”; “[s]egregation is not a good environment for those with  
10 mental health concerns because detainees reported increased levels of depression  
11 and anxiety when held in a short stay unit”; “[i]t is not possible to make segregation  
12 into a therapeutic setting in which a mentally ill detainee’s condition would  
13 improve”; and “[s]pecial management units should only be used at the detainee’s  
14 request, or for short periods when these units are the only option.”<sup>460</sup>

15 461. Nevertheless, Defendants have failed to ensure that Detention  
16 Facilities do not improperly use segregation or place detained individuals in  
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19 reports/416638.The\_Colorado\_Study\_vs\_the\_Reality\_of\_Supermax\_Confinement;  
20 see also Jennifer R. Wynn & Alisa Szatrowski, *Hidden Prisons: Twenty-Three-*  
21 *Hour Lockdown Units in New York State Correctional Facilities*, 24 Pace L. Rev.  
22 497, 516 (2004),  
23 <https://digitalcommons.pace.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1202&context=plr> (“More than half of prison suicides in New York take place in  
24 twenty-three-hour lockdown units, although less than 10 percent of the inmate  
25 population is housed in them.”).

26 <sup>459</sup> Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail*  
27 *Inmates*, 104 Am. J. Pub. Health 442, 444–46 (2014),  
28 <https://ajph.aphapublications.org/doi/10.2105/AJPH.2013.301742>.

<sup>460</sup> Office of Inspector Gen., Dep’t of Homeland Sec., *OIG-11-62: Management of*  
*Mental Health Cases in Immigration Detention*, at 15 (March 2011),  
<https://www.hsdl.org/?abstract&did=6985>.

1 segregation in lieu of providing them with proper mental health care or  
2 accommodations.

3 462. Indeed, ICE’s own policies authorize the placement in segregation of  
4 detained individuals with “special vulnerabilities” when “no other viable housing  
5 options exist.”<sup>461</sup> This includes detained individuals “who are known to be suffering  
6 from mental illness or serious medical illness; who have a disability or are elderly,  
7 pregnant, or nursing; who would be susceptible to harm in general population due  
8 in part to their sexual orientation or gender identity; or who have been victims—in  
9 or out of ICE custody—of sexual assault, torture, trafficking, or abuse.”<sup>462</sup>

10 463. Not surprisingly, many detained individuals with mental health  
11 disabilities are placed in segregation, rather than provided with appropriate mental  
12 health services. For example, according to data from the International Consortium  
13 of Investigative Journalists, nearly one-third of segregation placements consisted of  
14 detained individuals who were described as being “mentally ill.”<sup>463</sup>

15 464. The “vulnerable” populations ICE identified in its 2013 Segregation  
16 Directive<sup>464</sup> are subjected to an even higher risk of harm. The Division of  
17 Immigration Health Services—the agency responsible for detained individuals’  
18 medical care in 2008—estimated that, at that time, 15% of individuals detained by  
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20 <sup>461</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of*  
21 *Segregation for ICE Detainees*, at ¶ 2 (Sept. 4, 2013),  
22 [https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

23 <sup>462</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of*  
24 *Segregation for ICE Detainees*, at ¶ 3.3 (Sept. 4, 2013),  
25 [https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

26 <sup>463</sup> Antonio Cucho & Karrie Kehoe, *Solitary Voices: How US Immigration*  
27 *Authorities Use Solitary Confinement* (May 20, 2019),  
28 <https://www.icij.org/investigations/solitary-voices/how-us-immigration-authorities-use-solitary-confinement/>.

<sup>464</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of*  
*Segregation for ICE Detainees*, *supra* note 462, at ¶ 2.

1 ICE had at least one mental health disability.<sup>465</sup> The New York City study found  
 2 that detained individuals with serious mental health disabilities who were confined  
 3 to segregation were almost ten times more likely to engage in potentially fatal self-  
 4 harm.<sup>466</sup> One federal court, summarizing the literature in 1995, likened confining  
 5 inmates with mental health disabilities in isolation to “the mental equivalent of  
 6 putting an asthmatic in a place with little air.”<sup>467</sup>

7 465. Ellen Gallagher, former policy advisor at DHS’s Office for Civil  
 8 Rights and Civil Liberties, raised the alarm about abuse of segregation for people in  
 9 ICE custody.<sup>468</sup> Gallagher found that many people who were listed as having a  
 10 “serious mental illness” were assigned to extended periods of segregation. ICE’s  
 11 widespread use of segregation, particularly with regard to individuals with special  
 12 vulnerabilities, such as those with serious mental health disabilities, violated the  
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 14

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15 <sup>465</sup> Dana Priest & Amy Goldstein, *Suicides Point to Gaps in Treatment*, The  
 16 Washington Post, May 13, 2008, [http://www.washingtonpost.com/wp-](http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html?noredirect=on)  
[srv/nation/specials/immigration/cwc\\_d3p1.html?noredirect=on](http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html?noredirect=on).

17 <sup>466</sup> Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail*  
 18 *Inmates*, 104 Am. J. Pub. Health 442, 445 (2014); *see also* Human Rights Watch,  
 19 *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US*  
 20 *Jails and Prisons* (May 2015), [https://www.hrw.org/report/2015/05/12/callous-and-](https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and)  
 21 [cruel/use-force-against-inmates-mental-disabilities-us-jails-and](https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and) (Finding that  
 22 isolation may worsen and intensify pre-existing mental health related symptoms  
 23 such as depression, paranoia, psychosis, and anxiety, and can cause severe  
 24 impairment in isolated individuals’ ability to function).

25 <sup>467</sup> *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

26 <sup>468</sup> Maryam Saleh & Spencer Woodman, *A Homeland Security Whistleblower Goes*  
 27 *Public About Ice Abuse of Solitary Confinement*, The Intercept (May 20, 2019)  
 28 [https://theintercept.com/2019/05/21/ice-solitary-confinement-](https://theintercept.com/2019/05/21/ice-solitary-confinement-whistleblower/?utm_source=The+Marshall+Project+Newsletter&utm_campaign=ba0e9f0%E2%80%A6)  
[whistleblower/?utm\\_source=The+Marshall+Project+Newsletter&utm\\_campaign=ba0e9f0%E2%80%A6](https://theintercept.com/2019/05/21/ice-solitary-confinement-whistleblower/?utm_source=The+Marshall+Project+Newsletter&utm_campaign=ba0e9f0%E2%80%A6). *See also* Hannah Rappleye et al., *Thousands of immigrants*  
*suffer in solitary confinement in U.S. detention centers*, NBC News (May 20, 2019)  
[https://www.nbcnews.com/politics/immigration/thousands-immigrants-suffer-](https://www.nbcnews.com/politics/immigration/thousands-immigrants-suffer-solitary-confinement-u-s-detention-centers-n1007881)  
[solitary-confinement-u-s-detention-centers-n1007881](https://www.nbcnews.com/politics/immigration/thousands-immigrants-suffer-solitary-confinement-u-s-detention-centers-n1007881).

1 agency's policies and procedures. She found that segregation, meant to be used as a  
2 last resort in many cases, was often the first and only option in Detention Facilities.

3 466. There have been numerous examples of detained individuals with  
4 physical or mental disabilities that have been put at significant risk of substantial  
5 harm by being placed in segregation. For example, in 2017, an individual in the  
6 Aurora facility was placed in solitary confinement for almost a month due to  
7 frequent seizures.<sup>469</sup> According to the detained individual, "They told me it was to  
8 monitor my seizures. I felt like they were treating me like an animal by putting me  
9 in a room by myself for weeks. They ignored me and treated me horribly."<sup>470</sup>

10 467. This person's experience echoes the experiences of many of the  
11 Plaintiffs in this case, who have likewise been subjected to prolonged segregation,  
12 notwithstanding having conditions that make such placement dangerous.

13 468. Plaintiff Jimmy Sudney was placed in segregation for about a week  
14 after a verbal altercation with officers who were harassing him. He filed a grievance  
15 and was placed in segregation about two days after he submitted his complaint.  
16 Though Adelanto medical staff knew that Mr. Sudney had mental health disabilities  
17 including PTSD, the mental health assessment conducted prior to his placement in  
18 isolation was cursory—he was asked only if he would harm or kill himself. There  
19 was no other inquiry into his mental health or other possible symptoms of  
20 deterioration and exacerbation of symptoms related to his PTSD. The noise in  
21 segregation triggered a PTSD flashback in which he relived the earthquake in Haiti  
22 where his house collapsed around him.

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24 \_\_\_\_\_  
25 <sup>469</sup> Letter from American Immigration Council & American Immigration Lawyers  
26 Association to Thomas Homan, Acting Dir., Immigration & Customs Enf't, Dep't  
27 of Homeland Sec. et al. (June 4, 2018) at 15,  
[http://www.americanimmigrationcouncil.org/sites/default/files/general\\_litigation/complaint\\_demands\\_investigation\\_into\\_inadequate\\_medical\\_and\\_mental\\_health\\_care\\_condition\\_in\\_immigration\\_detention\\_center.pdf](http://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_demands_investigation_into_inadequate_medical_and_mental_health_care_condition_in_immigration_detention_center.pdf).

28 <sup>470</sup> *Id.*



1           469. For example, Plaintiff Hamida Ali, who has a mental health disability  
2 and a history of suicidal ideation and attempts, was effectively placed in  
3 segregation when she was housed alone at Aurora for approximately nine months.  
4 During one of the brief periods in which Ms. Ali was not alone in the dorm, the  
5 other detained woman with her told security staff that they should not leave Ms. Ali  
6 alone because she had a mental health disability. Ms. Ali heard security staff say  
7 that it was none of their business.

8           470. As a result of her housing placement, Ms. Ali experienced several  
9 episodes of extreme psychological distress and suicidal ideation. Despite this, and  
10 despite her repeated insistence that her placement in the dorm was the cause, mental  
11 health staff took no action, deferring to security staff classification and housing  
12 placements. Ms. Ali's repeated requests to her ICE Deportation Officer to move  
13 dorms also went unheeded. Ms. Ali was placed on suicide watch in April 2019 after  
14 hearing voices, crying uncontrollably, and wrapping a sweater around her neck. She  
15 was placed back in the dorm by herself when she was taken off of suicide watch.  
16 The conditions exacerbated her mental health difficulties.

17           471. Plaintiff Marco Montoya Amaya has been living with an untreated  
18 likely brain parasite for over a year. This brain parasite, left untreated, can cause  
19 severe and life-threatening symptoms, including irreversible cognitive and  
20 psychiatric symptoms, some of which Mr. Montoya Amaya already appears to be  
21 experiencing. Despite this known diagnosis, and despite his other diagnoses for  
22 PTSD and major depressive disorder, Mr. Montoya Amaya was placed in  
23 segregation for approximately one week in May 2019 for accidentally eating an  
24 extra tray he was given by an officer. He did not understand the officer's  
25 instructions—likely due to his cognitive impairment—that the tray was for other  
26 detained individuals who were fasting for Ramadan. He did not receive any  
27 opportunity to appeal or challenge his segregation. Further, Mr. Montoya Amaya  
28

1 was confused as to whether the segregation was disciplinary, or instead for his  
2 health or protection, as he was housed in medical isolation.

3 472. While in segregation, Mr. Montoya Amaya did not receive daily  
4 mental health or physical health evaluations, and it appears he instead had a total of  
5 only two mental health evaluations. To the extent he received any health evaluation  
6 before he entered segregation, that health evaluation was incomplete and incorrect;  
7 for example, despite indicating that the health professional had completed a chart  
8 review, a note in his medical record related to his segregation falsely indicated that  
9 Mr. Montoya Amaya did not have any headaches or dizziness, despite having those  
10 symptoms regularly documented in his medical records for over a year.

11 473. The risk of harm suffered by Plaintiffs and the Class as a result of  
12 Defendants' failure to sufficiently monitor and oversee Detention Facilities so as to  
13 prevent the Segregation Practices is neither remote nor minimal, but rather  
14 substantial and irreparable. Indeed, the tragic—and preventable—deaths of  
15 numerous detained individuals subjected to Segregation Practices demonstrate both  
16 the gravity and urgency of harm stemming from these practices. For example, in  
17 July 2018, Efrain De la Rosa died by suicide at Stewart.<sup>471</sup> Despite having  
18 schizophrenia, and despite IHSC's receipt of 12 separate notifications depicting  
19 suicidal ideation and psychosis, Mr. De la Rosa was not treated with psychotropic  
20 medication; instead, he was remanded to segregation for 23 hours a day for the  
21 entire three-week period leading up to his death.<sup>472</sup> On the day of his death,

22 \_\_\_\_\_  
23 <sup>471</sup> CoreCivic General Counsel Office of Investigations, *Investigation Report Form:*  
24 *Stewart Detention Center – FSC Case # 2018-2505-087-1: Efrain De La Rosa*  
25 *(August 6, 2018)*. See also Robin Urevich, *Newly released documents reveal*  
26 *mounting chaos and abuse at a troubled ICE detention center*, Fast Company (Jan.  
27 29, 2019), <https://www.fastcompany.com/90298739/newly-released-documents-reveal-mounting-chaos-and-abuse-at-a-troubled-ice-detention-center>.

28 <sup>472</sup> Ken Klippenstein, *ICE Detainee Deaths Were Preventable: Document*, The Young Turks (June 3, 2019),

1 detention officers repeatedly failed to perform required thirty-minute checks, and  
 2 failed to check on Mr. De la Rosa for nearly two hours before finding him  
 3 unresponsive in his cell.<sup>473</sup> The Georgia Bureau of Investigation’s report found a  
 4 series of mistakes in Mr. De la Rosa’s care, including that he was held in prolonged  
 5 segregation despite serious mental health disability.<sup>474</sup>

6 474. Likewise, on October 23, 2013, Tiombe Kimana Carlos died by  
 7 suicide while detained at York County in Pennsylvania.<sup>475</sup> Ms. Carlos was  
 8 diagnosed with schizophrenia prior to her arrival at the facility.<sup>476</sup> Ms. Carlos  
 9 showed symptoms of an acute mental health condition from the start of her two-  
 10 and-a-half-year detention at York County.<sup>477</sup> In April 2011, a Licensed Professional  
 11 Counselor documented that Ms. Carlos had a mental health history and took Haldol  
 12 by injection every two weeks.<sup>478</sup> Over the next two and a half years, she was placed  
 13 on suicide watch five times and attempted suicide once, and held in segregation for  
 14 at least nine months over 12 separate instances due to “behavioral issues and  
 15 associated mental health concerns.”<sup>479</sup>

16 475. After an attempted suicide on August 13, 2013, Ms. Carlos remained  
 17 in segregation.<sup>480</sup> The DDR states that Ms. Carlos’ record contains “no  
 18

19 \_\_\_\_\_  
 20 <https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h>;  
 Robin Urevich, *supra* note 471.

21 <sup>473</sup> CoreCivic General Counsel Office of Investigations, *supra* note 471. *See also*  
 Robin Urevich, *supra* note 471.

22 <sup>474</sup> Robin Urevich, *supra* note 471.

23 <sup>475</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
 24 *Death Review – Tiombe Kimana Carlos*, at 1,

<https://www.ice.gov/doclib/foia/reports/ddr-carlos.pdf>.

25 <sup>476</sup> *Id.* at 5.

26 <sup>477</sup> *Id.* at 3.

27 <sup>478</sup> *Id.*

28 <sup>479</sup> *Id.* at 6, 8–9, 10–11, 23.

<sup>480</sup> *Id.* at 10–12.

1 documentation [facility] mental health staff pursued alternative placement with  
2 [ICE Enforcement and Removal Operations].”<sup>481</sup>

3 476. Two independent experts reviewed Ms. Carlos’ medical records on  
4 behalf of HRW and found that the substantial amount of time Ms. Carlos was held  
5 in segregation was “counter to accepted norms for treating mental illness whereby  
6 segregation and use of restraints are temporizing measures for use in emergencies  
7 and as a last resort-rather than a routine response.”<sup>482</sup>

8 477. Clemente Ntangola Mponda died in September 2013 by apparent  
9 suicide while at the Houston Contract Detention Center in Texas.<sup>483</sup> Mr. Mponda  
10 was identified as having significant mental health needs early in his detention, when  
11 facility medical staff diagnosed him with “depression or schizophrenia.”<sup>484</sup> For  
12 eight months of his 15-month detention at the facility, Mr. Mponda was in  
13 segregation, including administrative segregation, disciplinary segregation, and  
14 three days on suicide watch.<sup>485</sup> A doctor interviewed for the DDR “stated he  
15 ordinarily does not recommend segregation because it is often a ‘destabilizing  
16 environment.”<sup>486</sup> Mr. Mponda attempted suicide twice.<sup>487</sup> The DDR found  
17 numerous violations of standards for placing someone in segregation and for  
18 reviewing whether continued segregation was justified, including failure to  
19 medically clear him for segregation and failure to include the input of mental health  
20 professionals.<sup>488</sup>

21 \_\_\_\_\_  
22 <sup>481</sup> *Id.* at 27.

23 <sup>482</sup> Human Rights Watch & CIVIC, *supra* note 181, at 34.

24 <sup>483</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
25 *Death Review – Clemente Ntangola Mponda*,  
26 <https://www.ice.gov/doclib/foia/reports/ddr-mponda.pdf>.

27 <sup>484</sup> *Id.* at 4.

28 <sup>485</sup> *Id.* at 24.

<sup>486</sup> *Id.* at 34.

<sup>487</sup> *Id.* at 5, 6.

<sup>488</sup> *Id.* at 25–30.

1           478. The second time Mr. Mponda attempted suicide, staff placed him in  
2 segregation upon his return from the hospital and did not create a mental health  
3 treatment or management plan for him.<sup>489</sup> Two experts reviewing this case on  
4 behalf of HRW identified substandard care.<sup>490</sup> One expert concluded that this case  
5 “might be the poster child for misuse of isolation for mental health patients.” The  
6 other noted that “standard psychiatric care is to utilize segregation and restraints as  
7 temporizing measures for short-term use and only urgent situations, rather than as a  
8 routine means of addressing psychiatric illness,” and that in Mr. Mponda’s case,  
9 “the repeated overuse of segregation without considering other options may well  
10 have contributed to an unstable individual becoming even more unstable and  
11 ultimately contributed to his death.”<sup>491</sup>

12           479. Defendants’ failure to monitor and prevent improper and exaggerated  
13 use of segregation at Detention Facilities also extends to other vulnerable  
14 populations, including pregnant women and the elderly.

15           480. Placing pregnant and nursing women in segregation has a host of  
16 negative health consequences and is prohibited by the United Nations Rules for the  
17 Treatment of Women Prisoners and Non-Custodial Measures for Women  
18 Offenders.<sup>492</sup> People with physical disabilities are also at heightened risk of harm in

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20 <sup>489</sup> *Id.* at 6, 31.

21 <sup>490</sup> Human Rights Watch & CIVIC, *supra* note 181, at 42.

22 <sup>491</sup> *Id.*

23 <sup>492</sup> *See Hearing on Reassessing Solitary Confinement: The Human Rights, Fiscal,*  
24 *and Public Safety Consequences Before the Subcomm. on Constitution, Civil Rights*  
25 *and Human Rights of the S. Comm. on the Judiciary, 112th Cong. (2012) (statement*  
26 *of the Correctional Association of New York),*  
27 [https://archive.org/stream/gov.gpo.fdsys.CHRG-112shrg87630/CHRG-](https://archive.org/stream/gov.gpo.fdsys.CHRG-112shrg87630/CHRG-112shrg87630_djvu.txt)  
28 [112shrg87630\\_djvu.txt](https://archive.org/stream/gov.gpo.fdsys.CHRG-112shrg87630/CHRG-112shrg87630_djvu.txt) (describing challenges pregnant women in isolation can  
face in trying to access medical care) (“[I]solation can compromise women’s ability  
to fulfill their particular needs related to reproductive health care, for instance by  
impeding pregnant women’s access to critical obstetrical services, preventing them  
from getting the regular exercise and movement vital for a healthy pregnancy.”)

1 segregation, as they are “often denied access to the very physical and  
2 pharmacological therapies that will help them maintain their health or prevent  
3 physical deconditioning.”<sup>493</sup>

4 481. Segregation of elderly individuals increases the risk that they will  
5 develop or exacerbate chronic health conditions, as sensory deprivation from  
6 prolonged confinement in an empty room can worsen mental health and lead to  
7 memory loss; limited space hinders mobility, which is crucial for maintaining  
8 health through exercise; and a lack of sunlight can cause vitamin D deficiencies and  
9 greater risk of fractured bones.<sup>494</sup> Likewise, people with serious and chronic  
10 medical conditions may suffer from exacerbations of their symptoms due to the  
11 stress, lack of exercise, reduced access to healthcare, and inability of staff to detect  
12 and quickly respond to medical emergencies.<sup>495</sup>

13 482. However, despite the well-known harm that segregation wreaks on  
14 detained individuals, ICE continues to explicitly allow its contractors to use it  
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16 Similarly, women in isolation may be dissuaded from requesting care related to  
17 sensitive gynecological issues because they are required to inform correction  
18 officers about details of their medical problem, may have serious difficulty  
19 accessing appropriate medical staff when they do reach out, may be shackled during  
20 gynecological appointments that do occur, and will often interact with medical  
21 providers in full view of correction officers and/or receive superficial evaluations  
22 through closed cell doors.”).

21 <sup>493</sup> Am. Civil Liberties Union, *Caged In: Solitary Confinement’s Devastating Harm*  
22 *on Prisoners with Physical Disabilities*, at 27 (Jan. 2017),  
23 [https://www.aclu.org/sites/default/files/field\\_document/010916-aclu-](https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf)  
[solitarydisabilityreport-single.pdf](https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf).

24 <sup>494</sup> Brie Williams, *Older Prisoners and the Physical Health Effects of Solitary*  
25 *Confinement*, 106 Am. J. Pub. Health 2126 (2016),  
26 <https://escholarship.org/uc/item/64n248wp>.

27 <sup>495</sup> Am. Civil Liberties Union, *Caged In: Solitary Confinement’s Devastating Harm*  
28 *on Prisoners with Physical Disabilities*, at 24–32 (Jan. 2017),  
[https://www.aclu.org/sites/default/files/field\\_document/010916-aclu-](https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf)  
[solitarydisabilityreport-single.pdf](https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf).

1 liberally for its general population and as long as “no other viable housing options  
2 exist” for those it deems especially vulnerable.<sup>496</sup>

3 483. These risks are not limited to those who currently have special  
4 vulnerabilities. Indeed, all individuals are at risk for developing mental health  
5 conditions when placed in segregation, especially for prolonged periods. The  
6 danger is well-known: “severe and prolonged restriction of environmental  
7 stimulation in solitary confinement is toxic to brain functioning.”<sup>497</sup> The United  
8 Nations Special Rapporteur on Torture, citing multiple studies regarding the  
9 harmful effects of even short period of isolation, has said that isolation can amount  
10 to “torture or cruel, inhuman or degrading treatment,” and that isolation for more  
11 than 15 days should be absolutely prohibited.<sup>498</sup>

12 484. Despite this overwhelming evidence, ICE policy allows extended  
13 placement in segregation “when necessary, after engaging in an individualized  
14 assessment of the case.”<sup>499</sup> A DHS OIG 2016 report recommended that ICE  
15 “[e]stablish time limits for holding mentally ill detainees in segregation outside of  
16 medical units, and identify recourses for Detention Facilities when segregated  
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20 <sup>496</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of*  
*Segregation for ICE Detainees*, at ¶ 2 (Sept. 4, 2013),

21 [https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

22 <sup>497</sup> Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. &  
Pol’y 325, 349 (2006),

23 [https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law\\_j](https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law_journal_law_policy)  
24 [ournal\\_law\\_policy](https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law_journal_law_policy).

25 <sup>498</sup> *Solitary confinement should be banned in most cases, UN expert says*, UN News  
(October 18, 2011), [https://news.un.org/en/story/2011/10/392012-solitary-](https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says)  
26 [confinement-should-be-banned-most-cases-un-expert-says](https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says).

27 <sup>499</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of*  
*Segregation for ICE Detainees*, at ¶ 7 (Sept. 4, 2013),

28 [https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

1 detainees are approaching set time limits.”<sup>500</sup> However, on information and belief,  
2 ICE did not adopt that recommendation.

3 485. Therefore, although those ICE has identified as having “special  
4 vulnerabilities” are at greatest risk of harm as a result of segregation, any detained  
5 individual is at risk for being sent to segregation for prolonged periods—and then,  
6 in turn, being at a heightened risk for developing mental or physical disabilities.

7 **2. Defendants Fail to Monitor and Oversee Segregation Practices on a**  
8 **Systemic Scale.**

9 486. ICE’s 2013 Segregation Directive established centralized policies and  
10 procedures governing placement of detained individuals in segregation.<sup>501</sup> These  
11 policies ostensibly mandate centralized review of many segregation placements.  
12 However, ICE fails to ensure implementation of these policies.<sup>502</sup>

13 487. Insufficient though the ICE policies are to protect against a serious risk  
14 of harm, ICE fails even to follow its own policies. For example, a 2017 DHS OIG  
15 report found that ICE Field Offices “did not record and promptly report all  
16 instances of segregation to ICE headquarters, nor did their system properly reflect  
17 all required reviews of ongoing segregation cases per ICE guidance.”<sup>503</sup> Nor does

18 <sup>500</sup> Office of Inspector Gen., Office of Homeland Sec., OIG-16-113-VR: *ICE Still*  
19 *Struggles to Hire and Retain Staff for Mental Health Cases in Immigration*  
20 *Detention*, at 6 (July 21, 2016), <https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf>.

21 <sup>501</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of*  
22 *Segregation for ICE Detainees*, at ¶ 2 (Sept. 4, 2013),  
[https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

23 <sup>502</sup> Office of Inspector Gen., Office of Homeland Sec., OIG-17-119: *ICE Field*  
24 *Offices Need to Improve Compliance with Oversight Requirements for Segregation*  
25 *of Detainees with Mental Health Conditions*, (Sept. 29, 2017),  
<https://www.oig.dhs.gov/sites/default/files/assets/2017-11/OIG-17-119-Sep17.pdf>.

26 <sup>503</sup> Office of Inspector Gen., Office of Homeland Sec., OIG-17-119: *ICE Field*  
27 *Offices Need to Improve Compliance with Oversight Requirements for Segregation*  
28 *of Detainees with Mental Health Conditions*, at 1 (Sept. 29, 2017),  
<https://www.oig.dhs.gov/sites/default/files/assets/2017-11/OIG-17-119-Sep17.pdf>.



1 ICE “regularly compare segregation data in the electronic management system with  
2 information at Detention Facilities to assess the accuracy and reliability of data in  
3 the system.”<sup>504</sup> Thirty-nine percent of placements were reported to ICE’s Custody  
4 Management Division after the three days mandated by the Segregation  
5 Directive.<sup>505</sup> OIG’s file reviews found that 74 percent of reviews were either  
6 missing or incomplete in ICE’s online case management system (“SMRS”).<sup>506</sup>  
7 Because ICE headquarters uses the SRMS to review detained individuals’  
8 placements in segregation, these failures preclude any centralized review of those  
9 placements. The report gives one example of a detained individual who was placed  
10 in disciplinary segregation on four separate occasions, none of which was  
11 documented in the SRMS.<sup>507</sup>

12 488. On information and belief, the “Detention Inspection Form  
13 Worksheet” (the “Inspection Worksheet”) that is used in connection with many  
14 inspections of Detention Facilities includes a section concerning segregation units  
15 that omits or gets wrong several parts of the Segregation Directive. Whereas the  
16 Directive requires that the ICE Field Office Director be notified whenever a  
17 detained individual has been held in segregation continuously for 21 days, or for 14  
18 days out of a 21-day- period,<sup>508</sup> the Inspection Worksheet requires only that the ICE  
19 Field Office Director be notified when a detained individual’s confinement in  
20 segregation exceeds 30 days. In addition, the Inspection Worksheet omits any  
21 mention of the Directive’s requirement that the Field Office Director be notified  
22 within 72 hours when a detained individual has been placed in administrative  
23

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24 <sup>504</sup> *Id.*

25 <sup>505</sup> *Id.* at 5.

26 <sup>506</sup> *Id.* at 6.

27 <sup>507</sup> *Id.* at 5.

28 <sup>508</sup> U.S. Immigration & Customs Enf’t, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 5.1(1) (Sept. 4, 2013), [https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

1 segregation on the basis of a medical or mental health condition, disability, or other  
2 special vulnerability, as well as any mention of the notification requirement any  
3 time a detained individual with a mental condition, serious mental health disability,  
4 or physical disability is placed in segregation.

5 489. Predictably, ICE’s insistence on letting its contractors confine detained  
6 individuals to segregation and lack of interest in monitoring conditions has led to  
7 disastrous results systemwide. Rather than providing a therapeutic environment for  
8 those most at risk for lasting damage from segregation, contractors use segregation  
9 as a panacea for all manner of perceived inconveniences.

10 490. A June 2019 OIG report summarizing unannounced inspections of  
11 Adelanto, Essex, Aurora, and LaSalle found that overly restrictive segregation  
12 practices were used.<sup>509</sup> For example, detained individuals at Adelanto and Essex are  
13 placed in disciplinary segregation before a disciplinary hearing finds them guilty of  
14 a charged offense. Facility forms also incorrectly state that individuals are in  
15 administrative segregation, when they are actually in disciplinary segregation.<sup>510</sup>

16 491. A May 2019 NBC News report found, after reviewing 8,488 cases,  
17 that half of segregation placements were not for disciplinary reasons but instead  
18 “involve the mentally ill, the disabled or others who were sent to solitary largely for  
19 what ICE described as safety reasons.”<sup>511</sup> In those cases, former CRCL policy  
20 analyst Ellen Gallagher explained that at facilities, “[s]olitary confinement was  
21 being used as the first resort, not the last resort.”<sup>512</sup> A third of the segregation  
22 placement reviews involved detained individuals who “were determined by ICE to

23 \_\_\_\_\_  
24 <sup>509</sup> Office of Inspector Gen., Office of Homeland Sec., *OIG-19-47*, *supra* note 97.

25 <sup>510</sup> *Id.* at 5.

26 <sup>511</sup> Hannah Rappleye et al., *Thousands of immigrants suffer in solitary confinement*  
27 *in U.S. detention centers*, NBC News (May 20, 2019)

28 <https://www.nbcnews.com/politics/immigration/thousands-immigrants-suffer-solitary-confinement-u-s-detention-centers-n1007881>.

<sup>512</sup> *Id.*

1 have a mental illness,” and some were placed in disciplinary segregation “for  
 2 offenses that stem from mental illness, such as acts of self-harm.”<sup>513</sup> Some records  
 3 show individuals with mental health disabilities confined to segregation shuttle  
 4 “chronically back and forth from the general population to administrative or  
 5 disciplinary segregation, with periodic, crisis-oriented admissions to psychiatric  
 6 hospitals punctuating their return to the same disturbing cycle.”<sup>514</sup> Records showed  
 7 that more than 60 detained individuals were confined in segregation “solely because  
 8 they required a wheelchair or some other aid.”<sup>515</sup> Though ICE’s Segregation  
 9 Directive requires it to document what alternatives to segregation were considered,  
 10 Ms. Gallagher “often found no evidence that ICE had done so.”<sup>516</sup>

11 492. Ms. Gallagher raised these concerns for five years, and circulated  
 12 memos about them within DHS and then to the US Office of Special Counsel, but  
 13 neither OIG nor CRCL has published any reports addressing the systemic use of  
 14 either prolonged segregation or segregation of those with special vulnerabilities.<sup>517</sup>  
 15 Nor have the abuses abated.

16 493. Disability Rights California’s March 2019 report found that facility  
 17 staff at Adelanto held detained individuals in segregation on the basis of  
 18 disability.<sup>518</sup> Unit rosters identify “mental illness or medical condition” as the  
 19 reason for many placements.<sup>519</sup> In its investigation, DRC found multiple examples  
 20 of facility staff knowingly sending detained individuals with mental health  
 21 disabilities to segregation, only to have those individuals attempt suicide.<sup>520</sup>

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23 <sup>513</sup> *Id.*

24 <sup>514</sup> *Id.*

25 <sup>515</sup> *Id.*

26 <sup>516</sup> *Id.*

27 <sup>517</sup> *Id.*

28 <sup>518</sup> Disability Rights Cal., *supra* note 36, at 29.

<sup>519</sup> *Id.* at 48.

<sup>520</sup> *Id.* at 8, 27, 32.

1           494. A 2017 investigation by The Verge of over 300 segregation logs at  
2 Stewart, Eloy, and Pearsall also found many examples of abuse, including one on  
3 June 8, 2016, when facility staff placed a detained individual in segregation for  
4 “standing up on his open bay bed and urinating in a cup followed by [the detainee]  
5 drinking the same urine.”<sup>521</sup> Staff, with ICE’s approval, placed this detained  
6 individual in solitary confinement for nearly a month, not for mental health  
7 treatment, but to discipline him for drinking his urine.<sup>522</sup> Detained individuals at  
8 Irwin also report staff regularly using prolonged periods of isolation, strapping  
9 those with mental health conditions in straitjackets, and involuntarily confining  
10 those with mental health conditions to segregation.<sup>523</sup> ICE itself has acknowledged  
11 that “[d]ue to housing limitations at various facilities, segregation use for suicide  
12 observation is a necessity.”<sup>524</sup>

13           495. ICE’s own death reviews also demonstrate the complete lack of  
14 accountability in its segregation system. Inspectors found failures to monitor  
15 individuals in segregation in a number of the publicly available DDRs.

16           496. Before his death on December 2, 2017, Kamyar Samimi spent the  
17 entirety of his 16-day detention at Aurora in medical observation and suicide  
18

19 \_\_\_\_\_  
20 <sup>521</sup> Spencer Woodman, *ICE Detainees are Asking to Be Put in Solitary Confinement*  
21 *for Their Own Safety*, The Verge (2017),

22 [https://www.theverge.com/2017/3/10/14873244/ice-immigrant-detention-solitary-](https://www.theverge.com/2017/3/10/14873244/ice-immigrant-detention-solitary-trump-corecivic-geo)  
23 [trump-corecivic-geo.](https://www.theverge.com/2017/3/10/14873244/ice-immigrant-detention-solitary-trump-corecivic-geo)

24 <sup>522</sup> Id.

25 <sup>523</sup> Ctr. for Immigrants’ Rights Clinic, PennState Law, *Imprisoned Justice: Inside*  
26 *Two Georgia Immigrant Detention Centers*, at 49 (May 2017),

27 [https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned Justice Report-](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf)  
28 [1.pdf.](https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf)

<sup>524</sup> Spencer Woodman, et al., *Thousands of Immigrants Suffer in US Solitary*  
*Confinement*, International Consortium of Investigative Journalists (May 21, 2019),  
[https://www.icij.org/investigations/solitary-voices/thousands-of-immigrants-suffer-](https://www.icij.org/investigations/solitary-voices/thousands-of-immigrants-suffer-in-us-solitary-confinement/)  
[in-us-solitary-confinement/.](https://www.icij.org/investigations/solitary-voices/thousands-of-immigrants-suffer-in-us-solitary-confinement/)

1 watch.<sup>525</sup> The DDR found that nursing staff failed to conduct a welfare check  
2 during the 14 hours he spent on suicide watch.<sup>526</sup> Additionally, the facility doctor  
3 did not renew his orders for Mr. Samimi's placement in medical housing, as  
4 required by GEO policy.<sup>527</sup>

5 497. On March 28, 2017, Osmar Epifanio Gonzalez-Gadba died by suicide  
6 while detained at Adelanto.<sup>528</sup> Though facility staff sent Gonzalez-Gadba to an  
7 outside doctor for mental health treatment, staff placed Mr. Gonzalez-Gadba in  
8 segregation upon his return to Adelanto.<sup>529</sup> Because staff knew of Mr. Gonzalez-  
9 Gadba's diagnosed mental health conditions and repeated medication refusals, they  
10 placed him on psychiatric observation status.<sup>530</sup> However, staff failed to  
11 consistently check on him every 30 minutes as required, including during the period  
12 that he hanged himself.<sup>531</sup>

13 498. Two independent experts who reviewed Mr. Gonzalez-Gadba's DDR  
14 found that facility staff were on notice that he had serious mental health conditions  
15 and had stopped taking his medicine, and that he should not have been placed in  
16 segregation because of the likelihood of inadequate coping mechanisms due to  
17 stress, resulting in personality disturbance or disintegration.<sup>532</sup>

18  
19  
20  
21 <sup>525</sup> Samimi DDR, *supra* note 220, at 60–62.

22 <sup>526</sup> *Id.* at 66.

23 <sup>527</sup> *Id.*

24 <sup>528</sup> Office of Professional Responsibility, Office of Detention Oversight, *Detainee*  
*Death Review – Osmar Epifanio Gonzalez-Gadba*, at 1  
<https://www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf>.

25 <sup>529</sup> *Id.* at 11.

26 <sup>530</sup> *Id.*

27 <sup>531</sup> *Id.* at 11–15.

28 <sup>532</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
Center & Detention Watch Network, *supra* note 155, at 53.

1           499. On May 15, 2017, Jean Carlos Alfonso Jimenez-Joseph died by  
 2 suicide while in solitary confinement at Stewart.<sup>533</sup> The Georgia Bureau of  
 3 Investigation reviewed his death and found that Mr. Jimenez-Joseph had been  
 4 prescribed medication at a mental health facility before he was detained by ICE, but  
 5 Stewart staff did not give him the full dosage.<sup>534</sup> Despite knowledge that Mr.  
 6 Jimenez-Joseph was diagnosed with schizophrenia, staff placed him in segregation  
 7 as punishment for attempting suicide by jumping from the top tier of his housing  
 8 unit.<sup>535</sup> On the night of his death, Mr. Jimenez was seen jumping rope with his  
 9 bedsheets and had written “Hallelujah the Grave Cometh” in large dark letters on  
 10 his cell wall. After 19 days in isolation, he died by suicide.<sup>536</sup>

11           500. Despite being identified as a suicide risk, he was never placed on  
 12 suicide watch, nor was he provided the upward adjustment of his anti-psychotic  
 13 medication he begged for in the days before his death.<sup>537</sup> He was also placed in a  
 14 cell that contained a known suicide hazard, a ceiling sprinkler head, upon which he  
 15 affixed his makeshift noose.<sup>538</sup>

16           501. In sum, evidence from facilities across the country makes clear that  
 17 segregation is overused, misused, and not properly tracked or reported, leaving  
 18 detained individuals who may be subjected to the practice at substantial risk of  
 19 harm. Despite extensive documentation of these problems, ICE has taken no  
 20 effective steps to prevent these abuses.

21  
 22 <sup>533</sup> *Id.*

23 <sup>534</sup> *Id.* at 40. *See also* Robin Urevich, *Private prison giant under fire for pressuring*  
 24 *Georgia to keep immigrant detainee’s death report sealed*, FAST COMPANY (Dec.  
 25 10, 2018) <https://www.fastcompany.com/90279208/private-prison-giant-under-fire-for-pressuring-georgia-to-keep-immigrant-detainees-death-report-sealed>.

26 <sup>535</sup> Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice  
 Center & Detention Watch Network, *supra* note 155, at 40.

27 <sup>536</sup> *Id.* at 53.

28 <sup>537</sup> *Id.* at 40.

<sup>538</sup> *Id.*

1 **VIII. As a Result of Defendants’ Failure to Monitor and Oversee Disability-**  
2 **Related Practices in Detention Facilities, Plaintiffs with Disabilities and**  
3 **Members of the Disability Subclass Are Subjected to Violations of the**  
4 **Fifth Amendment and Section 504 of the Rehabilitation Act.**

4 **A. Section 504 of the Rehabilitation Act Prohibits Discrimination on the**  
5 **Basis of Disability by Executive Agencies.**

6 502. Plaintiffs Sergio Salazar Artaga, José Baca Hernández, Raul Alcocer  
7 Chavez, Jimmy Sudney, Jose Segovia Benitez, Marco Montoya Amaya, Faour  
8 Abdallah Fraihat, Ruben Darío Mencías Soto, Aristoteles Sanchez Martinez, Alex  
9 Hernandez, Melvin Murillo Hernandez, Luis Manuel Rodriguez Delgadillo, and  
10 Hamida Ali (collectively the “Disability Plaintiffs”) and the Disability Subclass  
11 challenge ICE’s failure to ensure Detention Facilities comply with the requirements  
12 of Section 504 of the Rehabilitation Act (“Section 504”), 29 U.S.C. § 794.

13 503. Section 504 prohibits discrimination on the basis of disability in  
14 programs or activities conducted by executive agencies of the United States.  
15 Defendants DHS and ICE are executive agencies, and the Detention Facilities  
16 program they operate, whether directly or through contractual, licensing, or other  
17 arrangements, constitutes a covered program or activity conducted by executive  
18 agencies.

19 504. Defendants have an affirmative obligation to operate their Detention  
20 Facilities program so that it is readily accessible to and usable by individuals with  
21 disabilities, does not discriminate on the basis of disability, and is otherwise in  
22 compliance with Section 504 and its implementing regulations, 6 C.F.R. § 15.1 *et*  
23 *seq.*

24 505. Defendants have failed and continue to fail to comply with this  
25 affirmative obligation in the following ways (referred to herein as “the Disability  
26 Practices”): (1) failing to ensure that their programs are readily accessible to and  
27 usable by detained individuals with disabilities; (2) to the extent structural changes  
28 or other measures are necessary to make such facilities readily accessible to and

1 usable by detained individuals with disabilities, failing to ensure that such structural  
2 changes are made or other measures taken; (3) failing to conduct an adequate self-  
3 evaluation or prepare and implement an adequate Transition Plan to bring Detention  
4 Facilities into compliance with Section 504; (4) failing to ensure that Detention  
5 Facilities maintain and implement adequate screening to identify, track, and  
6 accommodate the needs of detained individuals with disabilities; (5) failing to  
7 ensure that Detention Facilities do not improperly place persons with disabilities in  
8 segregation and administrative segregation in Detention Facilities; (6) failing to  
9 ensure that Detention Facilities have an effective system in place to provide  
10 detained individuals with disabilities with reasonable accommodations necessary  
11 for meaningful access to the benefits available at Detention Facilities, as well as to  
12 provide auxiliary aids necessary for detained individuals with sensory impairments  
13 to have access to effective communication; (7) making determinations concerning  
14 the location of detention facilities that have the purpose or effect of discriminating  
15 on the basis of disability; (8) using criteria in the selection of contractors to operate  
16 detention facilities that subject members of the Disability Subclass to  
17 discrimination on the basis of disability; (9) failing to administer programs and  
18 activities in the most integrated setting appropriate to the needs of individuals with  
19 disabilities; and (10) using criteria or methods of administration that have the  
20 purpose or effect of discriminating on the basis of disability.

21 506. Organizational Plaintiffs ICIJ and Al Otro Lado have had to divert  
22 resources, and have had their missions frustrated, as a result of the Disability  
23 Practices.

24 507. The policies and practices described herein place members of the  
25 Disability Subclass at particular risk of infringement or denial of the rights secured  
26 by Section 504.  
27  
28



1       **1. Defendants Exercise Centralized Control Regarding Conditions**  
 2       **Impacting Persons with Disabilities at Detention Facilities Nationwide.**

3       508. Defendants have the sole authority to select and contract with the  
 4 facilities in which Disability Subclass members are detained. Further, as all  
 5 members of the Disability Subclass are in ICE custody, Defendants maintain  
 6 centralized control of the standards, policies, practices, and procedures applicable to  
 7 detained individuals with disabilities, discussed in detail below. Defendants have in  
 8 place centralized directives regarding program accessibility, reasonable  
 9 accommodations, and effective communications.

10       509. For example, in 2013, DHS issued Directive 065-01, requiring ICE  
 11 and other parts of DHS to, among other things, conduct a self-evaluation, develop a  
 12 plan that addresses any barriers identified in the self-evaluation, and document the  
 13 policies and procedures for providing reasonable accommodations and  
 14 modifications to persons with disabilities.<sup>539</sup>

15       510. DHS followed up with a 2015 instruction, Instruction #065-01-001,  
 16 requiring ICE and other DHS components to designate a lead Disability Access  
 17 Coordinator with “the ability and authority to reach across the Component’s  
 18 divisions and offices,” and to serve “as the central resource for Component  
 19 compliance with Section 504.”<sup>540</sup>

22 \_\_\_\_\_  
 23 <sup>539</sup> U.S. Dep’t. of Homeland Sec., *Nondiscrimination for Individuals with*  
 24 *Disabilities in DHS-Conducted Programs and Activities (Non-Employment)* (Sep.  
 25 2013), [https://www.dhs.gov/sites/default/files/publications/dhs-management-](https://www.dhs.gov/sites/default/files/publications/dhs-management-directive-disability-access_0.pdf)  
[directive-disability-access\\_0.pdf](https://www.dhs.gov/sites/default/files/publications/dhs-management-directive-disability-access_0.pdf).

26 <sup>540</sup> U.S. Dep’t. of Homeland Sec., *Instruction on Nondiscrimination for Individuals*  
 27 *with Disabilities in DHS-Conducted Programs and Activities (Non-Employment)*  
 28 (March 2015), [https://www.dhs.gov/sites/default/files/publications/dhs-instruction-](https://www.dhs.gov/sites/default/files/publications/dhs-instruction-nondiscrimination-individuals-disabilities_03-07-15.pdf)  
[nondiscrimination-individuals-disabilities\\_03-07-15.pdf](https://www.dhs.gov/sites/default/files/publications/dhs-instruction-nondiscrimination-individuals-disabilities_03-07-15.pdf).

1           511. Defendants also have in place a policy entitled “Assessment and  
2 Accommodations for Detainees with Disabilities.”<sup>541</sup> On information and belief,  
3 pursuant to this and other policies, detained individuals with communication and  
4 mobility disabilities are subjected to reviews by staff at ICE headquarters, in part to  
5 make recommendations on accommodations.

6           512. Despite the existence of these system-wide directives and policies,  
7 Defendants have failed to take the affirmative steps necessary to enforce them, to  
8 otherwise ensure that Detention Facilities have appropriate systems in place to  
9 ensure that detained individuals with disabilities have meaningful access to ICE  
10 programs and services, and to ensure that detained individuals with disabilities are  
11 not denied necessary accommodations or otherwise subject to the discriminatory  
12 Disability Practices described below.

13       **2. Defendants Systemically Fail to Ensure Access to ICE Programs and**  
14       **Services for Detained Individuals with Disabilities.**

15           513. Defendants have failed to ensure that their Detention Facilities  
16 Program is readily accessible to and usable by persons with disabilities (referred to  
17 as “Program Access”), including but not limited to failing to engage in alterations  
18 to existing facilities, construction of new facilities, redesigning equipment, or  
19 reassignment of services to accessible buildings. For example, several Detention  
20 Facilities contain architectural barriers and need facilities or program modifications  
21 for members of the Disability Subclass to have meaningful access to the benefits of  
22 those facilities. Yet Defendants have not adequately evaluated those barriers, much  
23 less implemented the changes needed to remedy them.

24           514. Defendants have further failed to conduct an adequate self-evaluation,  
25 including opportunities for meaningful input from the disability community in that

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26  
27 <sup>541</sup> U.S. Immigration & Customs Enforcement, Enforcement and Removal  
28 Operations, *Assessment and Accommodations for Detainees with Disabilities* (Dec.  
2016).

1 process, despite their own directives and federal regulations requiring such self-  
2 evaluation.

3 515. Defendants have also failed to ensure that Detention Facilities make  
4 modifications to their policies and practices where needed to avoid discrimination  
5 on the basis of disability and denial of access to programs and activities.

6 516. Despite their failure to ensure Program Access, Defendants have  
7 nonetheless housed thousands of members of the Disability Subclass in inaccessible  
8 facilities. On information and belief, many Detention Facilities lack accessible  
9 paths of travel, sufficient accessible restroom and shower facilities, and accessible  
10 recreational facilities for detainees with mobility disabilities, among other barriers.  
11 Detained individuals with disabilities are denied access to a range of benefits, from  
12 access to basic hygiene, recreation and visitation, among others, and face an  
13 increased risk of harm, as well as the denial of personal autonomy.

14 517. Examples of architectural barriers and other failures of Program  
15 Access at Detention Facilities include a lack of sufficient accessible shower  
16 facilities at La Salle, requiring at least one detained individual who uses a  
17 wheelchair to rely on the assistance of other detainees to shower; a lack of  
18 accessible paths of travel at Stewart, including barriers making it difficult for  
19 detained individuals who use wheelchairs to access the medical unit; and  
20 overcrowding that blocks accessible paths of travel and provides no access to  
21 accessible housing facilities for detained individuals who use wheelchairs at  
22 Krome, among many other issues.

23 518. Another example is Florence Correctional Center's lack of  
24 accessibility to persons with mobility impairments like Plaintiff Sergio Salazar  
25 Artaga. Because of his cerebral palsy, Mr. Salzar Artaga has difficulty standing,  
26 ambulating, and using the right side of his body. The shower to accommodate  
27 people with disabilities at Florence has been nonfunctional for the duration of Mr.  
28 Salazar Artaga's time at the facility. As a result, he has been nervous to take a

1 shower in the standard showers without slipping, falling, and hurting himself.  
2 While he made a request for a shower chair so that he would be less likely to fall,  
3 he was in the facility for nearly three months before he received the shower chair.

4 519. Defendants' failure to ensure access to adequate medical and mental  
5 health care, as alleged earlier in this Complaint, often has the effect of depriving  
6 Disability Subclass members of access to Detention Facility programs and services.

7 520. For example, instead of providing Plaintiff Melvin Murillo Hernandez  
8 timely consultation with an allergist and ready access to an EpiPen, LaSalle staff  
9 isolated him. This, and his repeated, avoidable bouts of anaphylactic shock, deny  
10 him access to the programs and activities accessible to other detained individuals.

11 521. As another example, while detained at Adelanto, Plaintiff Luis Manuel  
12 Rodriguez Delgadillo has not been provided therapy or all of the psychotropic  
13 medication he took prior to detention, causing him to repeatedly have acute mental  
14 health episodes that have denied him access to the programs and activities  
15 accessible to non-disabled detained individuals.

16 **3. Defendants Systemically Fail to Ensure Adequate Screening to Identify,**  
17 **Track, and Accommodate Detained Individuals with Disabilities.**

18 522. Defendants' Detention Facilities across the country fail to adequately  
19 identify, track, and provide accommodations for detained individuals with  
20 disabilities as required by Section 504.

21 523. Defendants' inadequate screening procedures, as alleged earlier this  
22 Complaint, also result in the failure to identify individuals with disabilities, track  
23 their needs, and provide accommodations required by their disabilities.

24 524. Defendants have sole authority to transfer and move detained  
25 individuals throughout their network of Detention Facilities. Class members are  
26 regularly shuffled from facility to facility with little to no regard for whether they  
27 have a disability that requires a particular placement, and Defendants fail to ensure  
28

1 that facilities in which Detained individuals with disabilities are housed provide  
2 access to the same essential services and programs as in all other facilities.

3 525. Upon transfer, information regarding any prior identification of  
4 disability is often not communicated, resulting in inadequate tracking of individuals  
5 with disabilities. Further, accommodations that have been approved and provided  
6 by Defendants are often discontinued or removed without cause when a person is  
7 transferred to a new facility. Individuals with disabilities must restart the process of  
8 requesting reasonable accommodations at each new facility, resulting in delay and  
9 denial of receiving those accommodations to meaningfully access programs and  
10 services.

11 526. The Plaintiffs' experiences are illustrative of Detention Facilities'  
12 failure to perform adequate screening and tracking of the needs of individuals with  
13 disabilities.

14 527. For example, Plaintiff José Baca Hernández is blind and has been  
15 detained at Theo Lacy and Adelanto, neither of which conducted an intake that  
16 included a discussion of reasonable accommodations. At Adelanto, it took more  
17 than one year for an Americans with Disabilities Act ("ADA") Coordinator to meet  
18 with Mr. Baca.

19 528. Plaintiff Alcocer Chavez is Deaf and communicates in ASL, but he  
20 was not provided ASL interpretation during medical intake. Accordingly, he was  
21 unable to communicate effectively with medical staff, among many other issues.

22 529. When Plaintiff Jimmy Sudney arrived at Adelanto, it took over a week  
23 to see a doctor for an intake meeting, and that doctor asked only about his mental  
24 health. When he arrived at Eloy, it took almost a month to have an intake meeting.  
25 Meanwhile, upon arrival at Eloy, he went without medication that he requires daily  
26 to stabilize his medical and mental health needs.

27 530. Plaintiff Alex Hernandez's rotator cuff and inflammation and pain in  
28 his back, legs, hip and feet impede his mobility and range of motion. When Mr.

1 Hernandez was transferred to Etowah, he was given a bottom bunk profile based on  
2 his disability, but he was assigned to a top bunk. He was told that no bottom bunks  
3 were available at that time.

4 531. As a result, for a month and half Mr. Hernandez was required to sleep  
5 on the top bunk. There was no ladder to get up to the top bunk, and no railing or  
6 other device to use for support. Mr. Hernandez relied on assistance from other  
7 detained individuals assigned to his cell to lift him so he could get into bed and also  
8 help support him as he was getting out of bed. He was fearful of falling or  
9 sustaining further injury to his shoulder, back, hip, and legs.

10 532. Plaintiff Sergio Salazar Artaga's initial screenings at Florence  
11 indicated that he had no mental health disability. As a result, he did not timely  
12 receive psychotropic medication, and he ended up on suicide watch twice over the  
13 next month for banging his head on the wall and auditory and visual hallucinations.

14 533. At Adelanto, Plaintiff Luis Manuel Rodriguez Delgadillo's intake was  
15 deficient, relying on his incomplete self-reporting of his psychotropic medication,  
16 declining to coordinate with his prior treating doctor even when provided that  
17 doctor's contact information by his family, and failing to gather records from that  
18 treatment. As a result, Mr. Rodriguez Delgadillo has become unstable and has had  
19 repeated episodes of acute mental health distress.

20 534. Further, Disability Rights California's 2019 report highlighted  
21 numerous examples of deficiencies in the intake screening process at Adelanto that  
22 resulted in discrimination against individuals with disabilities.<sup>542</sup>

23 535. For example, Adelanto's list of recognized disabilities in its screening  
24 protocol is arbitrary and incomplete.<sup>543</sup> Many common disabilities are missing  
25 entirely, such as those related to vision, hearing, and communication.<sup>544</sup> Physical

26 <sup>542</sup> Disability Rights California, *supra* note 36.

27 <sup>543</sup> *Id.* at 41.

28 <sup>544</sup> *Id.*

1 disabilities are inappropriately limited to “para/quadruplegia,” “stroke,”  
 2 “amputation,” and “cardiac condition.”<sup>545</sup> There is no screening for housing  
 3 accommodation needs, such as a placement in a lower bunk or accessible cell for  
 4 detained individuals with mobility impairments.<sup>546</sup> The facility’s screening also  
 5 lacks a reliable or valid tool to identify detained individuals with intellectual or  
 6 developmental disabilities.<sup>547</sup>

7 536. The DRC Adelanto report further documented the risk and, in some  
 8 instances, actual harm that results from Defendants’ failure to adequately identify  
 9 and track individuals with disabilities. For example, a deaf asylum seeker at  
 10 Adelanto was not provided sign language interpretation and had to go months with  
 11 no way to communicate with staff, including during medical appointments.<sup>548</sup>  
 12 Because of this, “[h]e had to point at the area of his body that was hurting and hope  
 13 medical staff understood.”<sup>549</sup>

14 537. Harm to people with disabilities also includes members of the  
 15 Disability Subclass being subjected to punitive and counter-therapeutic responses  
 16 when they engage in behavior that is a manifestation of their disability.<sup>550</sup> For  
 17 example, a detained individual at Adelanto reported that he was pepper sprayed  
 18 after staff saw him attempting suicide.<sup>551</sup>

19 **4. Defendants Systemically Fail to Prevent Improper Use of Segregation**  
 20 **for Detained Individuals with Disabilities.**

21 538. As alleged earlier in this Complaint, Defendants repeatedly place  
 22 detained individuals with disabilities in segregation, despite their own experts

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23 <sup>545</sup> *Id.*

24 <sup>546</sup> *Id.*

25 <sup>547</sup> *Id.*

26 <sup>548</sup> *Id.* at 42.

27 <sup>549</sup> *Id.*

28 <sup>550</sup> *Id.* at 27.

<sup>551</sup> *Id.*

1 having found that segregation is inappropriate and potentially harmful to detained  
 2 individuals with disabilities, particularly to detained individuals with mental health  
 3 disabilities.<sup>552</sup>

4 539. Indeed, Defendants' Segregation Directive recognizes that segregation  
 5 of detainees with disabilities and other vulnerable detainees "should be used only as  
 6 a last resort and when no other viable housing options exist."<sup>553</sup>

7 540. Detainee Death Reviews document improper placement and  
 8 monitoring of individuals with disabilities as a contributing factor to a number of  
 9 the deaths in Defendants' custody, including at Houston,<sup>554</sup> Hudson County,<sup>555</sup> and  
 10 Farmville,<sup>556</sup> among others.

11 541. Additionally, in a 2017 report, OIG found numerous instances in  
 12 which ICE failed to comply with its duties to oversee and monitor the segregation  
 13 of detained individuals with mental health conditions.<sup>557</sup>

14  
 15 \_\_\_\_\_  
 16 <sup>552</sup> U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of*  
 17 *Segregation for ICE Detainees*, at ¶¶ 3.3, 5.2(5) (Sept. 4, 2013),  
[https://www.ice.gov/doclib/detention-reform/pdf/segregation\\_directive.pdf](https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf).

18 <sup>553</sup> *Id.* at ¶ 2.

19 <sup>554</sup> *See, e.g.*, Office of Professional Responsibility, Office of Detention Oversight,  
 20 *Detainee Death Review – Clemente Ntangola Mponda*,  
<https://www.ice.gov/doclib/foia/reports/ddr-mponda.pdf>.

21 <sup>555</sup> *See, e.g.*, Office of Professional Responsibility, Office of Detention Oversight,  
 22 *Detainee Death Review – Santo Carela*,  
<https://www.ice.gov/doclib/foia/reports/ddr-Carela.pdf>.

23 <sup>556</sup> *See, e.g.*, U.S. Dep't. of Homeland Sec., *Report of Investigation: RAMIREZ-*  
 24 *Ramirez, Anibal/Unknown/0109 Detainee/Alien – Death (Known Cause – Terminal*  
 25 *Illness)/FARMVILLE, PRINCE EDWARD, VA*,  
[https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-](https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/)  
[Anibal.html#document/](https://www.documentcloud.org/documents/2695511-Ramirez-Ramirez-Anibal.html#document/).

26 <sup>557</sup> Office of Inspector Gen., Office of Homeland Sec., *OIG-17-119: ICE Field*  
 27 *Offices Need to Improve Compliance with Oversight Requirements for Segregation*  
 28 *of Detainees with Mental Health Conditions* (Sept. 29, 2017), available at  
<https://www.oig.dhs.gov/sites/default/files/assets/2017-11/OIG-17-119-Sep17.pdf>.



1           542. Defendants also fail to oversee and monitor detention facilities that  
2 utilize segregation to house detained individuals with disabilities due to  
3 inaccessible facilities or a lack of accommodations or auxiliary aids and services.  
4 For example, incident reports obtained and evaluated by The International  
5 Consortium of Investigative Journalists depict dozens of cases between 2012 and  
6 2017 of detained individuals in segregation because of a disability that required use  
7 of an aid, such as a wheelchair, cane, or crutches, or because of a mental health  
8 disability.<sup>558</sup>

9           543. Plaintiff Jimmy Sudney was never placed in segregation while in  
10 county jail or state prison, but he has been placed in disciplinary segregation while  
11 in ICE custody. Mr. Sudney was placed in disciplinary segregation at Adelanto  
12 because he filed a grievance against an officer who was harassing him and her  
13 fiancée—another guard—who had joined in that conduct. They had a verbal  
14 altercation and Mr. Sudney was put in segregation for one week. There was no  
15 hearing before Adelanto put Mr. Sudney in segregation and the mental health  
16 clearance was cursory—when Mr. Sudney reported that he would not hurt or kill  
17 himself in segregation, they cleared him to be segregated. While he was in  
18 segregation, the guards knocked loudly on the door, and the people above him made  
19 noise that triggered a PTSD flashback. Mr. Sudney jumped under the bed and  
20 relived the earthquake in Haiti with his house coming down over him.

21           544. Plaintiff Jose Segovia Benitez has been placed in disciplinary  
22 segregation for three to five days on several occasions. During some of those  
23 segregation stays, on information and belief, he often did not receive daily medical  
24  
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26 <sup>558</sup> Spencer Woodman, et al., *Solitary Voices: Thousands of Immigrants Suffer in*  
27 *Solitary Confinement in ICE Detention*, THE INTERCEPT (May 20, 2019),  
28 [https://theintercept.com/2019/05/21/ice-solitary-confinement-immigration-](https://theintercept.com/2019/05/21/ice-solitary-confinement-immigration-detention/)  
[detention/](https://theintercept.com/2019/05/21/ice-solitary-confinement-immigration-detention/).

1 or mental health check-ins, despite Adelanto's records documenting his physical  
2 and mental health conditions.

3 545. Plaintiff Marco Montoya Amaya not only has PTSD and major  
4 depressive disorder, but has also been living with a likely untreated brain parasite  
5 for over a year. This brain parasite, left untreated, can cause severe and life-  
6 threatening symptoms, including irreversible cognitive and psychiatric symptoms.  
7 Mr. Montoya Amaya was placed in disciplinary segregation for approximately one  
8 week in May 2019 for accidentally eating an extra tray of food based on his failure  
9 to understand the officer's instructions. While in segregation, Mr. Montoya Amaya  
10 did not receive daily mental health or physical health evaluations, instead receiving  
11 only two mental health evaluations overall. To the extent he may have received  
12 some health evaluation before he entered segregation, that health evaluation was  
13 incomplete and incorrect; for example, despite indicating that the health  
14 professional had completed a chart review, a note in his medical record regarding  
15 segregation falsely indicated that Mr. Montoya Amaya did not have any headaches  
16 or dizziness, despite having those symptoms regularly documented throughout his  
17 medical records for over a year.

18 546. Plaintiff Faour Abdallah Fraihat has been placed in medical  
19 segregation for medical reasons four times while detained at Adelanto, including  
20 for around one week each of the two times he returned to Adelanto from the  
21 hospital. A doctor would check on him for at most ten minutes per day, and nurses  
22 came twice per day to check his vitals and bring him medication. Each of the four  
23 times Mr. Fraihat was in medical segregation he was not allowed out of his cell at  
24 any time, though he asked to be let out.

25 547. LaSalle staff has confined Plaintiff Melvin Murillo Hernandez to  
26 medical segregation since arriving at LaSalle on May 8, 2019, based on his severe  
27 allergies. Though he relied on other detained individuals to bring him to facility  
28 staff during previous anaphylactic shocks in which he lost consciousness, he is now

1 confined alone in a cell 24 hours a day. Facility staff now bring all of his meals,  
2 which consist mostly of eggs and rice, to his cell.

3 548. Plaintiff Hamida Ali, who has schizophrenia, was segregated and  
4 placed in a dorm by herself for approximately nine months, causing her to  
5 experience extreme psychological distress and suicidal ideation.

6 **5. Defendants Systemically Fail to Provide People with Disabilities with**  
7 **Reasonable Accommodations, Auxiliary Aids, and Effective**  
8 **Communication.**

9 549. Despite the supposed existence of the centralized systems described  
10 above, as a matter of practice, Defendants systemically fail to ensure that Detention  
11 Facilities provide detained individuals with disabilities with necessary  
12 accommodations, including mobility devices or other aids necessary for detained  
13 individuals with mobility disabilities to engage in activities of daily living;  
14 auxiliary aids, such as video phones, ASL interpretation, or effective means of  
15 communication for persons who are deaf or hard of hearing; and materials in  
16 Braille, large print, or other alternate formats for persons who are blind or have low  
17 vision. As a result, Defendants systemically fail to ensure detained individuals with  
18 disabilities have meaningful access to the benefits of Defendants' Detention  
19 Facilities Program.

20 550. As an initial matter, Defendants do not ensure Detention Facilities  
21 provide information during intake about the facility's reasonable accommodation  
22 and modification process and and otherwise fail to make available information  
23 regarding Section 504, its implementation regulations, and its applicability to  
24 Defendants' programs or activities in such a manner as is necessary to apprise  
25 detained individuals of the protections against discrimination assured them by  
26 Section 504 and its implementation regulations. For example, there is often no  
27 formal process in place to request, review, or respond to such requests.  
28

1           551. Defendants also fail to ensure that, upon intake, Detention Facilities  
2 provide information to detained individuals regarding their rights under  
3 Section 504, including ensuring in an accessible format how to file a complaint  
4 under Section 504 and ensuring that such information is available in common areas  
5 in a manner that is accessible to individuals who have disabilities.

6           552. Further, Defendants fail to ensure that detention staff are trained in  
7 Section 504 obligations and related interactions with detained individuals with  
8 disabilities. For example, in Adelanto the Disability Compliance Manager disclosed  
9 he did not have prior disability-related training and received only a four-hour online  
10 training to fulfill the role requirement.<sup>559</sup>

11           553. The result of these failures is a broken system in which disability-  
12 based needs are routinely ignored, denying members of the Disability Subclass  
13 access to needed services and excluding them from critical benefits of Defendants'  
14 Detention Facilities Program.

15           554. Defendants fail to ensure that Detention Facilities provide deaf and  
16 hard of hearing detained individuals with auxiliary aids and services necessary to  
17 ensure effective communication. For example, Defendants fail to ensure that  
18 qualified interpreters are available for such interactions as medical appointments  
19 and disciplinary proceedings.

20           555. In many Detention Facilities, detained individuals who are deaf or hard  
21 of hearing must rely on peers, hand gestures, or lip reading to attempt to  
22 communication with staff because Defendants fail to ensure they have access to a  
23 qualified interpreter.

24           556. Further, many Detention Facilities lack timely processes to obtain  
25 devices and services needed to achieve effective communication. The processes to  
26  
27

28 \_\_\_\_\_  
<sup>559</sup> Disability Rights California, *supra* note 36, at 47.

1 request such devices are also discriminatory in themselves, because individuals are  
2 often required to submit a written request that does not come in accessible formats.

3 557. For example, Plaintiff Alcocer Chavez is Deaf and communicates in  
4 ASL. He has repeatedly been denied effective communication at Adelanto, which  
5 hinders his ability to communicate with ICE officials and medical staff. During Mr.  
6 Alcocer Chavez's time at Adelanto, he has never been provided with an ASL  
7 interpreter. Mr. Alcocer Chavez has had multiple interactions with ICE and medical  
8 staff without interpretation. There were several occasions during which he  
9 communicated with a doctor by writing notes back and forth. Due to his limited  
10 English, he did not understand much of the vocabulary the doctor used.  
11 Additionally, ICE officials have tried to convince Mr. Alcocer Chavez to sign  
12 documents without effectively communicating what the documents say.

13 558. Though Mr. Alcocer Chavez had access to a videophone when he was  
14 incarcerated in Riverside, California, he has not had access to a videophone in ICE  
15 detention at the Nevada Southern Detention Center or at Adelanto. Mr. Alcocer  
16 Chavez has requested a videophone at Adelanto, but a supervisor denied his  
17 request; instead, he was given limited access to Skype for short periods of time, and  
18 he is no longer allowed to even use Skype. He has also been granted TTY access  
19 for short periods of time. Yet the TTY is an antiquated communication system  
20 largely replaced in the deaf community by videophone. TTYs requires typing,  
21 which is difficult for most deaf people, including Mr. Alcocer Chavez, because of  
22 limited reading and writing skills in English. When Mr. Alcocer Chavez uses the  
23 TTY, guards take him to the intake area and lock him in a holding tank for hours  
24 before and after the call, measures not required of hearing detained individuals who  
25 wish to use a conventional telephone. As a result of ICE's failure to reasonably  
26 accommodate Mr. Alcocer Chavez, he has not been able to effectively  
27 communicate with his lawyers by phone while in detention.

1           559. Defendants also fail to ensure effective communication for detained  
2 individuals with vision disabilities.

3           560. For example, Plaintiff José Baca Hernández is blind. Neither Theo  
4 Lacy, where he had been detained, nor Adelanto, where he is currently detained,  
5 provided Mr. Baca a means of reading documents about his immigration case or  
6 medical care privately and independently, such as with a screen reader. At both  
7 facilities, Mr. Baca has been forced to rely on others—his cell mates, attorneys,  
8 and, at times, guards—to read documents for him. When he has needed to submit  
9 something in writing, such as a request to meet with an ICE officer, he has had to  
10 rely on others to write it for him.

11           561. Additionally, Detention Facilities routinely fail to provide inmates  
12 with mobility and other physical disabilities access to mobility devices, auxiliary  
13 aids, or other reasonable accommodations for their disability related-needs, and  
14 they often lack adequate processes to ensure that such accommodations are  
15 provided when needed.

16           562. For example, Plaintiff Faour Abdallah Fraihat has knee and back pain  
17 and a disc problem in his lower back that require the use of a wheelchair for  
18 mobility; his legs become numb when he tries to walk more than 10 to 15 feet.  
19 Though Adelanto provided Mr. Fraihat with a temporary wheelchair when he  
20 arrived in December 2016, staff took it away after one month and did not return the  
21 wheelchair to him until February 2019, two days after he filed a grievance because  
22 he had been making daily requests for months. For the more than one year in  
23 between, Mr. Fraihat was unable to get to the yard or to the cafeteria to eat. When  
24 officers did not bring him food, he ate whatever he was able to purchase from the  
25 commissary. His friends were not allowed to bring food from the cafeteria to him.

26           563. Staff also assigned Mr. Fraihat to the top bunk in his cell, though it is  
27 not accessible to him. The few times he made it up into the top bunk, it was very  
28 painful for him and he could not get down to use the bathroom. One time, he

1 slipped on the floor because he could not climb up. Mr. Fraihat has never met with  
2 an ADA Coordinator at Adelanto, and several of his requests for reasonable  
3 accommodations have been denied or delayed.

4 564. Plaintiff Aristoteles Sanchez Martinez has an expanding hernia,  
5 neuropathy, and a foot injury that has caused a bone spur and bone deterioration. As  
6 a result, Mr. Martinez has pain and uses a wheelchair for mobility. When Mr.  
7 Sanchez Martinez was transferred to the Stewart facility, he was placed in full  
8 restraints and could not use his wheelchair—leaving him no choice but to walk,  
9 despite his documented medical conditions that impair his mobility Three days after  
10 he arrived at Stewart, he was given a “provisional” wheelchair that was too small  
11 and uncomfortable. Over two weeks after arriving at Stewart, he was given a used,  
12 heavy wheelchair that strained his hernia every time he pushed it. A month after  
13 arriving at Stewart, Mr. Sanchez Martinez was finally given a suitable wheelchair  
14 when another detained individual who used a wheelchair left. At Stewart, Mr.  
15 Sanchez Martinez also sometimes has difficulty going through doorways without  
16 assistance from others. He was never offered a cane or crutches to help him walk  
17 shorter distances. There is one accessible shower, but the shower seat appears  
18 broken and not properly affixed and Mr. Sanchez Martinez fears using it. Instead,  
19 he has to use the wall to try to support himself when he showers.

20 565. When Mr. Sanchez Martinez arrived at Stewart, he was also forced to  
21 choose between his hernia belt and his back brace, despite the two accommodations  
22 serving different purposes from one another. Mr. Sanchez Martinez unwillingly  
23 relinquished his back brace. Despite requiring a cane or crutches to improve  
24 circulation throughout his feet, Mr. Sanchez Martinez has not been provided with  
25 either to help him move short distances.

26 566. Plaintiff Ruben Darío Mencías Soto has required multiple mobility  
27 aids after a fall in the shower while in detention severely reduced his mobility. At  
28 one time, Adelanto staff took away his crutches and told him he could have

1 crutches or a wheelchair, but not both. At the beginning of June, Adelanto took his  
2 wheelchair away, even though it is too painful for him to walk to the doctor or the  
3 cafeteria every time he needs to. Thus, for over a month, Mr. Mencías Soto ate only  
4 one meal a day at the cafeteria and tried to cobble together enough food from the  
5 commissary for the rest of the day. Rather than provide him with a mobility device,  
6 staff had suggested Mr. Mencías Soto live in the medical unit, where he will not  
7 have access to socialization or recreation activities. Mr. Mencías Soto only recently  
8 got his wheelchair back after sustained advocacy by an attorney.

9 567. Plaintiff Jimmy Sudney received reasonable accommodations in prison  
10 that are denied in ICE detention. For example, he had a wedge in prison to allow  
11 him to sleep with his head up so that his eye would drain, but the Adelanto ADA  
12 Coordinator denied his request because ICE has a “different standard.” In prison,  
13 Mr. Sudney had special shoes for his flat feet, but Adelanto denied his request  
14 because the shoes have laces. In prison, Mr. Sudney had prescription tinted glasses,  
15 but ICE would not pay for what the doctor prescribed so he has lower-quality  
16 glasses. An officer at Adelanto calls out “blind man walking” when she sees Mr.  
17 Sudney walk by with his tinted glasses, and one time, she tried to take them away.  
18 Mr. Sudney spoke with the ADA Coordinator about this harassment and he said,  
19 “Can’t do nothing about it. They bully you here.”

20 568. Because of the acute pain stemming from his right hip, legs, and feet,  
21 Plaintiff Alex Hernandez cannot stay standing for more than 15 to 20 minutes at a  
22 time. Mr. Hernandez would benefit from a cane or walking stick.

23 569. Further, Mr. Hernandez requested an additional chair for his  
24 designated-accessible cell after experiencing increased pain with prolonged sitting  
25 or standing. He was told that the medical unit does not provide special chairs and to  
26 instead change positions when he was in pain, despite Mr. Hernandez already  
27 having received oral confirmation from Etowah staff that he could receive a  
28 medical request pass for the chair. Because of his back and hip pain, it is painful for



1 him to sit on a stool because it offers no support. Further, although Mr. Hernandez,  
2 was told his cell is accessible, it does not have a handrail by his toilet and it is  
3 difficult for him to support himself as he gets up. Mr. Hernandez was not housed in  
4 a cell that has a handrail by the toilet to assist with support.

5 570. Similarly, Mr. Hernandez does not have access to a handicapped  
6 shower properly equipped with a shower seat. He is terrified of falling and further  
7 injuring himself in the shower.

8 571. Mr. Hernandez had to wait over a month for a bottom bunk to open up,  
9 despite having a medical pass for that bunk approved on December 21, 2018.  
10 During the time he was waiting, he was forced to climb to a top bunk without a  
11 ladder. He had to use tremendous effort on his right shoulder to climb up and down  
12 the top bunk.

13 572. Plaintiff Sergio Salazar Artaga has been delayed and denied reasonable  
14 accommodations for his cerebral palsy, a mobility disability that makes it difficult  
15 for him to walk and to use the right side of his body. His metal cane was  
16 confiscated when he entered Florence, and he did not receive a wooden replacement  
17 until a day or two later. Because the accessible shower was broken, Mr. Salzar  
18 Artaga also requested a shower chair multiple times to avoid falling. He received it  
19 only after he had been at Florence for nearly three months.

20 573. Mr. Salazar Artaga also requested shoes and braces for his legs and  
21 knee so that he can walk more stably in the facility. He had two falls inside  
22 Florence, only after which he was provided more stable shoes. After receiving his  
23 shoes, he still had a third fall on his way to immigration court on April 23, 2019,  
24 but he still has not been provided with leg or knee braces. The first medical  
25 provider he requested them from at Florence was unfamiliar with these braces, and  
26 the second made a request for Mr. Salazar Artaga to receive the braces, provided  
27 that they did not interfere with safety or security at the facility. However, when Mr.  
28 Salazar Artaga went to an outside clinic for prosthetics and orthotics, he was told

1 that he would not receive the braces until ICE authorized payment for them. No  
2 such authorization has happened to date, so Mr. Salazar Artaga walks unsteadily  
3 without the aid of leg or knee braces, in constant fear that he will fall again.

4 574. Further, Defendants select Detention Facilities that are located in  
5 remote, rural areas that do not have access to internal or off-site care providers,  
6 with the effect that detained individuals with disabilities do not receive the care and  
7 treatment necessary for them to have meaningful access to the privileges and  
8 advantages of these Facilities provided to nondisabled detainees.

9 575. Defendants' practice of detaining people in remotely located facilities  
10 also causes a shortage in resources available to accommodate people with  
11 disabilities. For example, the area around LaSalle is devoid of Mexican Sign  
12 Language and other rarer sign language interpreters, so Defendants cannot  
13 accommodate individuals who are deaf or hard of hearing. In addition, a shortage of  
14 qualified mental health professionals in these areas leads to mental health  
15 conditions going untreated and cognitive disabilities going unaccommodated.

16 576. Many of the Detention Facilities are also not accessible for persons  
17 with mobility impairments, and often are not equipped with videophone or video  
18 relay technology, further preventing Defendants from providing reasonable  
19 accommodations to detained individuals who are deaf or hard of hearing. Similarly,  
20 Defendants fail to ensure that Detention Facilities have screen readers and other  
21 accommodations to assist those who are blind or have low vision.

22 577. Defendants' decision to contract with facilities without ensuring they  
23 have necessary services available is a significant contributing factor to their  
24 inability to provide adequate care and program access for members of the Disability  
25 Subclass.

26 578. For example, Plaintiff Raul Alcocer Chavez is Deaf and communicates  
27 in ASL, but has never been provided ASL interpretation at Adelanto. When Mr.  
28 Alcocer Chavez requested to use a videophone at Adelanto, which would have

1 enabled him to call his hearing lawyer with the use of an interpreter, a supervisor  
2 denied his request. Additionally, ICE officials have tried to convince Mr. Alcocer  
3 Chavez to sign documents without providing effective communication regarding  
4 what the documents say.

5 579. As another example, in Folkston, the medical unit that Plaintiff  
6 Aristoteles Sanchez Martinez visited twice a day to receive his insulin shots was in  
7 a different building. He would either have other detained individuals help him to  
8 the medical unit or he would strain his hernia and push himself there in his  
9 wheelchair. His wheelchair did not easily fit through the doorways and there were  
10 ramps and other walkways that required assistance for him to navigate. At Folkston,  
11 whenever he had a legal visit, he had to use a non-accessible van to go to the visit.  
12 Lifting himself in and out of the non-accessible van would cause him to strain his  
13 hernia and risk falling due to his Charcot's foot, neuropathy, and other conditions  
14 that impact his balance and mobility.

15 **6. Defendants Systemically Fail to Ensure Contractors do Not Subject**  
16 **Detained Individuals with Disabilities to Discrimination on the Basis of**  
17 **Their Disability.**

18 580. The criteria used by Defendants to enter into, expand, and renew  
19 contracts with contractors do not take into consideration whether the contractors  
20 have engaged in disability discrimination or whether they have effective systems in  
21 place to ensure that detained individuals with disabilities are afforded rights secured  
22 under Section 504.

23 581. This failure directly conflicts with the Defendants' Section 504  
24 implementing regulations, which require Defendants to ensure that contract  
25 facilities and programs are readily accessible to and usable by detained individuals  
26 with disabilities. 6 C.F.R. §§ 15.10, 15.51.  
27  
28

1           582. Many contractors used by Defendants to operate Detention Facilities  
2 have a well-documented track record of failing to comply with disability statutes,  
3 including Section 504.

4           583. For example, one of Defendant's largest contractors, CoreCivic, fails  
5 to provide assistive devices, such as corrective lenses, to detained individuals with  
6 disabilities.<sup>560</sup>

7           584. Additionally, as set forth above, GEO-operated Adelanto has been the  
8 subject of numerous investigations, reports, and complaints documenting disability  
9 discrimination.<sup>561</sup>

10           585. GEO also operates the Aurora and South Texas Detention Facilities,  
11 and detained individuals with disabilities have been subjected to documented  
12 discrimination in both of those facilities.<sup>562</sup>

13           586. Nevertheless, ICE recently expanded its contract with GEO to increase  
14 the capacity of the Aurora facility,<sup>563</sup> and also awarded a direct contract to GEO to  
15

16 \_\_\_\_\_  
17 <sup>560</sup> Detainee Allies, *Testimony from Migrants and Refugees in the Otay Mesa*  
18 *Detention Center*, at 13 (Jan. 2019), [http://www.detaineeallies.org/wp-](http://www.detaineeallies.org/wp-content/uploads/2019/01/FINAL_Detainee-Allies-2019-0131b.pdf)  
19 [content/uploads/2019/01/FINAL\\_Detainee-Allies-2019-0131b.pdf](http://www.detaineeallies.org/wp-content/uploads/2019/01/FINAL_Detainee-Allies-2019-0131b.pdf).

20 <sup>561</sup> See, e.g., Disability Rights California, *supra* note 36.

21 <sup>562</sup> See, e.g., Letter from American Immigration Council & American Immigration  
22 Lawyers Association to Thomas Homan, Acting Dir., Immigration & Customs  
23 Enf't, Dep't of Homeland Sec. et al. (June 4, 2018) at 15,  
24 [http://www.americanimmigrationcouncil.org/sites/default/files/general\\_litigation/co](http://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_demands_investigation_into_inadequate_medical_and_mental_health_care_condition_in_immigration_detention_center.pdf)  
25 [mplaint\\_demands\\_investigation\\_into\\_inadequate\\_medical\\_and\\_mental\\_health\\_care](http://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_demands_investigation_into_inadequate_medical_and_mental_health_care_condition_in_immigration_detention_center.pdf)  
26 [\\_condition\\_in\\_immigration\\_detention\\_center.pdf](http://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_demands_investigation_into_inadequate_medical_and_mental_health_care_condition_in_immigration_detention_center.pdf) (Aurora); Human Rights First,  
27 *Ailing Justice: Texas* (June 2018),  
28 [https://www.humanrightsfirst.org/sites/default/files/Ailing\\_Justice\\_Texas.pdf](https://www.humanrightsfirst.org/sites/default/files/Ailing_Justice_Texas.pdf)  
(South Texas).

<sup>563</sup> *Extension of Use for Surge Beds at Aurora CDF*, Federal Business  
Opportunities,  
[https://www.fbo.gov/index.php?s=opportunity&mode=form&id=24bf5af8f106d92a](https://www.fbo.gov/index.php?s=opportunity&mode=form&id=24bf5af8f106d92a3abc7bc98fb8a51f&tab=core&_cview=0)  
[3abc7bc98fb8a51f&tab=core&\\_cview=0](https://www.fbo.gov/index.php?s=opportunity&mode=form&id=24bf5af8f106d92a3abc7bc98fb8a51f&tab=core&_cview=0).

1 continue operating Mesa Verde in California after the municipality with which ICE  
2 originally contracted withdrew from the contract.<sup>564</sup>

3 587. Plaintiff Hamida Ali had a GEO-employed security guard inform her  
4 that she should stop saying that she was suicidal—so Ms. Ali declined to seek  
5 medical help at a moment when she was actively expressing suicidal ideation, even  
6 though she had a history of suicidal ideation and attempts.

7 588. Plaintiff Aristoteles Sanchez Martinez has experienced several  
8 instances where he has been forced by contractors to abandon his accommodations.  
9 For example, when he was transferred from Folkston to Stewart, Mr. Sanchez  
10 Martinez was placed in full restraints, and staff did not allow him to use his  
11 wheelchair. He was forced to walk throughout the entire day of transport in  
12 constant fear of falling and suffering from potentially fatal consequences. In  
13 addition, upon arriving at Stewart, the medical staff forced him to choose between  
14 his back brace and hernia belt.

15 589. In addition to repeatedly being denied effective communication in the  
16 form of ASL interpretation and videophone access, Plaintiff Raul Alcocer Chavez  
17 has experienced several instances of harassment by staff at Adelanto. Mr. Alcocer  
18 Chavez is Deaf and communicates in ASL. Staff at Adelanto mock him for that  
19 fact; they respond to his signing with gang signs, and they refuse to write back  
20 when he attempts to communicate with them in writing with his limited English. On  
21 one occasion, a staff member used his foot to get Mr. Alcocer Chavez's attention.

22 590. On information and belief, the criteria used by Defendants to enter  
23 into, expand, and renew contracts with contractors do not take into consideration  
24 whether the contractors have engaged in disability discrimination, or whether they  
25

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26 <sup>564</sup> Joseph Luiz, *Mesa Verde center will stay open with new contract*, The  
27 Bakersfield Californian, [https://www.bakersfield.com/news/mesa-verde-center-will-stay-open-with-new-contract/article\\_29aef992-410b-11e9-a913-c75ff002d758.html](https://www.bakersfield.com/news/mesa-verde-center-will-stay-open-with-new-contract/article_29aef992-410b-11e9-a913-c75ff002d758.html).  
28

1 have effective systems in place to ensure that detained individuals with disabilities  
2 are afforded rights secured under Section 504.

3 591. This failure directly conflicts with Defendants' Section 504  
4 implementing regulations. Those regulations direct Detention Facilities to afford  
5 persons with disabilities equal opportunity to participate in or benefit from  
6 facilities' aids, benefits, or services, and to administer programs and activities in the  
7 most integrated setting appropriate. 6 C.F.R. § 15.30(b)(1).

8 592. As a result, members of the Disability Subclass have been denied such  
9 rights and are at significant risk of being denied those rights in the future.

10 **B. The Fifth Amendment Prohibits the Federal Government from**  
11 **Subjecting Members of the Disability Subclass to Conditions That Rise**  
12 **to the Level of Punishment.**

13 593. The Disability Plaintiffs and the Disability Subclass challenge ICE's  
14 failure to ensure that Detention Facilities do not subject civil detainees with  
15 disabilities to conditions that rise to the level of punishment.

16 594. Defendants fail to adequately monitor and oversee disability-related  
17 practices in Detention Facilities.

18 595. As a result, detained individuals with disabilities are subjected to the  
19 Disability Practices, which individually and collectively constitute punishment  
20 because they are expressly intended to punish, are not reasonably related to a  
21 legitimate governmental objective, and/or are excessive in relation to that objective.

22 596. In addition, due process requires that conditions in civil Detention  
23 Facilities may not be the same as or worse than those in a prison. *See King v. Cty.*  
24 *of Los Angeles*, 885 F.3d 548, 556–57 (9th Cir. 2018). However, as described in  
25 detail earlier in this Complaint, Defendants fail to ensure that detained individuals  
26 with disabilities are held in conditions that are not the same as or worse than those  
27 for persons with disabilities in criminal detention.

1           597. For example, Plaintiff Jimmy Sudney received reasonable  
2 accommodations in prison that were denied to him in ICE detention. Though Mr.  
3 Sudney had a wedge in prison to allow him to sleep with his head up so that his eye  
4 would drain, Eloy and Adelanto denied his request, both stating that ICE has a  
5 “different standard.” In prison, Mr. Sudney had special shoes for his flat feet, but  
6 Adelanto denied his request because the shoes have laces. In prison, Mr. Sudney  
7 had prescription tinted glasses, but ICE would not pay for what the doctor  
8 prescribed so he has to make do with lower-quality glasses that his family  
9 purchased for him.

10           598. As another example, Plaintiff Raul Alcocer Chavez is Deaf and,  
11 though he had access to a videophone while he was in Riverside County Jail, he has  
12 not had access to a videophone in ICE detention. Mr. Alcocer Chavez has requested  
13 a videophone at Adelanto, but a supervisor denied his request, implying that he was  
14 a liar and had already used it. He has only been granted occasional Skype calls to  
15 his family, and TTY access for short periods of time. Yet TTY is an outdated  
16 technology that requires typing, which is difficult for Mr. Alcocer Chavez because  
17 he has limited reading and writing skills in English. A videophone would allow him  
18 to communicate in his primary language, ASL. Mr. Alcocer Chavez had better  
19 communication because of the videophone in the Riverside County Jail.

20           599. Plaintiff José Baca Hernández is blind and, when he was in jail, an  
21 ADA Coordinator checked in with him monthly regarding his need for  
22 accommodations and other disability-related needs. In ICE detention, neither Theo  
23 Lacy nor Adelanto conducted an intake that included a discussion of reasonable  
24 accommodations. At Adelanto, it took more than one year from the time he arrived  
25 at the facility for an ADA Coordinator to meet with him.  
26  
27  
28

**CLASS ALLEGATIONS**

**IX. Class**

600. All individual Plaintiffs bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a class of all people currently detained, or who in the future will be detained, in ICE custody who are now, or will in the future be, subjected to the Challenged Practices as a result of Defendants’ failure to adequately administer, monitor, or oversee conditions at Detention Facilities (the “Class”).

601. The Class is so numerous that joinder of all members is impracticable. Recent reports state that the daily population of ICE detainees in Detention Facilities exceeds 50,000,<sup>565</sup> all of whom are at serious risk of substantial harm due to Defendants’ wholly inadequate monitoring and oversight policies and practices. Members of the Class are geographically dispersed at Detention Facilities throughout the country.

602. There are questions of law and fact common to the members of the Class. Such questions include, but are not limited to:

- a. Whether, as a result of Defendants’ failure to ensure that Detention Facilities provide minimally adequate health care and other conditions of confinement, members of the Class are subjected to one or more Challenged Practices;
- b. Whether, as a result of Defendants’ failure to ensure that Detention Facilities provide minimally adequate health care and other conditions of confinement, members of the Class are subjected to punishment in violation of the Due Process Clause of the Fifth Amendment;

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<sup>565</sup> Isabela Dias, *ICE Is Detaining More People Than Ever—and for Longer*, Pacific Standard (Aug. 1, 2019), <https://psmag.com/news/ice-is-detaining-more-people-than-ever-and-for-longer>.



- 1 c. Whether, as a result of Defendants' failure to ensure that  
2 Detention Facilities provide minimally adequate health care and  
3 other conditions of confinement, members of the Class are at  
4 substantial risk of serious harm in violation of the Due Process  
5 Clause of the Fifth Amendment;
- 6 d. Whether Defendants have been deliberately indifferent to the  
7 serious health care and other needs of Class members; and
- 8 e. Whether Defendants have systemically abdicated their  
9 constitutional and statutory duty to monitor conditions in the  
10 Detention Facilities.

11 603. Defendants are expected to raise common defenses to these claims,  
12 including denying that their actions violate the law.

13 604. The claims of the Plaintiffs are typical of those of the Class, as their  
14 claims arise from the same policies, practices, omissions, or courses of conduct, and  
15 their claims are based on the same theory of law as the Class's claims.

16 605. Plaintiffs are capable of fairly and adequately protecting the interests  
17 of the Class because Plaintiffs do not have any interests antagonistic to the Class.  
18 Plaintiffs, as well as the Class members, seek to enjoin the unlawful acts and  
19 omissions of Defendants. Finally, Plaintiffs are represented by counsel experienced  
20 in civil rights litigation, litigation regarding the rights of detained individuals, and  
21 complex class action litigation.

22 606. This action is maintainable as a class action pursuant to Federal Rule  
23 of Civil Procedure 23(b)(1) because there are more than 50,000 class members, and  
24 the prosecution of separate actions by individuals would create a risk of  
25 inconsistent and varying adjudications, which in turn could establish conflicting  
26 and incompatible standards of conduct for Defendants. Additionally, the  
27 prosecution of separate actions by individual members could result in adjudications  
28

1 with respect to individual members that, as a practical matter, would substantially  
2 impair the ability of other members to protect their interests.

3 607. This action is also maintainable as a class action pursuant to Federal  
4 Rule of Civil Procedure 23(b)(2) because Defendants' policies, practices, actions,  
5 and omissions that form the basis of this Complaint are common to and apply  
6 generally to all members of the Class, and the injunctive and declaratory relief  
7 sought is appropriate and will apply to all members of the Class. Defendants'  
8 monitoring and oversight practices and policies are centrally promulgated,  
9 disseminated, and enforced. The injunctive and declaratory relief sought is  
10 appropriate and will apply to all members of the Class.

#### 11 **X. Segregation Subclass**

12 608. The Segregation Plaintiffs bring this action on their own behalf and,  
13 pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil  
14 Procedure, on behalf of a subclass (the "Segregation Subclass") consisting of all  
15 people currently detained, or who in the future will be detained, in ICE custody  
16 who are now, or will in the future be, subjected to the Segregation Practices as a  
17 result of Defendants' failure to adequately administer, monitor, or oversee  
18 conditions at Detention Facilities.

19 609. The Segregation Subclass is so numerous that joinder of all members  
20 is impracticable. For example, a 2017 OIG report looked at segregation placements  
21 at just seven facilities from October 1, 2015, to June 30, 2016. During that time,  
22 there were 713 segregation placements for detained individuals with mental health  
23 conditions.<sup>566</sup> In addition, members of the Segregation Subclass are geographically  
24 dispersed at Detention Facilities throughout the country.

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26 <sup>566</sup> Office of Inspector Gen., Dep't of Homeland Sec., *OIG-17-119: ICE Field*  
27 *Offices Need to Improve Compliance with Oversight Requirements for Segregation*  
28 *of Detainees with Mental Health Conditions*, at 15 (Sep. 29, 2017),  
<https://www.oig.dhs.gov/sites/default/files/assets/2017-11/OIG-17-119-Sep17.pdf>.

1           610. There are questions of law and fact common to the members of the  
2 Segregation Subclass. Such questions include, but are not limited to:

- 3           a. Whether Defendants violate the Due Process Clause of the Fifth  
4 Amendment by failing to ensure that placement of detained  
5 individuals in administrative and disciplinary segregation at  
6 Detention Facilities is consistent with constitutional  
7 requirements;
- 8           b. Whether Defendants have been deliberately indifferent to the  
9 Subclass members' serious risk of substantial injury from the  
10 debilitating isolation and inhumane conditions to which they are  
11 subjected; and
- 12           c. Whether the Segregation Practices constitute punishment in  
13 violation of the Due Process Clause of the Fifth Amendment.

14           611. Defendants are expected to raise common defenses to these claims,  
15 including denying that their actions violated the law.

16           612. The claims of the Segregation Plaintiffs are typical of those of the  
17 Segregation Subclass, as their claims arise from the same policies, practices, or  
18 courses of conduct, and their claims are based on the same theory of law as the  
19 Segregation Subclass's claims.

20           613. The Segregation Plaintiffs are capable of fairly and adequately  
21 protecting the interests of the Segregation Subclass because these Plaintiffs do not  
22 have any interests antagonistic to the Subclass. The Segregation Plaintiffs, as well  
23 as the Segregation Class members, seek to enjoin the unlawful acts and omissions  
24 of Defendants. Finally, the Segregation Plaintiffs are represented by counsel  
25 experienced in civil rights litigation, litigation regarding the rights of detained  
26 individuals, and complex class action litigation.

27           614. This action is maintainable as a class action pursuant to Federal Rule  
28 of Civil Procedure 23(b)(1) because the Segregation Subclass exceeds 1,000

1 members, and the prosecution of separate actions by individuals would create a risk  
2 of inconsistent and varying adjudications, which in turn could establish  
3 incompatible standards of conduct for Defendants. Additionally, the prosecution of  
4 separate actions by individual members could result in adjudications with respect to  
5 individual members that, as a practical matter, would substantially impair the ability  
6 of other members to protect their interests.

7 615. This action is also maintainable as a class action pursuant to Federal  
8 Rule of Civil Procedure 23(b)(2) because Defendants' monitoring and oversight  
9 policies and practices regarding segregation are common to and apply generally to  
10 all members of the Segregation Subclass, and the injunctive and declaratory relief  
11 sought is appropriate and will apply to all members of the Segregation Subclass.  
12 Defendants' monitoring and oversight practices and policies regarding segregation  
13 are centrally promulgated, disseminated, and enforced. The injunctive and  
14 declaratory relief sought is appropriate and will apply to all members of the  
15 Segregation Subclass.

## 16 **XI. Disability Subclass**

17 616. The Disability Plaintiffs bring this action on their own behalf and,  
18 pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil  
19 Procedure, on behalf of a subclass (the "Disability Subclass") consisting of all  
20 qualified individuals with a disability, as that term is defined in 29 U.S.C. § 705(9),  
21 who are now, or will in the future be, subjected to the Disability Practices as a  
22 result of Defendants' failure to adequately administer, monitor, and oversee  
23 conditions at Detention Facilities.

24 617. The Disability Subclass is so numerous that joinder of all members is  
25 impracticable. For example, according to a 2008 Washington Post report, internal  
26 ICE memos estimate that about 15% of the detained population (which would be in  
27 excess of 8,000 detained individuals with today's detention population) have  
28

1 mental health disabilities.<sup>567</sup> The total number of detained individuals with any  
2 disability exceeds this number. In addition, the Disability Subclass is  
3 geographically dispersed at Detention Facilities throughout the country.

4 618. There are questions of law and fact common to the members of the  
5 Disability Subclass. Such questions include, but are not limited to:

- 6 a. Whether Defendants' failure to ensure that Detention Facilities  
7 have in place systems that identify detained individuals with  
8 disabilities, and provide for reasonable accommodations for  
9 detained individuals with disabilities, violates Section 504;
- 10 b. Whether Defendants' failure to ensure that Detention Facilities  
11 have in place systems to provide auxiliary aids and services to  
12 ensure effective communications with detained individuals with  
13 disabilities violates Section 504;
- 14 c. Whether Defendants' failure to ensure that Detention Facilities  
15 do not use segregation in lieu of proper mental health treatment  
16 violates Section 504;
- 17 d. Whether the discriminatory effect on detained individuals with  
18 disabilities of Defendants' selection of Detention Facilities and  
19 contractors violates Section 504; and
- 20 e. Whether the Disability Practices constitute punishment in  
21 violation of the Due Process Clause of the Fifth Amendment.

22 619. Defendants are expected to raise common defenses to these claims,  
23 including denying that their actions violated the law.

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26 <sup>567567</sup> Dana Priest et al., *Suicides Point to Gaps in Treatment: Errors in Psychiatric*  
27 *Diagnoses and Drugs Plague Strained Immigration System*, Wash. Post (May 13,  
28 2008), [https://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc\\_d3p1.html?noredirect=on](https://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html?noredirect=on).

1           620. The claims of the Disability Plaintiffs are typical of those of the  
2 Disability Subclass, as their claims arise from the same policies, practices, or  
3 courses of conduct, and their claims are based on the same theory of law as the  
4 Disability Subclass's claims.

5           621. Plaintiffs are capable of fairly and adequately protecting the interests  
6 of the Disability Subclass because the Disability Plaintiffs do not have any interests  
7 antagonistic to the class. The Disability Plaintiffs, as well as the Disability Subclass  
8 members, seek to enjoin the unlawful acts and omissions of Defendants. Finally,  
9 the Disability Plaintiffs are represented by counsel experienced in civil rights  
10 litigation, litigation regarding the rights of detained individuals, and complex class  
11 action litigation.

12           622. This action is maintainable as a class action pursuant to Federal Rule  
13 of Civil Procedure 23(b)(1) because the Disability Subclass exceeds 8,000  
14 members, and the prosecution of separate actions by individuals would create a risk  
15 of inconsistent and varying adjudications, which in turn could establish  
16 incompatible standards of conduct for Defendants. Additionally, the prosecution of  
17 separate actions by individual members could result in adjudications with respect to  
18 individual members that, as a practical matter, would substantially impair the ability  
19 of other members to protect their interests.

20           623. This action is also maintainable as a class action pursuant to Federal  
21 Rule of Civil Procedure 23(b)(2) because Defendants' monitoring and oversight  
22 policies and practices relevant to detained individuals with disabilities are common  
23 to and apply generally to all members of the Disability Subclass, and the injunctive  
24 and declaratory relief sought is appropriate and will apply to all members of the  
25 Disability Subclass. Defendants' disability policies are centrally promulgated,  
26 disseminated, and enforced. The injunctive and declaratory relief sought is  
27 appropriate and will apply to all members of the Disability Subclass.  
28

1 CLAIMS FOR RELIEF

2 FIRST CLAIM FOR RELIEF

3  
4 **XII. Violation of the Due Process Clause of the Fifth Amendment: Failing to**  
5 **Monitor and Prevent the Challenged Practices (All Plaintiffs and the**  
6 **Class Against All Defendants).**

7 624. Plaintiffs reallege and incorporate the allegations set forth in the  
8 preceding paragraphs as though fully set forth herein.

9 625. By their policies, omissions, and practices described herein,  
10 Defendants fail to adequately monitor, oversee, and administer Detention Facilities,  
11 and as a result, Plaintiffs and the Class are subjected to the Challenged Practices.

12 626. The Challenged Practices, alone or in combination, constitute  
13 punishment and subject Individual Plaintiffs and the Class to a significant risk of  
14 serious harm.

15 627. As a result of the Challenged Practices, the Organizational Plaintiffs  
16 have had to divert resources, and have had their missions frustrated.

17 628. Defendants have a nondelegable duty to ensure that the conditions of  
18 confinement in the facilities operated by ICE's employees and contractors are  
19 constitutionally adequate.

20 629. These policies, omissions, and practices have been and continue to be  
21 implemented by Defendants and their agents, officials, employees, and all persons  
22 acting in concert with them, in their official capacities, and are the proximate cause  
23 of the Plaintiffs' and the Class's ongoing deprivation of rights secured by the  
24 United States Constitution under the Fifth Amendment.

25 630. Defendants have been and are aware of all the deprivations  
26 complained of herein and have condoned or been deliberately indifferent to such  
27 conduct.  
28

**SECOND CLAIM FOR RELIEF**

**XIII. Violation of the Due Process Clause of the Fifth Amendment: Failing to Monitor and Prevent the Segregation Practices (Organizational Plaintiffs, Segregation Plaintiffs, and the Segregation Subclass Against All Defendants).**

631. Plaintiffs reallege and incorporate the allegations set forth in the preceding paragraphs as though fully set forth herein.

632. By their policies, omissions, and practices described herein, Defendants fail to adequately monitor, oversee, and administer segregation at Detention Facilities. As a result, the Segregation Plaintiffs and the Segregation Subclass are subjected to the Segregation Practices, which constitute punishment and subject them to a substantial risk of serious harm and injury, including without limitation harm to their mental health and subjecting them to conditions of extreme social isolation and environmental deprivation.

633. As a result of the Segregation Practices, the Organizational Plaintiffs have had to divert resources, and have had their missions frustrated.

634. These policies, omissions, and practices have been and continue to be implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them, in their official capacities, and are the proximate cause of the Organizational Plaintiffs, Segregation Plaintiffs' and the Segregation Subclass's ongoing deprivation of rights secured by the United States Constitution under the Fifth Amendment.

635. Defendants have a nondelegable duty to ensure that detained individuals are not subject to segregation practices that constitute punishment, or that create a substantial risk of significant harm and injury from inadequate mental health treatment and conditions of extreme social isolation and environmental deprivation.



1 636. Defendants have been and are aware of all the deprivations  
2 complained of herein and have condoned or been deliberately indifferent to such  
3 conduct.

4 **THIRD CLAIM FOR RELIEF**

5 **XIV. Violation of Due Process Clause of the Fifth Amendment: Failing to**  
6 **Monitor and Prevent Disability-Related Practices That Constitute**  
7 **Punishment (Organizational Plaintiffs, Disability Plaintiffs, and**  
8 **Members of the Disability Subclass Against All Defendants).**

9 637. Plaintiffs reallege and incorporate the allegations set forth in the  
10 preceding paragraphs as though fully set forth herein.

11 638. By their policies, omissions, and practices described herein,  
12 Defendants fail to adequately monitor, oversee, and administer Detention Facilities.  
13 As a result, the Disability Plaintiffs and the Disability Subclass are subject to  
14 conditions of confinement that constitute punishment.

15 639. As a result of these policies, omissions, and practices, the  
16 Organizational Plaintiffs have had to divert resources, and have had their missions  
17 frustrated.

18 640. These policies, omissions, and practices have been and continue to be  
19 implemented by Defendants and their agents, officials, employees, and all persons  
20 acting in concert with them, in their official capacities, and are the proximate cause  
21 of the Organizational Plaintiffs, Disability Plaintiffs' and the Disability Subclass's  
22 ongoing deprivation of rights secured by the United States Constitution under the  
23 Fifth Amendment.

24 641. Defendants have a nondelegable duty to ensure that members of the  
25 Disability Subclass are not held in conditions that are punitive in violation of the  
26 Due Process Clause.

27 642. The conditions described above for members of the Disability  
28 Subclass, alone or in combination, are identical to, similar to, or more restrictive

1 than those under which persons accused or convicted of crimes are confined in jails  
2 or prisons; are expressly intended to punish civil detainees; are not reasonably  
3 related to legitimate governmental objective; and/or are excessive in relation to any  
4 proffered objective and more restrictive than necessary. This violates the Due  
5 Process Clause.

6 643. Defendants have been and are aware of all the deprivations  
7 complained of herein and have condoned or been deliberately indifferent to such  
8 conduct.

9 **FOURTH CLAIM FOR RELIEF**

10 **XV. Violation of Section 504 of the Rehabilitation Act, 29 U.S.C. § 794**  
11 **(Organizational Plaintiffs, Disability Plaintiffs, and the Disability**  
12 **Subclass Against Defendants DHS, ICE, and IHSC).**

13 644. Plaintiffs reallege and incorporate the allegations set forth in the  
14 preceding paragraphs as though fully set forth herein.

15 645. At all times relevant to this action, Defendants are federal executive  
16 agencies within the meaning of the Rehabilitation Act. As such, they are required to  
17 comply with the provisions of Section 504.

18 646. Defendants are legally responsible for all violations of Section 504  
19 committed by their contractors arising from their operation of Detention Facilities.  
20 6 C.F.R. § 15.30(b)(1).

21 647. Defendants are also directly responsible for their systemic use of  
22 deficient monitoring and oversight practices and policies that result in the denial of  
23 detained individuals with disabilities' rights under Section 504. *Id.*

24 648. Detention Facilities are required to reasonably accommodate detained  
25 individuals with disabilities, to provide them with auxiliary aids and services, and  
26 to ensure effective communication, so that those detained individuals can avail  
27 themselves of and participate in all programs and activities offered at the Detention  
28 Facilities.

1           649. As described above, Defendants have failed to ensure that Detention  
2 Facilities reasonably accommodate the Disability Plaintiffs and members of the  
3 Disability Subclass, provide them with auxiliary aids and services, and provide  
4 them with effective communication.

5           650. Detention Facilities must also comply with regulations promulgated by  
6 DHS implementing Section 504. *See* 6 C.F.R. Part 15. Detention Facilities are in  
7 violation of many of these regulations, including without limitation by:

- 8           a. Denying the Disability Plaintiffs and members of the Disability  
9 Subclass “the opportunity to participate in or benefit from the  
10 aid, benefit, or service.” 6 C.F.R. § 15.30(b)(1)(i).
- 11           b. Affording the Disability Plaintiffs and members of the Disability  
12 Subclass with “an opportunity to participate in or benefit from  
13 the aid, benefit, or service that is not equal to that afforded  
14 others.” 6 C.F.R. § 15.30(b)(1)(ii).
- 15           c. Providing the Disability Plaintiffs and members of the Disability  
16 Subclass “with an aid, benefit, or service that is not as effective  
17 in affording equal opportunity to obtain the same result, to gain  
18 the same benefit, or to reach the same level of achievement as  
19 that provided to others.” 6 C.F.R. § 15.30(b)(1)(iii).
- 20           d. Providing the Disability Plaintiffs and members of the Disability  
21 Subclass with “different or separate aid, benefits or services . . .  
22 than is provided to others unless such action is necessary to  
23 provide qualified individuals with a disability with aid, benefits  
24 or services that are as effective as those provided to others.” 6  
25 C.F.R. § 15.30(b)(1)(iv).
- 26           e. Otherwise denying the Disability Plaintiffs and members of the  
27 Disability Subclass “the enjoyment of any right, privilege,  
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1 advantage, or opportunity enjoyed by others receiving the aid,  
2 benefit, or service.” 6 C.F.R. § 15.30(b)(1)(vi).

3 f. Using “criteria or methods of administration,” “directly or  
4 through contractual or other arrangements,” “the purpose or  
5 effect of which” is to subject the Disability Plaintiffs and  
6 members of the Disability Subclass to “discrimination on the  
7 basis of disability.” 6 C.F.R. § 15.30(b)(4), (b)(4)(i).

8 g. Using “criteria or methods of administration,” “directly or  
9 through contractual or other arrangements,” “the purpose or  
10 effect of which” is to “[d]efeate or substantially impair  
11 accomplishment of the objectives of a program or activity with  
12 respect to” the Disability Plaintiffs and members of the  
13 Disability Subclass. 6 C.F.R. § 15.30(b)(4)(ii).

14 h. Making determinations “concerning the site or location” of  
15 Detention Facilities, “the purpose or effect of which” as to the  
16 Disability Plaintiffs and members of the Disability Subclass is to  
17 “[e]xclude individuals with disabilities from, deny them the  
18 benefits of, or otherwise subject them to discrimination under  
19 any program or activity conducted by the Department.” 6 C.F.R.  
20 § 15.30(b)(5)(i).

21 i. Making determinations concerning “the site or location” of  
22 Detention Facilities, “the purpose or effect of which” is to  
23 “[d]efeate or substantially impair the accomplishment of the  
24 objectives of a program or activity” with respect to the  
25 Disability Plaintiffs and members of the Disability Subclass. 6  
26 C.F.R. § 15.30(b)(5), (b)(5)(ii).

27 j. Using “criteria” “in the selection of procurement contractors”  
28 that as to the Disability Plaintiffs and members of the Disability

1 Subclass “subject qualified individuals with a disability to  
2 discrimination on the basis of disability.” 6 C.F.R. § 15.30(b)(6).

3 k. Failing to “administer programs and activities in the most  
4 integrated setting appropriate to the needs of” the Disability  
5 Plaintiffs and members of the Disability Subclass. 6 C.F.R. §  
6 15.30(d).

7 l. Failing to conduct an adequate self-evaluation to identify  
8 modifications to policies and practices at Detention Facilities  
9 needed to ensure the programs and services at such facilities are  
10 readily accessible to and usable by detained individuals with  
11 disabilities, and to provide opportunity for input from the  
12 disability community in this process. 6 C.F.R. § 15.10; *see*  
13 *generally* 6. C.F.R. § 15.1 *et seq.*

14 m. Failing to conduct adequate transition planning to identify  
15 structural or other changes needed to achieve program  
16 accessibility at Detention Facilities. 6 C.F.R. § 15.50(d).

17 651. The Disability Plaintiffs and the Disability Subclass they represent are  
18 qualified individuals with disabilities as defined in the Rehabilitation Act.

19 652. Because of Defendants’ Disability Practices, and systemic policy and  
20 practice of failing to adequately monitor, oversee, and administer Detention  
21 Facilities, members of the Disability Subclass are subject to violations of Section  
22 504, including the Disability Practices, at Detention Facilities, and these violations  
23 are continuing and recurring.

24 653. As a result, the Disability Plaintiffs and the members of the Disability  
25 Subclass are discriminated against, not reasonably accommodated, do not have  
26 equal access to detention center activities, programs, and services for which they  
27 are otherwise qualified, and otherwise suffer violations of Section 504 by  
28 Defendants.

1           654. Further, as a result of these policies and practices, the Organizational  
2 Plaintiffs have had to divert resources, and have had their missions frustrated.

3           655. Accordingly, Defendants have violated rights secured under the  
4 Rehabilitation Act to the Organizational Plaintiffs, the Disability Plaintiffs and the  
5 Disability Subclass.

6   **PRAYER FOR RELIEF**

7           656. Plaintiffs and the Class and Subclasses they represent have no  
8 adequate remedy at law to redress the wrongs alleged in this complaint. Plaintiffs  
9 and the Class and Subclasses they represent have suffered and will continue to  
10 suffer irreparable injury as a result of the unlawful acts, omissions, policies, and  
11 practices of defendants, as alleged herein, unless Plaintiffs and the Class and  
12 Subclasses they represent are granted the relief they request. The need for relief is  
13 critical because the rights at issue are paramount under the United States  
14 Constitution and the laws of the United States.

15           657. WHEREFORE, the Plaintiffs and the Class and Subclasses they  
16 represent request that this Court grant them the following relief:

- 17           a. Declare that the suit is maintainable as a class action pursuant to  
18 Federal Rules of Civil Procedure 23(a), 23(b)(1), and 23(b)(2),  
19 and appoint the undersigned as Class Counsel;
- 20           b. Declare that the conditions, acts, omissions, policies, and  
21 practices described above are in violation of the rights of  
22 Plaintiffs and the Class and Subclasses they represent under the  
23 Fifth Amendment to the United States Constitution, and the  
24 Rehabilitation Act;
- 25           c. Permanently enjoin Defendants, their agents, employees, and  
26 officials, from subjecting Plaintiffs and the Class and Subclasses  
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1 to the illegal and unconstitutional conditions, acts, omissions,  
2 policies, and practices set forth above;

3 d. Order Defendants and their agents, employees, and officials to  
4 develop and implement, as soon as practicable, a plan to  
5 eliminate the substantial risk of serious harm, discrimination,  
6 and statutory violations that Plaintiffs and members of the Class  
7 and Subclasses they represent suffer due to the unlawful acts,  
8 omissions, conditions and practices described in this Complaint.  
9 Defendants' plan shall include at a minimum taking all  
10 necessary steps to ensure the following conditions at  
11 immigration Detention Facilities:

- 12 i. Access: Ensure that Individual Plaintiffs and the Class  
13 have timely access to healthcare;
- 14 ii. Specialty and chronic care: Ensure that Individual  
15 Plaintiffs and the Class have timely access to competent  
16 specialty care and care for chronic conditions;
- 17 iii. Training and qualifications: Ensure that Detention Facility  
18 staff and medical providers that provide healthcare to  
19 Individual Plaintiffs or the Class are adequately qualified  
20 and trained to carry out their duties;
- 21 iv. Emergency care: Ensure timely and competent responses  
22 to healthcare emergencies suffered by Individual  
23 Plaintiffs or the Class;
- 24 v. Screening: Ensure reliable screening for medical or  
25 mental health conditions of Individual Plaintiffs or the  
26 Class that need treatment;
- 27 vi. Staffing: Ensure staffing that is sufficient to provide  
28 Individual Plaintiffs and the Class with timely access to

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- qualified and competent clinicians who can provide routine, urgent, emergent, and specialty healthcare;
- vii. Mental health treatment: Ensure that Individual Plaintiffs and the Class have timely access to necessary treatment for serious mental health conditions, including medication, therapy, inpatient treatment, suicide prevention, and suicide watch;
  - viii. Medical records: Ensure that Defendants properly maintain medical records of Individual Plaintiffs and the Class, including by transferring medical records and medications with detained individuals when they are transferred to ensure continuity of care;
  - ix. Remote locations: Ensure that detained individuals are not placed in detention facilities in locations where necessary medical and mental health care are not reasonably and timely available;
  - x. Segregation: Ensure that the Segregation Plaintiffs and the Segregation Subclass are not confined in punitive segregation conditions, including conditions that are similar to, or worse than, those found in jails and prisons, and conditions that put them at substantial risk of serious physical or mental harm; are not placed in segregation because they are part of a vulnerable population; are properly monitored by Defendants for abuses in Detention Facilities' use of segregation; and are provided procedural safeguards to ensure fairness in segregation determinations; and



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- xi. Disability: Ensure that Detention Facilities have in place systems and practices so that the Disability Plaintiffs and the Disability Subclass are:
  - 1. Provided meaningful access to the programs, services, and facilities of Detention Facilities;
  - 2. Adequately screened to identify disability-related needs and ensure that such needs are effectively tracked throughout the entire period that members of the Disability Subclass are detained by Defendants;
  - 3. Not improperly subjected to segregation;
  - 4. Provided access to reasonable accommodations, auxiliary aids, and effective communication for disability-related needs in a timely manner;
  - 5. Provided with mobility aids in a timely manner;
  - 6. Not subjected to discrimination based on Defendants' determinations concerning the site or location of Detention Facilities;
  - 7. Not subjected to discrimination based on the criteria that Defendants use to select contractors to operate, in whole or in part, Detention Facilities; and
  - 8. Not confined in Detention Facilities with punitive conditions of confinement, including conditions that are similar to, or worse than, those for persons with disabilities found in jails and prisons;

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- xii. Award Plaintiffs the costs of this suit, and reasonable attorneys’ fees and litigation expenses;
- xiii. Retain jurisdiction of this case until Defendants have fully complied with the orders of this Court, and there is a reasonable assurance that Defendants will continue to comply in the future absent continuing jurisdiction; and
- xiv. Award Plaintiffs, the Class, and the Subclasses such other and further relief as the Court deems just and proper.

Dated: August 19, 2019

Respectfully Submitted,

/s/ Timothy P. Fox  
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 Elizabeth Jordan  
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