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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT; MARCO MONTOYA AMAYA; RAUL ALCOCER CHAVEZ; JOSE 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

HERNÁNDEZ; EDILBERTO GARCÍA GUERRERO; MARTIN MUÑOZ; LUIS MANUEL RODRIGUEZ DELGADILLO; RUBEN DARÍO MENCÍAS SOTO; ALEX HERNANDEZ; ARISTOTELES SANCHEZ MARTINEZ; and SERGIO SALAZAR ARTAGA; on behalf of themselves and all those similarly situated; INLAND COALITION FOR IMMIGRANT JUSTICE, an organization; and AL OTRO LADO, an organization,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; U.S. DEPARTMENT OF HOMELAND SECURITY; KEVIN MCALEENAN, in his official capacity as Acting Secretary, U.S. Department of Homeland Security; MATTHEW T. ALBENCE, in his official capacity as Acting Director, U.S. Immigration and Customs Enforcement; DEREK N. BRENNER, in his official capacity as Deputy Director, U.S. Immigration and Customs Enforcement; TIMOTHY S. ROBBINS, in his official capacity as Acting Executive Associate Director, Enforcement and Removal Operations; TAE JOHNSON, in his official capacity as Assistant Director of 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.*

Customs Enforcement Health Service Corps; JACKI BECKER KLOPP, in her official capacity as Assistant Director of Operations Support, Enforcement and Removal Operations; and DAVID P. PEKOSKE, in his official capacity as Senior Official Performing Duties of the Deputy Secretary, Department of Homeland Security,

Defendants.

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*Pro Hac Vice Application Forthcoming

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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

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)

J

Joe Corley	Joe Corley Detention Center (TX)

K

Krome	Krome Service Processing Center (FL)

L

LaSalle	LaSalle ICE Processing Center (LA)
LVN	Licensed Vocational Nurse

M

Mesa Verde	Mesa Verde ICE Processing Center (CA)
MRI	Magnetic Resonance Imaging

N

Nakamoto	The Nakamoto Group Inc.
NIJC	National Immigrant Justice Center

O

OAM	ICE Office of Acquisitions Management
ODO	ICE Office of Detention Oversight
OIG	DHS Office of the Inspector General
Orange County	Orange County Jail (CA)
Otay Mesa	Otay Mesa Detention Center (CA)
Otero County	Otero County Processing Center (TX)

P

Pahrump	Pahrump Detention Center (NV)
PBNDS	Performance Based National Detention Standards
Port Isabel	Port Isabel Detention Center (TX)
PTSD	Post-Traumatic Stress Disorder

R

Rio Grande	Rio Grande Detention Center (TX)
River	River Correctional Center (LA)
Riverside	Riverside County Jail (CA)
RN	Registered Nurse
Rolling Plains	Rolling Plains Correctional Facility (TX)

S

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

T

Tallahatchie	Tallahatchie County Correctional Facility (MS)
Teller	Teller County Jail (CO)
Theo Lacy	Theo Lacy Facility (CA)
TTY	Teletypewriter

U

Utah County	Utah County Jail (UT)

V

Victorville	Victorville Federal Correctional Complex (CA)

Y

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

INTRODUCTION

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[1] 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.

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

[1] 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.

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

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

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

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

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

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

7. This Complaint challenges the conditions in the approximately 158 facilities that hold ICE detainees for more than 72 hours ("Detention Facilities").[2]

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

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

[3] *See id*.

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

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

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

10. ICE Health Service Corps ("IHSC"), a component of ICE, is responsible for overseeing medical care at all of these facilities, and it directly provides healthcare at some Detention Facilities.[6]

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

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

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

[6] *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.

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

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

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

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[7] *See* ICE, *List of Over-72-Hour ICE Detention Facilities*, *supra* note 2.

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

14. Approximately 24 people have died in ICE custody in the last two years.[9] During this fiscal year alone, at least seven individuals in ICE custody have died.[10]

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

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

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[9] Lisa Riordan et al., *22 immigrants died in ICE detention centers during the past 2 years*, NBC News, (Jan. 6, 2019), https://www.nbcnews.com/politics/immigration/22-immigrants-died-ice-detention-centers-during-past-2-years-n954781; ICE News Release, *ICE detainee passes away in Houston-area hospital* (July 1, 2019), 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).

[10] ICE News Release, *ICE detainee passes away in Houston-area hospital* (July 1, 2019), 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).

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

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

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

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

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

19. Further, according to a January 2018 report by the Detention Watch Network ("DWN") and National Immigrant Justice Center ("NIJC"), ICE "aggressively seeks to weaken the standards that govern immigration detention."[13]

20. As a result, each year, Defendants' detention policies and practices place the mental and physical health of detained people at grave risk, deny them reasonable accommodations, and otherwise subject them to discrimination on the basis of disability. Absent intervention by this Court, Defendants will continue to subject Plaintiffs and the Class to this unconstitutional and unlawful treatment.

PARTIES

I. Plaintiffs

21. Each named Plaintiff has been harmed and faces the ongoing and substantial possibility of being harmed in the future by any of a number of systemic failures by Defendants, including failure to ensure constitutionally adequate medical and mental health care, failure to ensure that segregation is not improperly administered, and failure to ensure that Detention Facilities comply with Section 504 of the Rehabilitation Act.

A. Plaintiff Faour Abdallah Fraihat

22. Plaintiff Faour Abdallah Fraihat is 57 years old and currently detained at Adelanto. He is diagnosed with vision loss and mental health disabilities, and he uses a wheelchair for mobility. He is a qualified individual with a disability as defined in the Rehabilitation Act. Mr. Fraihat has required emergency care twice while detained at Adelanto, and he has been placed in segregation for medical reasons and denied access to any out-of-cell activities.

[13] National Immigrant Justice Center & Detention Watch Network, *ICE Lies: Public Deception, Private Profit*, at 4 (Jan. 2018), https://www.immigrantjustice.org/sites/default/files/content-type/research-item/documents/2018-02/IceLies_DWN_NIJC_Feb2018.pdf.

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

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

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

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

B. Plaintiff Marco Montoya Amaya

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

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

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

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

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

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

C. Plaintiff Raul Alcocer Chavez

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

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

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

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

D. Plaintiff Jose Segovia Benitez

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

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

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

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

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

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

E. Plaintiff Hamida Ali

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

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

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

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

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

F. Plaintiff Melvin Murillo Hernandez

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

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

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

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

49. Prior to being detained at LaSalle, Mr. Murillo Hernandez, was detained at Tallahatchie County Correctional Facility ("Tallahatchie") and Mississippi and River Correctional Center ("River").

50. Plaintiff Melvin Murillo Hernandez challenges Defendants' failure to ensure constitutionally adequate medical and mental health care and their failure to ensure compliance with Section 504 in Detention Facilities.

G. Plaintiff Jimmy Sudney

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

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

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

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

55. In retaliation for filing a grievance against an officer, Mr. Sudney was improperly placed in segregation at Adelanto for a week. While in isolation, Mr.

Sudney heard banging in and around his cell that triggered a PTSD flashback in which he relived the earthquake in Haiti where his house collapsed around him.

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

H. Plaintiff José Baca Hernández

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

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

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

60. Plaintiff José Baca Hernández challenges Defendants' failure to ensure constitutionally adequate medical and mental health care, failure to ensure proper administration of the use of segregation, and failure to ensure compliance with Section 504 at Detention Facilities.

I. Plaintiff Edilberto García Guerrero

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

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

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

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

J. Plaintiff Martín Muñoz

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

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

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

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

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

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

K. Plaintiff Luis Manuel Rodriguez Delgadillo

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

71. Mr. Rodriguez Delgadillo is a nearly lifelong California resident; most of his family members are United States citizens, including his two small children. Prior to his detention, he resided in Palm Desert, California.

72. Prior to his detention, Mr. Rodriguez Delgadillo had been diagnosed with schizophrenia and bipolar disorder, for which he was taking medication, and he is a qualified person with a disability as defined in the Rehabilitation Act. After years of instability and acute psychotic episodes, with the support of his family and in the care of a treating psychiatrist, Mr. Rodriguez Delgadillo had finally achieved some measure of mental health stability before he was detained. However, since his detention at Adelanto, his shifting medication regime, lack of therapy and failure of mental health staff to mitigate stressors, have all caused his mental health to noticeably decline.

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

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

L. Plaintiff Ruben Darío Mencías Soto

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

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

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

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

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

M. Plaintiff Alex Hernandez

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

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

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

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

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

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

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

N. Plaintiff Aristoteles Sanchez Martinez

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

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

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

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

90. Plaintiff Aristoteles Sanchez Martinez challenges Defendants' failure to provide constitutionally adequate medical and mental health care and failure to ensure compliance with Section 504 in Detention Facilities.

O. Plaintiff Sergio Salazar Artaga

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

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

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

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

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

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

P. Plaintiff Inland Coalition for Immigrant Justice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Plaintiff Al Otro Lado

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

II. Defendants

A. Defendant U.S. Immigration Customs and Enforcement

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

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

B. Defendant U.S. Department of Homeland Security

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

C. Defendant Kevin Mcaleenan, Acting Secretary of DHS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

J. Defendant David P. Pekoske, Senior Official Performing Duties of the Deputy Secretary of DHS

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

JURISDICTION

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

VENUE

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

FACTUAL ALLEGATIONS

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

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

one-third of asylum-seeking women experience sexual or gender-based violence on their journey to the U.S.[14]

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

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

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[14] *Forced to Flee Central America's Northern Triangle: A Neglected Humanitarian 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.

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

[16] *Profile of the Unauthorized Population: United States*, Migration Policy Institute https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/US#yearsresidence.

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

proportion—four out of five—either had no record or had only committed a minor offense such as a traffic violation.[18]

142. Most individuals in ICE custody also do not speak English and therefore require interpreters, translators, or related technology to ensure that they can communicate with facility staff—including medical providers—and their immigration attorneys. Yet, ICE's systemic failure to ensure that Detention Facilities consistently provide adequate interpretation services means that detained individuals are routinely unable to communicate with facility staff and their attorneys.[19]

143. It is estimated that between October 2010 and February 2013, the U.S. detained approximately 6,000 survivors of torture that were seeking asylum.[20] Based on the increased number of individuals who are currently being detained, it is likely that the number of survivors of torture who are detained has substantially increased since then.

144. Between 2013 and 2018, the United States deported at least 92 veterans of the U.S. armed services.[21] From the data available, the U.S. Government Accountability Office ("GAO") also identified 250 noncitizen veterans who were put in removal proceedings during this same time period.[22]

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[18] *Id*.

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

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

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

[22] *Id.*

145. Immigration proceedings are civil matters, and immigration detention is likewise civil and therefore should be "nonpunitive" in nature.[23] Accordingly, because neither Plaintiffs nor putative Class members are detained pursuant to criminal charges or convictions, the conditions in which they are held must reflect that distinct custody status and must not be similar to, or worse than, the conditions of confinement in jails and prisons.

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

147. When the core standards governing detention in federal facilities were promulgated in January 2000, the U.S. Department of Justice allowed the core standards for immigration detention facilities to be the same as those governing the U.S. Bureau of Prisons. [24] Likewise, ICE's current national standards governing immigration prisons were promulgated in cooperation with the American Correctional Association ("ACA"). [25]

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

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[23] *See Zadvydas v. Davis*, 533 U.S. 678, 690 (2001).

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

[25] *Facility Inspections*, ICE, https://www.ice.gov/facility-inspections.

[26] *See, e.g.*, Sarah N. Lynch et al., *Exclusive: U.S. Sending 1,600 Immigration 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, http://www.corecivic.com/facilities/tallahatchie-county-correctional-facility.

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

149. When detained individuals are transported outside of the facilities, corrections officers fully shackle their ankles and wrists. While some detained individuals are offered the "opportunity" to work, they earn only about a dollar a day, and reprisals for refusal to work are also common.[27] Corrections officers use solitary confinement as punishment for disciplinary infractions both real and pretextual, often without processes to determine which is which.

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

151. Detention Facilities also routinely obstruct detained individuals from meaningfully communicating with their attorneys.[28] Contact visitation between

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

[28] *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.

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

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

153. Similarly, in February 2019, the California Department of Justice published the findings of its review of all ten Detention Facilities in California.[34] Overall, the review found that detained individuals often face highly restrictive and

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[29] Leticia Miranda, *Dialing with Dollars: How County Jails Profit From Immigrant Detainees*, The Nation (May 15, 2014), https://www.thenation.com/article/dialing-dollars-how-county-jails-profit-immigrant-detainees/.

[30] *See* ICE, 2011 Performance-Based National Detention Standards (revised 2016), at § 5.1.

[31] *See* ICE, 2011 Performance-Based National Detention Standards (revised 2016), at § 2.5.

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

[33] *Id.* at 106.

[34] Becerra, *supra* note 19, at ii.

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

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

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

155. Denial of medical care, mental health care, and disability accommodations contributes to and exacerbates the punitive conditions in Defendants' Detention Facilities. Indeed, as detailed herein, Plaintiffs and the Class are routinely denied access to crucial medical and mental health care, refused necessary accommodations for their disabilities, and subjected to near-constant isolation. Viewed in their totality, these brutal conditions and punitive practices

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[35] *Id*. at iii–iv, 78, 122–27.

[36] Disability Rights Cal., *There Is No Safety Here*, at 17 (Mar. 2019), https://www.disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTION_MARCH2019.pdf.

[37] *Id*. at 2 (emphasis in original).

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

156. Notwithstanding ICE's regulatory and statutory authority to release detained individuals, Defendants' knowledge of the inadequate and inhumane conditions in Detention Facilities, and the availability of multiple cost-effective alternatives to detention, Defendants choose to detain thousands of individuals every year—knowing that they are unable to provide the minimum level of care and accommodations required by the Constitution and federal law. For example, 8 C.F.R. § 212.5 gives ICE the authority to parole asylum seekers who have presented themselves at a port of entry into the U.S. during the pendency of their asylum hearings. In fact, 8 C.F.R. § 212.5(b)(1) specifically authorizes release for those with serious medical conditions. Another regulatory subdivision likewise authorizes the release of pregnant women. 8 C.F.R. § 212.5(b)(2). ICE policy directives also authorize parole for those asylum seekers who have passed the "Credible Fear Interview," a mechanism by which DHS filters out non-meritorious asylum claims.[38] Despite authorization to use its parole power, ICE now does so only in a "negligible" number of cases.[39] To provide but one example, although approximately 90 percent of asylum seekers processed in New Orleans were previously granted parole, parole was granted in just two of 130 cases in 2018.[40]

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[38] U.S. Immigration & Customs Enf't, *Directive No. 11002.1, Parole of Arriving Aliens Found to Have a Credible Fear of Persecution or Torture*, at ¶ 6.2 (Jan. 4, 2010), https://www.ice.gov/doclib/dro/pdf/11002.1-hd-parole_of_arriving_aliens_found_credible_fear.pdf.

[39] *Damus v. Nielsen*, 313 F. Supp. 3d 317, 330 (D.D.C. 2018).

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

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

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

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[41] *Compare* Memorandum from Jeh Charles Johnson, Sec'y of Homeland Sec., to Thomas S. Winkowski, Acting Dir., U.S. Immigration & Customs Enf't, et al. (Nov. 20, 2014), 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 individuals "who are known to be suffering from serious physical or mental illness, who are disabled, elderly, pregnant, or nursing, who demonstrate that they are primary caretakers of children or an infirm person, or whose detention is otherwise not in the public interest") *with* Memorandum from John Kelly, Sec'y of Homeland Sec., to Thomas D. Homan, Acting Dir., U.S. Immigration & Customs Enf't, et al. (Feb. 20, 2017), https://www.dhs.gov/sites/default/files/publications/17_0220_S1_Enforcement-of-the-Immigration-Laws-to-Serve-the-National-Interest.pdf (explicitly rescinding November 20, 2014 Memorandum and providing that "[e]xcept as specifically 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").

[42] 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.

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

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

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

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

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

161. In procuring space in facilities for its detainees, ICE does not use any of the three lawful procurement means available to federal agencies.[46] Instead, it

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

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

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

[46] 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.

most commonly uses Intergovernmental Service Agreements ("IGSAs") with local entities who then contract with private prison companies to operate the facilities.[47] In 2018, the DHS Office of the Inspector General ("OIG") found that "ICE has no assurance that it executed detention center contracts in the best interest of the Federal Government, taxpayers, or detainees."[48] In particular, this 2018 OIG Report found that ICE had intentionally circumvented the federal procurement process to render the private prison company's performance "effectively insulated from government scrutiny."[49]

162. In 2019, OIG found that Defendants fail to thoroughly vet programs and services at Detention Facilities, use lax procurement requirements, and enter into vague and toothless contracts, as described below.[50] Thus, Defendants' failure to properly monitor Detention Facilities begins with the very contracts intended to govern the conditions in which non-citizens are detained.

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

164. Shortly thereafter, then-Secretary of DHS Jeh Johnson established a Subcommittee at DHS to consider whether DHS should follow suit. While acknowledging that the use of private providers and local jails was likely to

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[47] *Id.*; *see also* 2 C.F.R. § 200; 48 C.F.R. § 1.

[48] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-55, supra* note 46, at 3.

[49] *Id.* at 6.

[50] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-19-18, supra* note 4546, at 15.

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

continue, the Subcommittee, in a report issued in December 2016, offered multiple recommendations, including that DHS expand its oversight over such facilities, improve the quality and quantity of inspections at facilities, and initiate unannounced inspections.[52] Significantly, the Subcommittee recommended shifting away from privately provided healthcare toward ICE-Health-Service-Corps-provided healthcare at ICE facilitates for cost and quality reasons.[53]

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

166. Instead, ICE has expanded its use of private prison corporations with histories of negligence and abuse, such as GEO and CoreCivic.[55]

167. GEO, ICE's most frequently used contractor, has repeatedly failed to provide adequate care. In 2012, 26 members of Congress requested an investigation of the GEO-operated Broward Transitional Center in Florida after receiving reports

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[52] Homeland Security Advisory Council, U.S. Dep't of Homeland Sec., *Report of the Subcommittee on Privatized Immigration Detention Facilities*, at 3 (Dec. 1, 2016), https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf.

[53] *Id.* at 2.

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

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

of inadequate medical care for detained immigrants.[56] The same year, the Department of Justice found "systematic, egregious, and dangerous practices," including inadequate medical care, at a GEO facility in Mississippi.[57] At another GEO facility in Pennsylvania, seven people died in less than two years, with several deaths resulting in lawsuits alleging that the facility failed to provide adequate medical care.[58] In 2011, GEO was held civilly liable in a wrongful death action brought by the estate of an inmate at a GEO facility in Oklahoma.[59] There are dozens more suits that have been filed against GEO, ranging from allegations of inmate death to abuse to medical neglect, many of which were settled before trial.[60] In the past year, both OIG- and state-contracted disability monitor Disability Rights

[56] Letter from Christina Fialho, Co-Founder & Exec. Dir. of Cmty. Initiatives for Visiting Immigrants in Confinement to Karen Tandy, Subcomm. Chair of Privatized Immigration Det, Facilities Subcomm. (Oct. 3, 2016), https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf.

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

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

[59] The GEO Group, Inc., Annual Report (Form 10-K) (Mar. 1, 2013), https://www.sec.gov/Archives/edgar/data/923796/000119312513087892/d493925d10k.htm#tx493925_21.

[60] *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-prisons-geo-group-rap-sheet; *GEO Group/GEO Care Rapsheet*, Private Corrections Working Group, https://www.privateci.org/rap_geo.html; *GEO Group*, Project on Government Oversight, https://www.contractormisconduct.org/contractors/253/geo-group.

California reported widespread lack of medical care and disability accommodation at the GEO-run Adelanto.[61]

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

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

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[61] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-86: Management Alert – Issues Requiring Action at the Adelanto ICE Processing Center in Adelanto, California*, at 9 (Sep.27, 2018), https://www.oig.dhs.gov/sites/default/files/assets/2018-10/OIG-18-86-Sep18.pdf; Disability Rights Cal., *supra* note 36, at 4.

[62] *See, e.g.*, *Grae v. Corr. Corp. of Am.*, No. 3:16-CV-2267, 2019 WL 1399600, at *2 (M.D. Tenn. Mar. 26, 2019) (shareholder class certified alleging CoreCivic's "failure to provide sufficient medical services to its inmates."); *Dodson v. 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).

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

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

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[64] *Parsons v. Ryan*, No. CV-12-0601-PHX-DKD, 2018 WL 3239691, at *11 (D. Ariz. June 22, 2018).

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

[66] *Amid safety concerns, company ending medical services contract for Tecumseh State Prison*, Omaha World Herald (Jun. 3, 2017), 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; Company Loses Contracts*, Prison Legal News (Aug. 30, 2017), https://www.prisonlegalnews.org/news/2017/aug/30/numerous-lawsuits-filed-against-corizon-nationwide-company-loses-contracts/; *Corizon, the Prison Healthcare Giant, Stumbles Again*, The Appeal (February 8, 2019), https://theappeal.org/corizon-the-prison-healthcare-giant-stumbles-again/; *City 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/; *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/.

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

170. Defendants divide responsibility for monitoring Detention Facilities between government employees and private contractors. There is no independent oversight, inasmuch as all entities that conduct inspections are paid and vetted—either as contractors or as direct employees—by DHS.[67]

171. Enforcement and Removal Operations, the branch of ICE responsible for apprehending and deporting noncitizens, is responsible for overseeing confinement across its facilities. Nearly a quarter of Detention Facilities are smaller jails that were permitted to conduct their own unregulated "self-assessments."[68]

172. ICE's Custody Management Division ("CMD") contracts with inspectors to conduct routine inspections of Detention Facilities, assess compliance with ICE detention standards, and develop corrective actions plans. OMD also oversees the on-site Detention Monitoring Program and operates the Detention Reporting and Information Line, which detained individuals and others can use to file complaints.[69]

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

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

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

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

standards and applicable law.[70] ODO and ICE's External Reviews and Analysis Unit are also responsible for conducting a Detainee Death Review ("DDR") after a detained individual dies.[71]

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

175. Finally, ICE has also created a Detention Monitoring Council ("DMC"), comprised of ICE senior leadership, that is supposed to meet regularly to review problems uncovered by the internal or external oversight entities.[73] In addition, the DMC supposedly meets immediately after any detained individual's death or other critical incident.[74]

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

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[70] *Id.*

[71] *See e.g.*, Office of Professional Responsibility, *Detainee Death Review – Sergio Alonso Lopez*, at 1 ("Sergio Alonso Lopez DDR"), https://www.ice.gov/doclib/foia/reports/ddrLopez.pdf; Office of Professional Responsibility, *Detainee Death Review – Moises Tino Lopez*, at 1 ("Moises Tino Lopez DDR"), https://www.ice.gov/doclib/foia/reports/ddr-Tino.pdf.

[72] U.S. Gov't Accountability Office, *GAO-16-231*, *supra* note 69, at 11.

[73] *Holiday on ICE: The U.S. Dep't of Homeland Sec.'s New Immigration Detention Standards Before the Subcomm. on Immigration Policy & Enf't, H. Comm. on the 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-112hhrg73543/CHRG-112hhrg73543_djvu.txt.

[74] *Id.*

contracts. Nakamoto annually or biennially inspects facilities that hold ICE detainees more than 72 hours.[75]

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

178. Likewise, in 2018, OIG found major deficiencies in ICE's external and internal monitoring mechanisms.[80] The OIG report included a telling recitation of the long-standing deficiencies in Defendants' monitoring practices:

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

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[75] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-47: ICE's Inspections and Monitoring of Detention Facilities Do Not Lead to Sustained 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.
[76] U.S. Gov't Accountability Office, *GAO-16-231*, *supra* note 69, at 26.
[77] *Id.* at 21–22.
[78] *Id.* at 27.
[79] *Id.* at 26–27
[80] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-47*, *supra* note 75, at 5–10.

> Facility inspections and implementation of corrective actions. In our 2006 report, we recommended that ICE "improve the inspection process and ensure that all non-compliance deficiencies are identified and corrected." In a December 2017 report, which related to OIG's unannounced inspections of five Detention Facilities, we identified problems in some of the same areas noted in the 2006 report.[81]

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

180. The 2018 OIG report also found that Nakamoto's inspectors did not follow inspection protocols and misrepresented information in final inspection reports.[83] OIG detailed how some inspectors relied on brief answers from staff interviews and reviews of written policies to evaluate facility conditions, instead of conducting personal observations as required.[84] Nakamoto inspectors also made misrepresentations in their inspection reports that were inconsistent with OIG observations during the same visit. At one facility, Nakamoto reported that detained individuals understood how to get assistance from ICE officers and their case managers, and that detained individuals also made positive comments about access

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[81] *Id.*
[82] *Id.*
[83] *Id.* at 5.
[84] *Id.* at 6–7.

to law library services and family visitation. In contrast, however, OIG inspectors noted that they "heard detainees tell inspectors they did not know the identity of their ICE deportation officer or how to contact the officer" and "did not observe inspectors asking any detainees about law library services or visiting opportunities."[85] At another facility, inspectors reported that corrections officers "exhibited an understanding of the detention standards and civil detention" without having spoken to any such officers during the visit.[86]

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

182. Additionally, a 2016 Homeland Security Advisory Council report found Nakamoto's inspections flawed because they "focus on quantitative

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[85] *Id.* at 9.
[86] *Id.* at 10.
[87] *Id.* at 7.
[88] *Id.*
[89] *Id.* at 10.
[90] *At Immigration Detention Facilities, 'Inspectors for Hire' Miss Signs of Neglect, Say Critics*, Yahoo News (Mar. 12, 2019), 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.
[91] *Id.*

measurement of inputs rather than qualitative inquiry."[92] That is, Nakamoto inspections use yes/no checklists, instead of reviewing the extent to and means by which facilities can improve compliance. Notably, none of the items in Nakamoto's checklist requires review of disability access or accommodation.[93]

183. As for inspections by ODO, the 2018 OIG report concluded that "these inspections are too infrequent to ensure the facilities implement all corrections."[94] Of the approximately 158 facilities that ICE monitors, ODO inspects only approximately 30 facilities each year.[95]

184. The 2018 OIG report also identified problems with monitoring by ICE's Detention Service Monitors ("DSMs"). First, DSMs are in place at only 52 Detention Facilities. Second, "to correct instances of noncompliance, DSMs usually must rely on local ERO field office assistance"—and, in some instances, local ERO management was disengaged or reluctant to work with DSMs."[96]

185. In 2019, OIG issued a report summarizing unannounced inspections at Adelanto, Aurora, LaSalle, and Essex County Correctional Facility ("Essex County"). These inspections "revealed violations of ICE's detention standards and

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[92] Homeland Sec. Advisory Council, U.S. Dep't of Homeland Sec., *Report of the Subcommittee on Privatized Immigration Detention Facilities*, *supra* note 52, at 14. https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf.

[93] *See, e.g.*, Letter from Lead Compliance Inspector, The Nakamoto Grp., to Assistant Dir. for Detention Mgmt. (Oct. 11, 2018), https://www.ice.gov/doclib/facilityInspections/adelantoEastCa_CL_10_11_2018.pdf; Letter from Lead Compliance Inspector, The Nakamoto Grp., to Assistant Dir. for Detention Mgmt. (May 3, 2018), https://www.ice.gov/doclib/facilityInspections/stewartDetCtrGA_CL_05_03_2018.pdf.

[94] 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.

[95] *Id.* at 10.

[96] *Id.* at 14–15.

raised concerns about the environment in which detainees are held."[97] The report recommended that ICE improve its oversight detention facility management and operations, and that "ICE could mitigate and resolve many of these issues through increased engagement and interaction with the facilities and their operations."[98]

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

187. Nongovernmental organizations have also repeatedly identified the systemic problems with ICE's inspection system. For example, a January 2018 report by the Detention Watch Network and National Immigrant Justice Center

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[97] Office of Inspector General, U.S. Dep't of Homeland Sec., *OIG-19-47: Concerns About ICE Detainee Treatment and Care at Four Detention Facilities*, at 3 (Jun. 3, 2019), https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf.

[98] *Id.* at 12.

[99] Memorandum to Matthew Albence, Acting Deputy Dir., U.S. Immigr. and Customs Enf't (Dec. 3, 2018), https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h.

[100] *Id.*

[101] *Id.*

[102] *Id.*

concluded that these inspections are fundamentally flawed in that "they are not independent, they do not include interviews with detained people, they provide advance notice to the facilities and look for the existence of policies rather than evidence that these policies are followed, and they often misrepresent conditions inside the facility, for example counting an indoor room with a skylight as outdoor recreation."[103]

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

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[103] Detention Watch Network & National Immigrant Justice Center, *supra* note 13, at 6.

[104] Office of Inspector General, U.S. Dep't of Homeland Sec., *OIG Freedom of Information Act Request No. 2018-IGFO-00059 Final Response*, at 16 (April 25, 2018), https://www.wabe.org/wp-content/uploads/2018/05/2018-IGFO-00059_Final-Response_watermark-4.pdf; *see also Investigation finds ICE detention 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-detention-center-cuts-corners-and-skirted-federal; Katherine Hawkins, *Outsourced Oversight*, Project on Government Oversight (March 12, 2019), https://www.pogo.org/investigation/2019/03/outsourced-oversight/.

[105] Letter from Lead Compliance Inspector to Assistant Dir. for Detention Mgmt., *supra* note 93, at 2.

[106] Investigative Summary, GA Bureau of Investigation, at 92–93 (May 19, 2017) (on file with Plaintiffs' Counsel).

[107] *ICE detainee passes away*, U.S. Immigration & Customs Enf't, (Jan. 31, 2018), https://www.ice.gov/news/releases/ice-detainee-passes-away.

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

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

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[108] Investigation Report Form, CoreCivic General Counsel Office of Investigation, at 10 (Aug. 6, 2018) (on file with Plaintiffs' Counsel).

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

[110] Letter from Lead Compliance Inspector to Assistant Dir. for Detention Mgmt., *supra* note 93, at 2.; Letter from Lead Compliance Inspector, The Nakamoto Grp., to Assistant Dir. for Detention Mgmt., at 2 (Oct. 11, 2018), https://www.ice.gov/doclib/facilityInspections/adelantoWestCa_CL_10_11_2018.pdf.

[111] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-86 supra* note 61, at 2, 7, 8.

office and ICE."[112] A March 2019 report by Disability Rights California subsequently confirmed and supported OIG's findings that medical and mental health care and segregation policies were seriously deficient at Adelanto.[113]

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

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

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[112] Letter from Lead Compliance Inspector to Assistant Dir. for Detention Mgmt., *supra* note 93, at 2.

[113] Disability Rights Cal., *supra* note 36, at 4.

[114] Katherine Hawkins, *Outsourced Oversight*, Project on Government Oversight (March 12, 2019), https://www.pogo.org/investigation/2019/03/outsourced-oversight/.

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

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

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

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[116] Office of Detention Oversight, U.S. Dep't of Homeland Sec., *Enforcement and Removal Operations ERO Denver Field Office Denver Contract Detention Facility Aurora, CO*, at 9 (April 2016), https://www.ice.gov/doclib/foia/odo-compliance-inspections/denverContractDetentionFacilityAuroraCoApr_12_14_2016.pdf.

[117] Office of Professional Responsibility, Detainee Death Review – Kamyar Samimi, at 2, ("Kamyar Samimi DDR") https://bento.cdn.pbs.org/hostedbento-prod/filer_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf.

[118] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-47*, *supra* note 75, at 4.

[119] "*DHS Office of the Inspector General" Before the Subcomm. on Homeland Sec., 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

[120] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-47*, *supra* note 75, at 11.

[121] *Id*. at 12.

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

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

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[122] Office for Civil Rights & Civil Liberties, U.S. Dep't of Homeland Sec., *Fiscal Year 2015 Annual Report to Congress*, at 45 (Jun. 10, 2016), https://www.hsdl.org/?view&did=801456.

[123] *Id*.

[124] *Id*. at 40.

[125] *See* 6 U.S.C. § 345.

[126] H.R. Rep. No. 115-239 (2018).

[127] *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*

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

196. Those few times when ICE makes adverse findings regarding conditions in Detention Facilities, they typically do not result in any consequences. A January 2019 OIG report found numerous deficiencies in ICE's contract enforcement mechanisms.[132]

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

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

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

[129] *Id.*

[130] *Id.*

[131] *Death Detainee Report*, Immigration & Customs Enf't, *supra* note 127.

[132] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-19-18*, *supra* note 45, at 15.

contractor fails to meet those standards.[133] This results in confusion among contracting officers as to whether they can issue Discrepancy Reports documenting noncompliance, and whether they can seek financial penalties for noncompliance.[134]

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

199. Third, the 2019 OIG report noted that ICE uses waivers to excuse substandard conditions in Detention Facilities.[140] ICE frequently issues waivers of compliance to facilities with deficient conditions; however, ICE lacks a formal policy to govern the waiver process, and it has allowed ERO officials without clear authority to grant waivers.[141] Contract facilities may be exempt from compliance

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[133] *Id.* at 7.
[134] *Id.*
[135] *Id.* at 7–8.
[136] *Id.*
[137] *Id.* at 9.
[138] Department of Homeland Security Appropriations Act of 2009, H.R. 6947, 110th Cong. at 18 (2008).
[139] Hawkins, *supra* note 114.
[140] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-19-18*, *supra* note 45, at 7.
[141] *Id.*

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

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

201. Fifth, a lack of direct access to important contract files hinders CORs' and DSMs' ability to monitor detention contracts.[147] CORs and DSMs both monitor detention contracts, but they lack consistent access to essential contract files including contracts and modifications.[148] CORs and DSMs do not have electronic access to contract files, and instead must maintain their own files—but they do not

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[142] *Id.* at 10.
[143] *Id.* at 12.
[144] *Id.*
[145] *Id.* at 13.
[146] *Id.*
[147] *Id.* at 14–15.
[148] *Id.* at 15.

always receive contracts and modifications and must try to obtain these documents on their own, which can be time-consuming and inefficient.[149]

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

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

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

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

[149] *Id.*
[150] *Id.* at 17.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

221. For example, a report OIG produced on Adelanto concluded that "detainees do not have timely access to proper medical care," and that "detainees are placed on wait lists for months and, sometimes, years to receive basic dental care." [151]

222. According to a December 2017 OIG report, detained individuals at the Stewart Detention Center in Georgia and the Santa Ana City Jail in California, which previously contracted with ICE, reported "long waits for the provision of medical care, including instances of detainees with painful conditions, such as infected teeth and a knee injury, waiting days for medical intervention."[152]

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

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[151] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-86*, *supra* note 61, at 7.

[152] Office of Inspector Gen., Office of Homeland Sec., *OIG-18-32: Concerns About 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.

224. A 2018 Human Rights Watch ("HRW") report further documents detainee deaths connected to dangerous and unreasonable delays in medical care at Adelanto, El Paso, Otero County Processing Center ("Otero County"), and San Diego County Detention Facility ("San Diego County").[153]

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

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

227. On April 6, 2015 Raul Ernesto Morales-Ramos died at Adelanto of organ failure with signs of widespread gastrointestinal cancer, which went undiagnosed despite two and a half years of Mr. Morales-Ramos' complaints about gastrointestinal issues at Theo Lacy and Adelanto.[158]

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[153] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *Code Red: The Fatal Consequences of 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.

[154] Sergio Alonso Lopez DDR, *supra* note 71, at 16.

[155] *Id.*

[156] *Id.*

[157] *Id.*

[158] 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.

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

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

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

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[159] Office of Professional Responsibility, *Detainee Death Review – Olubunmi Toyin Joshua* (2016) ("Olubunmi Toyin Joshua DDR"), https://www.ice.gov/doclib/foia/reports/ddr-Joshua.pdf.
[160] *Id.* at 17.
[161] *Id.* at 18.
[162] *Id.* at 19.
[163] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 33.
[164] Disability Rights Cal., *supra* note 36, at 33.

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

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

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

233. Another detained individual at Otay Mesa complained of hemorrhaging for over two months and was repeatedly ignored until she fainted.[173] She was taken to the hospital, where she had a blood transfusion in the hospital parking garage.[174]

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[165] Human Rights First, *Prisons and Punishment: Immigration Detention in California*, at 11 (Jan. 2018), https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf.
[166] *Id.*
[167] *Id.*
[168] *Id.* at 12.
[169] *Id.*
[170] *Id.*
[171] *Id.*
[172] *Id.*
[173] *Id.*
[174] *Id.*

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

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

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[175] *Id.* at 11.
[176] *Id.*
[177] *Id.*
[178] *Id.*
[179] *Id.*
[180] 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/.
[181] 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.
[182] *Id.*
[183] *Id.*
[184] *Id.*

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

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

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

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

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

[185] U.S. Gov't Accountability Office, *GAO-16-23, supra* note 6970, at 18.

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

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

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

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[186] Human Rights Watch & CIVIC, *supra* note 181193, at 70.
[187] Becerra, *supra* note 19, at 115–16.
[188] New York Lawyers for the Public Interest, *Detained and Denied: Healthcare Access in Immigration Detention*, at 7–11 (February 2017), https://www.nylpi.org/wp-content/uploads/2017/02/HJ-Health-in-Immigration-Detention-Report_2017.pdf.

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

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

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

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

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

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

[189] *Parasites—Cysticercosis*, Centers for Disease Control and Prevention, available at https://www.cdc.gov/parasites/cysticercosis/health_professionals/index.html.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[190] Office of Inspector Gen., Office of Homeland Sec., *FOIA Response No. 2018-IGFO-00059*, *supra* note 104, at 35.

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

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

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

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

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

274. Sergio Alonso Lopez died in April 2017 due in part to heroin and alcohol withdrawal, after medical staff at Adelanto failed to monitor and assess his withdrawal.[193] Mr. Lopez had been taking methadone for more than 17 years for heroin withdrawal.[194] Although a doctor diagnosed Mr. Lopez with opioid dependence with withdrawal a day after Mr. Lopez's arrival at the facility on

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[191] *Id.* at 24.
[192] *Id.* at 75.
[193] Sergio Alonso Lopez DDR, *supra* note 71at 16.
[194] *Id.* at 4.

February 9, 2017, the doctor did not order recommended assessments and did not order nurses to monitor Mr. Lopez during his withdrawal.[195]

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

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

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

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[195] *Id.* at 11–12.
[196] *Id.* at 16.
[197] Office of Professional Responsibility, *Detainee Death Review – Moises Tino-Lopez*, at 1 ("Moises Tino-Lopez DDR") https://www.ice.gov/doclib/foia/reports/ddr-Tino.pdf.
[198] *Id.*
[199] *Id.* at 5, 6, 8, 21.
[200] Office of Professional Responsibility, *Detainee Death Review – Thongchay Saengsiri*, at 1, https://www.ice.gov/doclib/foia/reports/ddr-Saengsiri.pdf.
[201] *Id.*

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

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

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[202] *Id.* at 18–21.
[203] *Id.*
[204] *Id.* at 19.
[205] *Id.*
[206] *Id.*
[207] *Id.*
[208] Human Rights Watch, Am. Civil Liberties Union National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 19.
[209] *Id.*
[210] Raul Ernesto Morales-Ramos DDR, *supra* note 158, at 23.

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

279. Based on the doctor's findings and referrals, Mr. Morales Ramos was scheduled for a colonoscopy, which did not occur until about one month later.[213] During the colonoscopy, he began to experience abdominal bleeding after the doctor attempted to remove "a huge rectal mass."[214] He was transferred to the hospital and died three days later.[215]

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

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

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

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

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[211] *Id.*
[212] *Id.* at 24–25.
[213] *Id.* at 29.
[214] *Id.* at 30.
[215] *Id.* at 32.

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

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

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

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

286. Detention Facilities' reliance on untrained and unqualified personnel is widespread, occurring at Detention Facilities across the country, and resulting from

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[216] Email to Matthew Albence, Acting Deputy Dir., U.S. Immigr. and Customs Enf't, at 2 (Dec. 3, 2018), https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h.

[217] *Id*.

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

systemic deficiencies in Defendants' oversight and monitoring practices and policies.

287. For example, HRW's 2017 report details substandard provision of medical care by Defendant's healthcare providers. The report found a pervasive practice of vocational and practical nurses practicing outside of their scopes of practice, without licensed practitioner and doctor supervision, at Imperial, Yuba County, Eloy, and Laredo Detention Center ("Laredo"), causing grave injury to detained individuals there.[219]

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

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

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

[219] Human Rights Watch & CIVIC, *supra* note 181, at 25–26, 61–64, 67–68.

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

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

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

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

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

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

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

297. Additionally, nurses were never trained in opiate withdrawal, and so never completed ordered withdrawal monitoring.[225]

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[220] Office of Professional Responsibility, *Detainee Death Review- Kamyar Samimi*, at 3 (2017) ("Samimi DDR"), https://bento.cdn.pbs.org/hostedbento-prod/filer_public/RMPBS%20PDFs/RMPBS%20News/2018-ICFO-47347.pdf.

[221] *Id.*

[222] Memorandum from Jennifer M. Fenton, Assistant Dir., U.S. Immigr. and Customs Enf't, to Matthew Albence, Exec. Assoc. Dir., Enf't and Removal 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.

[223] Samimi DDR, *supra* note 220, at 32.

[224] *Id*. at 29.

[225] *Id*. at 31.

298. Overall, nurses "demonstrated a lack of understanding of opioid withdrawal symptoms" and "failed to properly monitor [Mr. Samimi] as he withdrew from opioids and to recognize his related life-threatening symptoms."[226]

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

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

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[226] *Id*. at 31.
[227] Olubunmi Toyin Joshua DDR, *supra* note 159, at 1.
[228] *Id*. at 17.
[229] *Id*. at 17.
[230] *Id*. at 19.
[231] 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.
[232] *Id*. at 16.
[233] *Id*. at 16.
[234] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 30–3.

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

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

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

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[235] Morales-Ramos DDR, *supra* note 158, at 1.
[236] *Id.* at 37.
[237] *Id.*
[238] Office of Professional Responsibility, *Detainee Death Review – Igor Zyazin*, https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf.
[239] *Id.* at 7–8.
[240] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 155, at 27.
[241] Human Rights Watch & CIVIC, *supra* note 181, at 63 (internal citation omitted).
[242] *Id.* at 63.

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

304. Regarding a woman who was detained at Eloy, independent medical experts for HRW found multiple examples of her receiving inadequate care from nurses when her symptoms required care from a nurse practitioner, a general practice doctor, or a gynecologist.[249] According to one expert, "There was a repeat pattern of nurses making decisions they're not qualified to make and little to no oversight by nurse-practitioners or physicians, which is dangerous."[250]

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

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[243] *Id*. at 63.
[244] *Id*. at 63.
[245] *Id*. at 64.
[246] *Id*. at 64.
[247] *Id*. at 64.
[248] *Id*. at 63.
[249] *Id*. at 67–68.
[250] *Id*. at 68.
[251] Office of Professional Responsibility, *Detainee Death Review – Marjorie Annmarie Bell*, https://www.ice.gov/doclib/foia/reports/ddr-bell.pdf.

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

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

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

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

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

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[252] *Id.* at 22.
[253] *Id.*
[254] *Id.*
[255] Human Rights Watch & CIVIC, *supra* note 181, at 36.

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

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

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

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

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

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

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

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

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

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

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

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

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

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[256] Office of Professional Responsibility, *Detainee Death Review – Efrain Romero De La Rosa*, https://www.ice.gov/doclib/foia/reports/ddrDeLaRosaEfrainRomero.pdf.

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

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

[259] *Id*.

320. On December 2, 2017, Kamyar Samimi died while in custody at Aurora after his withdrawal symptoms progressively worsened to the point that a nurse observed that he likely had liver failure. In separate encounter, a nurse stated: "He's dying."[260] Yet, rather than calling 911, medical staff assumed he was faking his symptoms.[261]

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

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

323. On November 30, Mr. Samimi appeared to have blood coming from his mouth. The responding nurse ordered that Mr. Samimi be monitored and given water, but the nurse did not notify a doctor that Mr. Samimi was bleeding, "which was significant given his compromised condition."[262]

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

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[260] Samimi DDR, *supra* note at 220, at 47.
[261] *Id.*
[262] *Id.*
[263] *Id.* at 43.
[264] *Id.*
[265] *Id.*
[266] *Id.*

325. When an officer asked why 911 was not being called, "neither nurse responded."[267] Only after Mr. Samimi vomited blood and officers acted on their concern did a Lieutenant order a call to 911. The nurse had not called 911 himself because he did not think Mr. Samimi's condition was a "super emergency."[268]

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

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

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

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[267] *Id.* at 47.
[268] *Id.* at 52.
[269] *Id.* at 3.
[270] *Id.* at 60.
[271] 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.
[272] *Id.*
[273] *Id.* at 9.

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

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

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

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[274] *Id.*
[275] *Id.* at 12.
[276] *Id.*
[277] *Id.* at 14.
[278] Zyazin DDR, *supra* note 238.
[279] *Id.*
[280] *Id.* at 6.
[281] *Id.* at 8.

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

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

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

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[282] *Id.* at 7.
[283] *Id.* at 8.
[284] *Id.*
[285] Office of Professional Responsibility, *Office of Detention Oversight, Detainee Death Review – Rafael Barcenas Padilla*, at 1 ("Barcenas Padilla DDR").
[286] *Id.* at 3–4.
[287] *Id.* at 4.
[288] *Id.* at 6–8.
[289] *Id.* at 8.
[290] *Id.* at 8–9.
[291] *Id.* at 9–12.

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

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

334. The DDR found that facility staff failed to triage Mr. Azurdia-Hernandez. Medical experts for HRW concluded that proper, timely care could have saved Mr. Azurdia-Hernandez's life, stating that "[t]ime is absolutely critical", and "[d]uring a heart attack, every minute counts."[297] Additionally, they found the

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[292] *Id*. at 13.
[293] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153, at 19–22.
[294] *Id*. at 21.
[295] *Id*. at 20–21.
[296] Professional Responsibility, Office of Detention Oversight, *Detainee Death Review- Jose Manuel Azurdia-Hernandez* at 6–7 (2016) ("Azurdia-Hernandez DDR"), https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.pdf.
[297] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 17.

nurse's refusal to see Mr. Azurdia-Hernandez to be "an egregious nursing decision."[298]

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

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

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

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

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

[298] *Id.* at 15.

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

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

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

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

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

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

343. For example, in 2009, DHS released a report entitled "Immigration detention overview and recommendations," which concluded that "[t]he current mental health intake assessment is quite brief and does not lend itself to early identification and intervention."[299]

344. The report also concluded that, because ICE assigns detained individuals to facilities prior to completing medical screening, detained individuals with mental health disabilities are not always assigned to facilities where the staffing, proximity to emergency care, and physical space are most conducive to their conditions.[300]

345. Two years later, OIG published a report entitled "Management of Mental Health Cases in Immigration Detention."[301] OIG reviewed intake forms for 85 detained individuals with mental health disabilities and found that only ten of those forms included any notes relating to mental health observations during the intake process.[302]

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[299] U.S. Immigration & Customs Enforcement, Dep't of Homeland Sec., *Immigration Detention Overview and Recommendations*, at 25 (Oct. 6, 2009), https://www.ice.gov/doclib/about/offices/odpp/pdf/ice-detention-rpt.pdf.

[300] *Id*. at 27.

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

[302] *Id*.

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

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

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

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

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

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

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

[305] *Id*.

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

351. On June 2, 2016, Juan Luis Boch-Paniagua, while detained at LaSalle, died of a gastrointestinal hemorrhage.[308] Mr. Boch-Paniagua's DDR found that he received his intake health screening from an officer via an intake medical questionnaire, but there was no documentation showing that the intake officer had received necessary training to conduct a health screening. The intake officers also failed to use interpreters at Mr. Boch-Paniagua's intake and classification.[309] Though Mr. Boch-Panigua reported his acetaminophen and ibuprofen allergy to medical staff, his "problem list" was left blank, causing medical staff to dangerously prescribe him 17 doses of acetaminophen and 50 doses of ibuprofen.[310]

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

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[306] *Id.* at 17.
[307] *Id.*
[308] Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review- - Juan Luis Boch-Paniagua* at 18 (2016) ("Boch-Paniagua DDR").
[309] *Id.* at 29.
[310] *Id.* at 28.
[311] Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review- - José Leonardo Lemus Rajo* at 1 (2016) ("Lemus Rajo DDR"), https://www.ice.gov/doclib/foia/reports/ddr-Lemus.pdf.

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

353. The DDR concluded that the facility "delayed [Mr. Lemus Rajo's] access to care by failing to conduct a baseline [withdrawal assessment] upon the detainee's acknowledged heavy alcohol use and report of experiencing tremors, maintaining him in the intake area for a protracted period without medical monitoring, and failing to give him vitamins immediately."[316]

354. Two independent medical experts reviewing this case concluded that the DDR raised serious unresolved concerns about the quality of care given to Mr. Lemus Rajo during the intake process.[317] One of those doctors stated, "They had hours and hours to treat him. He was not treated until he got to the hospital. Delaying treatment for over seven hours with someone with serious alcohol withdrawal is a problem." The other found, "Mr. Lemus reported very heavy

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[312] *Id.* at 8.
[313] *Id.* at 18.
[314] *Id.* at 6.
[315] *Id.* at 17.
[316] *Id.*
[317] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153, at 22–25.

alcohol use which—very predictably—led to alcohol withdrawal.[318] The failure of the facility to administer medications to him promptly was significant."[319]

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

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

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[318] *Id*. at 24.
[319] *Id*.
[320] Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review- - Jose de Jesus Deniz-Sahagun* at 1 (2016) ("Deniz-Sahagun DDR").
[321] *Id*. at 2.
[322] *Id*.
[323] *Id*. at 31.
[324] *Id*. at 32.
[325] *Id*. at 24.

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

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

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

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

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

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

[326] Office of Professional Responsibility, *Detainee Death Review – Lelis Rodriguez*, at 12, https://www.ice.gov/doclib/foia/reports/ddr-rodriguez.pdf.

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

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

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

364. For example, in July 2019, four Colorado politicians visited Aurora and reported that, in addition to a psychologist vacancy, senior positions in the health unit, including the top two positions of Health Services Administrator and deputy HSA, were vacant.[327]

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

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

[328] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 36.

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

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

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

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[330] *Id.* at 3.
[331] *Id.* at 5.
[332] *Id.* at 5.
[333] *Id.* at 6–7.
[334] *Id.* at 7.
[335] *Id.* at 11.
[336] *Id.* at 11.
[337] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 37.

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

368. According to a March 2019 complaint filed by Project South, CoreCivic's staffing levels were so low that immigrants at Stewart were forced to request medical attention at four in the morning or receive none at all.[341]

369. In a communication signed by an ICE official on January 25, 2017,[342] ICE noted it "urgently requires" on-site medical staffing support services at Stewart and Berks County, and that the facilities were in "critical need of RN staffing to sustain operations at each site."[343] The document also stated that Public Health Service positions at Stewart were staffed at only 20% of the fill rate, and that "ICE's failure to sustain minimum RN staffing levels will require healthcare

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[338] Email from Am. Immigration Council & Am. Immigration Lawyers Ass'n, to Stewart D. Smith, Assistant Dir., ICE Health Servs. Corps., et al. (June 11, 2019) (on file with Plaintiffs' Counsel).
[339] *Id.* at 1.
[340] *Id.* at 1–2.
[341] Compl. For Declaratory and Inj. Relief at 5, Project South v. U.S. Immigr. and Customs Enf't, No. 1:19-cv-895-APM (D.C. Mar. 29, 2019) ECF No. 3-1.
[342] Justification for Other than Full and Open Competition, Ex. A to Compl. For Declaratory and Inj. Relief, Project South v. U.S. Immigr. and Customs Enf't, No. 1:19-cv-00895 (ECF No. 1-4).
[343] *Id.* at 1–2.

services to be reduced at each facility; endangering detainee and non-detainee safety . . . ."[344]

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

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

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[344] *Id.* at 2.
[345] Women's Refugee Comm'n, *Prison for Survivors, the Detention of Women Seeking Asylum in the United States.* (Oct. 2017), file:///C:/Users/ADiaz/Downloads/Prison-for-Survivors-REPORT-FINAL%20(3).pdf.
[346] *Id.* at 30, 31.
[347] *Id.* at 30.
[348] *Id.* at 31.
[349] *Id.*
[350] *Id.*
[351] 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.

the 18 facilities staffed with IHSC employees were 50% or more; (3) ICE failed to allocate mental health staff in accordance with the needs of facilities—for example, the only mental health staff allocated at two facilities was one social worker, even though those facilities housed 76 and 59 detained individuals with mental health disabilities; (4) to compensate for short-staffing, "facilities without a psychiatrist must rely on other medical professionals qualified to prescribe any medications, even though they may not be knowledgeable of specific psychiatric medications"; and (5) some facilities were located in remote locations without access to third-party providers of mental health care.[352]

372. According to that same report, "IHSC officials from headquarters and field locations cited staffing shortages as a critical challenge. In addition, health service administrators and clinical directors throughout IHSC expressed the need for more mental health providers."[353]

373. In 2016, OIG issued another Mental Health Staffing Report, concluding that ICE continued to fail to attract and retain adequate qualified mental health care providers, at least in part due to the "rural and remote" areas where Defendants have elected to detain individuals.[354]

374. That same year, the HSA at Stewart told an OIG inspector that the facility had "chronic shortages of almost all medical staff positions."[355] Specifically, Stewart at the time was staffed with only "18 of 25 Registered Nurses;

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[352] *Id.* at 1, 8, 11, 16,

[353] *Id.* at 8.

[354] Office of Inspector Gen., Office of Homeland Sec., OIG-16-113-VR: ICE Still Struggles to Hire and Retain Staff for Mental Health Cases in Immigration Detention, at 2 (2016), https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf.

[355] Office of Inspector Gen., Office of Homeland Sec., *FOIA Response No. 2018-IGFO-00059*, *supra* note 104, at 34.

8 of 11 Licensed Practical Nurses; 2 of 3 License Clinical Social Workers; no Psychiatrists; and 1 of 2 Medical Doctors."[356]

375. A 2017 report by HRW[357] described the experience of Dr. John Rubel, a clinical psychologist with decades of experience in the federal Bureau of Prisons, who spent two years providing mental health services at Hutto Detention Center in Texas. Dr. Rubel found a tremendous need for mental health care, but trying to provide it at Hutto eventually posed an "ethical and moral dilemma"[358] that led him to leave. Dr. Rubel described the prevalence of trauma in the facility, which housed more than 500 women, as "extremely high," saying, "it's not just a single event [for these women], but multiple episodes of trauma."[359] Despite the great need, mental health staff at the facility consisted of one to two full-time staff members and one half-time staff member. Without more mental health staff, he said, it was impossible to provide the comprehensive mental health services required under IHSC policy.[360]

376. A 2017 Penn State Law report also found understaffing issues at Irwin County Detention Center ("Irwin"). Although the facility's website[361] lists a capacity of 1,201 individuals, the report found that these individuals had infrequent access to only one doctor, who worked at the facility part-time.[362] At Victorville Federal Correctional Complex, ICE detained 1,000 individuals despite protestations

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[356] *Id.*
[357] Human Rights Watch & CIVIC, *supra* note 181.
[358] *Id.* at 72.
[359] *Id.* (internal citation omitted).
[360] *Id.*
[361] *Our Locations*, LaSalle Corrections, http://www.lasallecorrections.com/locations/georgia/irwin-county-detention-center/?back=locations.
[362] *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.

by the local facility employee union there that an existing medical staffing shortage would cause some detained individuals to go without treatment.[363] In 2018, a former CoreCivic training officer at Otay Mesa testified in a wrongful death suit brought by the estate of a former detained individual there that short-staffing hindered officers' ability to notice when detained individuals required medical care and a referral to the medical unit.[364]

377. The systemic deficiencies in staffing at Detention Facilities, and Defendants' failure to address those deficiencies, have put detained individuals across the country at significant risk of serious harm.

378. On December 2, 2017, Kamyar Samimi died of methadone withdrawal at Aurora.[365] His DDR found that the facility had vacancies in key medical personnel, including a Director of Nursing and a mid-level provider, for longer than six months.[366] The DDR also found a high turnover of staff and slow hiring processes.[367]

379. Additionally, the absence of a midlevel provider contributed to the facility's failure to provide a complete initial physical assessment of Mr. Samimi.[368] A doctor interviewed for the Medical and Security Compliance Analysis portion of the DDR[369] stated that, due to the vacancies, it was likely there were other detained

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[363] Samantha Michaels, *Understaffed Federal Prison Is Taking in 1,000 Noncriminal Immigrants, and Even the Guards Are Protesting*, Mother Jones, (June 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/.

[364] McGinnis Dep. at 162:24-164:7, *Estate of Cruz-Sanchez by & through Rivera v. United States*, No. 317-cv--00569-AJB--NLS, 2017 WL 9853749, ECF No. 67-1 (S.D. Cal. Oct. 4, 2017).

[365] Samimi DDR, *supra* note 220.

[366] *Id.* at 25.

[367] *Id.* at 59.

[368] *Id.* at 26.

[369] *Id.*

individuals with significant medical problems whose initial examinations were conducted by registered nurses.[370] In addition, as a result of the facility's lack of a Director of Nursing or other nurse supervisor, "clinical supervision was inadequate to assure adherence to provider orders and necessary and appropriate care."[371]

380. Moises Tino Lopez died in September 2016 while detained at Hall County Jail in Nebraska.[372] The DDR identified a number of serious staffing problems, including that the facility's mid-level provider, a nurse practitioner, only provided one to three hours of coverage per week, making it "a challenge to conduct patient encounters and review telephone orders and diagnostic reports . . . ."[373] The facility physician "is located in Peoria, Illinois [and] provides no on-site services or supervision of the [nurse practitioner] beyond remotely reviewing her orders every three months."[374] The facility also lacked any on-site registered nurses to provide administrative oversight of health care operations or clinical supervision of licensed practical nurses.[375] This staffing shortage likely led to delays in evaluation and medical staff doing jobs for which they were not qualified, as the facility improperly had a licensed nurse practitioner assess Mr. Tino Lopez.[376]

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[370] *Id*. at 7.
[371] *Id*. at 63.
[372] Office of Professional Responsibility, *Detainee Death Review – Moises Tino-Lopez*, https://d1zbh0am38bx6v.cloudfront.net/wp-content/uploads/2018/07/17044550/ddr-Tino.pdf.
[373] *Id*. at 14–15.
[374] *Id*. at 14.
[375] *Id*. at 15.
[376] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161, at 31.

381. Igor Zyazin died in May 2016 while detained at Otay Mesa.[377] He was previously detained at the San Luis Detention Center. The DDR found that, notwithstanding that "oversight of clinical decision making, and care is critical in a correctional health care operation," San Luis did not have a designated clinical medical authority or physician coverage.[378]

382. Jose Manuel Azurdia-Hernandez died in December 2015 while detained at Adelanto in California.[379] The DDR found the facility had an ongoing shortage of medical personnel, including leadership vacancies in the director of nurses and the assistant HSA positions, five registered nurse vacancies, and a "high turnover rate among nursing staff, which impacts delivery and quality of care."[380] It also found that the facility had had two different HSAs since October 2014, the first of whom moved to the assistant HSA position and was on administrative leave at the time of the DDR.[381]

383. Raul Ernesto Morales-Ramos died in April 2015 while detained at Adelanto.[382] According to the DDR, "many members of [Adelanto's] medical staff [stated] that a high turnover rate among nurses is of great concern, particularly given an increasing population of detainees with chronic health care needs."[383] The facility has difficulty recruiting and retaining nurses, which necessitates hiring new graduates with minimal experience; approximately 50 percent of Adelanto's medical staff are new graduates, with "a definite difference between their skills and

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[377] Office of Professional Responsibility, *Detainee Death Review – Igor Zyazin*, https://www.ice.gov/doclib/foia/reports/ddr-Zyazin.pdf.
[378] *Id.* at 11.
[379] Office of Professional Responsibility, *Detainee Death Review – Jose Manuel Azurdia-Hernandez*, https://www.ice.gov/doclib/foia/reports/ddr-Azurdia.pdf.
[380] *Id.* at 16.
[381] *Id.* at 16.
[382] Raul Ernesto Morales-Ramos DDR, *supra* note 158.
[383] *Id.* at 37.

those of more experienced nurses."[384] Additionally, two doctors at Adelanto reported that there is a great variation in nursing skills among current nursing staff.[385]

384. Lelis Rodriguez died in July 2013, shortly after being transferred from the Brooks County Detention Facility to the Rio Grande Detention Facility, both in Texas.[386] The DDR determined that the Brooks County facility had significant staffing problems, including that medical staff consisted of mostly low-level medical personnel without appropriate clinical oversight, that a physician was present only two hours per week, and that the facility lacked mental health staff, physicians assistants, and nurse practitioners.[387] The DDR noted that "[a]dequate staffing by medical professionals of appropriate levels is critical to ensuring the healthcare needs of detainees are met in a timely manner."[388]

385. Another detainee, Federico Mendez Hernandez, died at this same facility just one month earlier, in June 2013.[389] The DDR determined that, although there were more than 25,000 detainee admissions to Brooks County during 2013, and although the facility had 63 chronic care patients, a physician was present at the facility for only two hours each week.[390] There were no physician assistants, nurse practitioners, or mental health staff at the facility. Most medical care was provided by low-level medical professionals, and oversight and clinical supervision of onsite medical staff was limited to services that could be provided by the physician and

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[384] *Id.*
[385] *Id.*
[386] Office of Professional Responsibility, *Detainee Death Review – Lelis Rodriguez*, https://www.ice.gov/doclib/foia/reports/ddr-rodriguez.pdf.
[387] *Id.* at 12.
[388] *Id.*
[389] Office of Professional Responsibility, *Detainee Death Review – Federico Mendez-Hernandez*, https://www.ice.gov/doclib/foia/reports/ddr-mendezhernandez.pdf.
[390] *Id.* at 12.

the HSA, who was a registered nurse.[391] According to the DDR, "Nursing staff reported they believe demanding work schedules and the heavy workload contributed to the abbreviated clinical assessments and inadequate documentation in the medical record of [Mr. Mendez Hernandez]."[392]

386. Pablo Gracida-Conte, held at Eloy in Arizona, died in October 2011.[393] Many detained individuals at Eloy had extensive medical needs. For example, the HSA stated that a quarter of the facility's population had chronic care issues, and that the number of detained individuals requiring higher levels of care was increasing.[394] According to a facility nurse, there were up to 110 sick call encounters per day, and the facility was grossly understaffed to handle these needs.[395] A facility doctor reported that "she badly needs help."[396] Further, at the time of Mr. Gracida-Conte's death, mid-level practitioners were understaffed by 17%, nursing was understaffed by 25%, physicians were understaffed by 50%, and the facility had no clinical director for four of the five years it had been open.[397] ICE was fully aware of this problem; the Assistant Field Office Director, an employee of ICE, stated that she had been aware of the staffing issues since assuming her post in April 2011.[398]

387. Staffing shortages are persistent, systemic, and dangerous to detained individuals throughout Defendants' network of Detention Facilities. Despite being on notice for years of these staffing shortages and the risks that they pose to people

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[391] *Id.*
[392] *Id.*
[393] Office of Professional Responsibility, *Detainee Death Review – Pablo Gracida-Conte*, https://www.documentcloud.org/documents/2695513-Gracida-Conte-Pablo.html#document/p1/a272669.
[394] *Id.* at 13.
[395] *Id.* at 14.
[396] *Id.* at 13.
[397] *Id.* at 13–14.
[398] *Id.* at 14.

in their custody, Defendants with deliberate indifference have failed to effectively monitor or oversee this issue or take measures to eliminate it.

G. Defendants Systemically Fail to Ensure Adequate Mental Health Care.

388. At Detention Facilities across the country, detained individuals receive substandard mental health care. Despite numerous reports documenting this fact, and litigation substantiating it, Defendants have taken no effective steps to ensure that detained individuals receive appropriate mental health care, exposing Plaintiffs and the Class to significant risk of serious harm.

389. The problem of substandard mental health care is systemic, occurring at Detention Facilities across the country, and continuing to occur due to systemic deficiencies in Defendants' oversight and monitoring practices and policies.

390. Plaintiff Jimmy Sudney has mental health disabilities including PTSD from the earthquake in Haiti. Though he arrived at Eloy with a thirty-day supply of medication which had stabilized him while he was in prison, he was told he could not continue with that medication because "ICE has a different standard." While detained at Eloy, Mr. Sudney had only one 30 to 60-minute session per month. At Adelanto, therapy further decreased to once every month or two, for five to fifteen minutes each session. He now has difficulty sleeping and regularly experiences flashbacks to violence and the earthquake in Haiti, especially after the recent Southern California earthquakes, after which his requests for mental health care went unanswered.

391. Plaintiff Hamida Ali had a history of schizophrenia and suicidal ideation prior to coming into ICE custody, but she was nonetheless housed in Aurora alone in a dormitory designed for dozens of people, leaving her completely isolated for approximately nine months. Her mental health symptoms grew worse, yet no steps were taken to move her or otherwise mitigate her symptoms. Upon information and belief, ICE made no attempt to obtain her prior treatment or

custodial records. When she was transferred within ICE custody from Aurora to Teller, medical staff at Teller did not receive any of her medical records from Aurora.

392. Plaintiff Luis Manuel Rodriguez Delgadillo, who has had diagnoses of schizophrenia and bipolar disorder for years, and who was taking medication and feeling stable prior to his detention, has noticed his mental health significantly decline since his detention at Adelanto in March 2019. He has been repeatedly placed in medical observation after expressing suicidal and other harmful ideation, and he has not received the same medication he was taking prior to his detention, nor any of the therapy or other support services he had in place.

393. Plaintiff Alex Hernandez is diagnosed with PTSD, for which he was receiving treatment prior to his placement in ICE custody. While detained at Mesa Verde and Otay Mesa, he received psychotropic medication to treat his PTSD. When Mr. Hernandez was transferred to Etowah in December 2018, his medication to treat his PTSD was abruptly stopped without explanation. As a result, he experienced night sweats, irritable and aggressive behavior, hypervigilance, difficulty sleeping, feelings of hopelessness, and emotional numbness.

394. Mr. Hernandez did not meet with a psychiatrist until February 2019, at least two months after he arrived at Etowah. He was then diagnosed with anti-social personality disorder, without any basis for that diagnosis in his medical records. He was not prescribed any medication to treat his mental health needs until on or around July 9, 2019, and he did not begin receiving the medication until on or around July 22, 2019. He has not received any therapy or counseling in Etowah.

395. Prior to detention, Plaintiff Jose Segovia Benitez received mental health care through the Veteran's Administration to manage his combat PTSD and other mental health diagnoses. However, since being detained at Adelanto, his combat PTSD has become unmanageable in a way that affects his ability to control his emotions and anger.

396. Plaintiff Marco Montoya Amaya has also had inconsistent mental health treatment, often at odds with the recommendations of the mental health providers at the facilities in which he was detained. For example, when he was first transferred to Mesa Verde in March 2019, a therapist indicated that he should receive follow-up talk therapy in two weeks; however, despite his prior diagnoses of Major Depressive Disorder and severe PTSD, he did not have another talk therapy appointment until two months later, in May 2019. Rather than provide assistance for his mental health conditions, a therapist repeatedly told Mr. Montoya Amaya that she thought he would and should be deported.

397. Plaintiff Salazar Artaga has been hearing voices, experiencing visual hallucinations, and grappling with suicidal ideation from the time he was a teenager. He also suffers from severe anxiety that has manifested as panic attacks in his time in detention. He requested mental health care early in his time at Florence. He has been put on suicide watch at least two times for banging his head against the wall and picking at his wounds in the midst of panic attacks. However, the psychologist he saw did not refer him to a psychiatric provider until weeks later, apparently suspecting that Mr. Salazar Artaga was seeking secondary gain. Even now, when Mr. Salazar Artaga tells officers he is having a panic attack and hearing voices, they often ridicule or ignore him and refuse to call for medical assistance.

398. These problems are not unique to Plaintiffs but are pervasive throughout Defendants' Detention Facilities.

399. For example, Disability Rights California's 2019 report concerning Adelanto[399] identified many people at the facility with serious mental health needs who received deficient mental health treatment. DRC found that the facility responds harshly and in non-therapeutic ways to people in psychiatric crisis, such as with the use of pepper spray or extreme isolation.[400]

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[399] Disability Rights Cal., *supra* note 36.

[400] *Id.* at 20.

400. Further, the "treatments" prescribed to detained individuals—even as their mental health conditions declined—often consist only of breathing exercises, physical exercise, and religious coping.[401]

401. DRC identified key deficiencies, including (1) cursory clinical contacts and non-individualized treatment, (2) a lack of structured programming and activities, (3) harmful institutional responses to patients in psychiatric crisis, and (4) deficient medication management practices.[402]

402. Overall, the DRC report found that "Adelanto's mental health care system does not meet the needs of the detainee population, and facility conditions are counter-therapeutic, all of which places people with mental health disabilities at a significant risk of harm. We found that the conditions and practices at Adelanto result in the abuse and neglect of detainees with mental health disabilities as defined in federal law."[403]

403. Defendants' own reports and DDRs also substantiate these problems.

404. On March 28, 2017, Osmar Epifanio Gonzalez-Gadba died by suicide after a three-month detention at Adelanto.[404] He was evaluated by a doctor on March 20 and 22, but the doctor was unaware that Mr. Gonzalez-Gadba had been refusing psychiatric medications.[405] Mr. Gonzalez-Gadba killed himself on March 22. The DDR found that Mr. Gonzalez-Gadba's medical record did not contain a consent form for psychotropic medications; that nurses did not use the Spanish version of refusal forms for eight doses of psychotropic medications refused by Mr. Gonzalez-Gadba, and did not document whether Mr. Gonzalez-Gadba was counseled about the risks of refusing medication or whether efforts were made to

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[401] *Id.* at 20–21.
[402] *Id.* at 20.
[403] *Id.* at 20 (internal citation omitted).
[404] Office of Professional Responsibility, *Detainee Death Review – Osmar Epifanio Gonzalez-Gadba*, https://www.ice.gov/doclib/foia/reports/ddrGonzalez.pdf.
[405] *Id.* at 15.

encourage medication compliance; and that nurses did not notify a physician or a mental health provider after Mr. Gonzalez-Gadba's medication refusals.[406]

405. On May 15, 2017, Jean Carlos Jimenez-Joseph died by suicide while detained at Stewart.[407] The Georgia Bureau of Investigation reported that Mr. Jimenez-Joseph had been prescribed medication at a mental health facility before he was detained by ICE, but facility staff did not give him the full dosage.[408] On the night of his death, Mr. Jimenez was seen jumping rope with his bedsheets and had written "Hallelujah the Grave Cometh" in large dark letters on his cell wall.[409] Despite being identified as a suicide risk, he was never placed on suicide watch, nor was he provided the upward adjustment of his anti-psychotic medication he begged for days before his death.[410]

406. Jose de Jesus Deniz-Sahagun died by suicide in May 2015 at Eloy.[411] The DDR documents that, upon his arrival at the facility on May 18, 2015, a nurse became aware that he had attempted suicide the day before and that he was still fearful, but because Mr. Deniz-Sahagun did not express suicidal ideation to the nurse, he was referred for a routine, rather than urgent, mental health evaluation.[412]

407. On May 19, a doctor diagnosed Mr. Deniz-Sahagun with delusional disorder and placed him on suicide watch until May 26.[413] The doctor also ordered anti-psychotic and anti-anxiety medications; medical staff later decided not to administer these medications, but this decision was not documented, and the doctor

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[406] *Id.* at 19–20, 22.
[407] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 153161.
[408] *Id.* at 40.
[409] *Id.* at 53 (internal citation omitted).
[410] *Id.* at 53.
[411] Office of Professional Responsibility, *Detainee Death Review – Jose De Jesus Deniz-Sahagun*, https://www.ice.gov/doclib/foia/reports/ddr-denizshagun.pdf.
[412] *Id.* at 2–4.
[413] *Id.* at 88.

was not notified.[414] On May 20, a doctor removed Mr. Deniz-Sahagun from suicide watch early because he believed that Mr. Deniz-Sahagun was no longer a danger to himself.[415] Less than 12 hours later, Mr. Deniz-Sahagun was found unresponsive in his cell due to suicide.[416]

408. Overall, the DDR found that the mental health care and treatment provided to Mr. Deniz-Sahagun was deficient for a number of reasons, including the facts that the decision not to administer ordered medication to Mr. Deniz-Sahagun was not documented, his doctor was not notified, and the doctor did not perform a suicide risk assessment addressing all required factors before removing Mr. Deniz from suicide watch.[417] In addition, the facility had not developed a suicide prevention plan, even though this was the third suicide at Eloy since April 2013, and the fifth since 2005.[418] The DDR noted that the facility did not have any on-call mental health providers.[419]

409. Two experts reviewed this case on behalf of HRW. One expert noted that Mr. Deniz-Sahagun should have been thoroughly evaluated by a psychiatrist and strongly considered for hospitalization.[420] In addition, the experts had serious concerns about the appropriateness of the doctor's decision to downgrade Mr. Deniz from suicide watch.[421]

410. On October 23, 2013, Tiombe Kimana Carlos died while detained at the York County Prison in Pennsylvania. Ms. Carlos was diagnosed with

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[414] *Id.* at 14, 15.
[415] *Id.* at 17.
[416] *Id.* at 20, 24–25.
[417] *Id.* at 27, 28, 32.
[418] *Id.* at 30.
[419] *Id.* at 29.
[420] Human Rights Watch & CIVIC, *supra* note 181, at 44.
[421] *Id.*

schizophrenia that, before her death, manifested in suicide attempts, behavioral issues and mental health concerns, and extended stays in segregation.[422]

411. The DDR found that Ms. Carlos's record lacked "documentation of a treatment plan with measurable goals and objectives . . . to guide mental health interventions over the period of detention."[423] The DDR also noted that, because Ms. Carlos was a mental health chronic care patient for the duration of her detention, and because she attempted suicide in August 2013, "a psychiatric alert was appropriate for her, but none was generated."[424]

412. Two independent experts for HRW reviewed her case and found that subpar mental health care likely contributed to Ms. Carlos' death.[425] One expert concluded that the mental health evaluation and treatment she received was "woefully inadequate."[426]

413. These examples illustrate Defendants' systemic failure to ensure that adequate mental health care is provided to people in their network of Detention Facilities. Defendants with deliberate indifference have failed to properly monitor and oversee this sad excuse of a system, leaving detained people experiencing mental health issues exposed to substantial risk of harm, including death.

H. Defendants Systemically Fail to Ensure the Adequacy of Medical Records and Documentation.

414. Defendants have a policy and practice of failing to monitor and ensure that Detention Facilities adequately maintain medical records.

415. Detention Facilities commonly fail to properly document information gleaned in medical visits by detained individuals, sometimes failing to document

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[422] Office of Professional Responsibility, *Detainee Death Review – Tiombe Kimana Carlos*, ice.gov/doclib/foia/reports/ddr-carlos.pdf.
[423] *Id.* 27.
[424] *Id.* at 28.
[425] Human Rights Watch & CIVIC, *supra* note 181, at 34.
[426] *Id.*

that visits happened at all. Further, when detained individuals are transferred between Detention Facilities, their medical records and medications often do not travel with them, preventing timely continuity of care.

416. Detained individuals experience harm and unnecessary pain and suffering from interruptions of care resulting from inadequate medical recordkeeping. Examples of the harm include suicide by individuals whose anti-psychotic medications were not administered after transfer, as well as delayed diagnosis of serious conditions like cancer.

417. Defendants are deliberately indifferent to the risk of harm and injury to detained individuals that results from this systemic failure. Inadequate medical records have been cited repeatedly, including without limitation in government reports, DDRs, and nonprofit reports. Despite these reports, Defendants have failed to effectively eliminate or mitigate inadequacies in the maintenance of medical records, exposing Plaintiffs and members of the Class to significant risk of serious medical harm.

418. The inadequate maintenance of medical records is ubiquitous in Detention Facilities across the country.

419. Plaintiff Alex Hernandez was incarcerated prior to his transfer to ICE custody. Upon information and belief, ICE did not request his medical records, which delayed his ability to receive appropriate treatment for his torn rotator cuff, PTSD, and his hip, leg, and foot pain. Each time Mr. Hernandez was transferred from one ICE facility to another, his medical records were not transferred with him, which delayed his access to treatment and disrupted his care. For instance, upon his transfer from Otay Mesa to Etowah, his medication for PTSD was discontinued without reason and he had to restart the process to request treatment for his PTSD; it took several months before his medication was resumed.

420. Mr. Hernandez had an eye exam on June 2, 2019, that was administered by a nurse. His medical records, however, contain no documentation

of a complete eye exam or the actual results of the vision test. He was told the vision exam did not meet ICE requirements for him to see an optometrist, but there is no way for medical staff or a doctor to review the exam because it is not in his records. Given Mr. Hernandez's other medical conditions, his blurry vision could indicate other serious medical issues, but he has not been evaluated by a doctor. Because of the lack of documentation, there is no recorded reason why Mr. Hernandez's vision exam did not meet ICE requirements to see an optometrist. He was given a diagnosis of anti-social personality disorder, but there is no mention of his previous PTSD diagnosis, and his medical records lack the basis for the diagnosis of a personality disorder.

421. Very few of Plaintiff Marco Montoya Amaya's records were transferred with him when he transferred, while in ICE custody, from the Yuba County Jail to the Mesa Verde ICE Processing Center. For example, on information and belief, most of Mr. Montoya Amaya's extensive mental health records from Yuba County Jail were not sent to Mesa Verde, and that fact contributed to the over two-month lapse in treatment for his mental health conditions once he arrived in Mesa Verde.

422. Similarly, when Plaintiff Salazar Artaga was transferred to Florence from the Maricopa County Jail, it does not appear that Florence request his medical records. Because of that, the initial Florence screening did not detect any symptoms of psychosis. Mr. Salazar Artaga noted in subsequent sick calls that he had been previously diagnosed with schizophrenia in jail. Although the medical records indicate that Florence staff planned to seek his jail medical records from the Maricopa County Jail to confirm the diagnosis, it is unclear whether they ever asked for or received these records.

423. These deficiencies are known by Defendants, but Defendants have not rectified them, leaving Plaintiffs and the Class at substantial risk of serious harm.

424. For example, DDRs document inadequate maintenance of medical records at a number of facilities, including Adelanto, Albany, Dodge, El Paso, Hall, Houston, Hudson, Joe Corley, Otay Mesa, Otero, Rolling Plains, Theo Lacy, and Utah. Experts concluded that these inadequate medical records contributed to a substantial number of the deaths reviewed.

425. These DDRs demonstrate that many Detention Facilities fail to request or receive records from other facilities that the detained individual may have cycled through, including hospitals, off-site medical providers, and other Detention Facilities, resulting in a lack of communication among medical providers.

426. Jose de Jesus Deniz-Sahagun died by suicide on May 20, 2015, at Eloy.[427] Even though Mr. Deniz-Sahagun was prescribed anti-psychotic and anti-anxiety medications, medical staff opted not to administer these medications without documenting their decision or contacting the physician.[428] The DDR concluded that several actions by staff were deficient, including this failure of documentation.[429]

427. Similarly, Petra Albrecht, who had, among other conditions, fluid on her heart and a gastrointestinal perforation, was transferred to Adelanto from Otay Mesa, where she had an appointment to see a specialist.[430] The Adelanto staff told her that because she had moved to a new facility, they would "start over" with tests

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[427] Office of Professional Responsibility, *Detainee Death Review – Jose de Jesus Deniz-Sahagun*, https://www.ice.gov/doclib/foia/reports/ddr-denizshagun.pdf.
[428] *Id.* at 15.
[429] *Id.* at 27.
[430] CIVIC & Detention Watch Network, *Abuse in Adelanto: An Investigation Into a California Town's Immigration Jail*, at 15 (Oct. 2015), http://www.endisolation.org/wp-content/uploads/2015/11/CIVIC_DWN-Adelanto-Report_old.pdf.

and medical care.[431] Albrecht later became unconscious during a presumed heart attack.[432]

428. Similarly, the 2017 HRW report documents significant gaps in detained individuals' health care records while in detention, including with one individual detained at Etowah, diagnosed with stomach cancer after over a year of medical complaints and spotty medical record-keeping.[433] One medical expert found opined the missing records might show a failure to timely address the problems, leading to a delay of diagnosis for a likely fatal condition.[434]

429. These examples illustrate Defendants' systemic failure to ensure that adequate medical records are kept as to people in their network of Detention Facilities. Defendants are aware that their network of Detention Facilities fails to adequately maintain medical records but have not corrected this issue through monitoring and oversight, resulting in detained individuals suffering substantial harm and even death.

VII. As a Result of Defendants' Failure to Monitor and Oversee Segregation Practices at Detention Facilities, Conditions in Those Facilities Constitute Punishment and Subject Plaintiffs in Segregation and Members of the Segregation Subclass to Violations of the Fifth Amendment.

430. Plaintiffs Alex Hernandez, Jimmy Sudney, Hamida Ali, and Marco Montoya Amaya (collectively the "Segregation Plaintiffs") and the Segregation Subclass challenge ICE's systemic failure to ensure that Detention Facilities do not improperly subject the Subclass to segregation in violation of the Fifth Amendment.

431. As with medical and mental health care, Defendants have sole authority to select and contract with the facilities in which Segregation Subclass members are detained. Defendants maintain centralized control of the standards,

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[431] *Id.*
[432] *Id.*
[433] Human Rights Watch & CIVIC, *supra* note 181, at 56, 67, 77.
[434] *Id.* at 77.

policies, practices, and procedures applicable to segregation. Defendants likewise have ultimate authority—and the legal obligation—to monitor those facilities and to ensure that policies and practices concerning segregation satisfy constitutional dictates. Yet, as detailed below, Defendants have systemically abdicated their duty to ensure that segregation practices throughout the nationwide detention system comply with the minimal requirements of substantive and procedural due process under the Fifth Amendment. Indeed, despite numerous internal and external reports alerting Defendants to systemic failures in ICE's segregation system, Defendants have refused to take any effective steps to remediate the improper use of segregation throughout the country's Detention Facilities. Accordingly, absent intervention by this Court, individuals in the Segregation Subclass will continue to be subjected to punitive conditions of confinement and face an ongoing and substantial risk of serious harm.

432. Specifically, as a result of ICE's failure to monitor and oversee segregation in Detention Facilities, detained individuals in segregation are subjected to unconstitutional policies, practices, and omissions, including but not limited to: (1) confinement in conditions that are punitive, (2) exposure to a substantial risk of serious harm, and (3) inadequate procedural protections (collectively, the "Segregation Practices"). Both alone and in their totality, these conditions violate the Segregation Subclass's Fifth Amendment rights.

433. Organizational Plaintiffs ICIJ and Al Otro Lado have had to divert resources, and have had their missions frustrated, as a result of the Segregation Practices.

434. Plaintiffs Alex Hernandez, Jimmy Sudney, Hamida Ali, and Marco Montoya Amaya have all been harmed and subjected to, and face the ongoing possibility of being harmed and subjected to, constitutionally deficient segregation as a result of Defendants' failure to properly monitor and oversee Segregation Practices at Detention Facilities.

A. Defendants Violate the Fifth Amendment by Failing to Ensure That Civil Detainees in Segregation Are Not Subjected to Punitive Conditions of Confinement.

435. Under the Fifth Amendment, segregation conditions in civil Detention Facilities may not rise to the level of punishment.

436. As set forth in detail below, Defendants fail to adequately monitor and oversee segregation practices in Detention Facilities.

437. As a result, detained individuals are subjected to the Segregation Practices, which individually and collectively constitute punishment because they are expressly intended to punish, are not reasonably related to a legitimate governmental objective, and/or are excessive in relation to that objective.

438. In addition, segregation conditions in civil Detention Facilities cannot be the same as or worse than those in a prison. As the Ninth Circuit explained, "purgatory cannot be worse than hell."[435]

439. Nevertheless, Defendants maintain a policy and practice of failing to ensure that detained immigrants in segregation are not subjected to punitive conditions. As a result, conditions in segregation throughout Detention Facilities are indistinguishable from—and in some cases worse than—those in prison. Indeed, detained individuals confined in segregation "are typically locked down for at least 22 hours a day, with limited access to recreation or contact with other human beings. Depending on the restrictions, individuals in solitary can be limited or outright denied access to phone calls, visitation, books or personal items, such as photographs of loved ones."[436]

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[435] *Jones v. Blanas*, 393 F.3d 918, 933 (9th Cir. 2004).

[436] Hannah Rappleye, *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-solitary-confinement-u-s-detention-centers-n1007881.

440. ICE's Directive 11065.1, "Review of the Use of Segregation for ICE Detainees" (the "Segregation Directive"), characterizes disciplinary segregation as punitive and administrative detention as nonpunitive.[437]

441. Yet ICE's characterization draws a distinction without a difference. Throughout the Detention Facilities, the conditions in both disciplinary segregation and administrative detention are punitive in nature, and those punitive conditions are materially the same throughout the Detention Facilities. Indeed, regardless of the underlying basis for isolation, individuals subjected to both forms of segregation are subjected to near constant isolation—for 22 or 23 hours per day—in a closed cell; overwhelmingly denied outdoor recreation; restricted from communicating with counsel, their families, and friends; frequently shackled when they are outside their cell, regardless of disciplinary infractions; and denied access to programming, telephones, commissary, personal effects, and law libraries, among other restrictions.

442. The similarly punitive conditions in all forms of ICE segregation are well-documented. For example, Penn State Law's 2017 report found that at Stewart and Irwin, "Detained immigrants report no difference between administrative or disciplinary segregation; both are considered to be equally severe," and both subject individuals to the same draconian depravations of liberty.[438]

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[437] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 3.1-3.2 (Sep. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

[438] Penn State Law, *Imprisoned Justice: Inside Two Georgia Immigrant Detention Centers*, at 36 (May 2017) https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf.

443. Human Rights First's 2019 report found that staff at three New Jersey facilities confined individuals to their cells for at least 23 hours per day for disciplinary segregation, as compared to 22 hours in administrative segregation.[439]

444. Likewise, a 2019 report on conditions at Adelanto concluded that "[d]etainees are subject to prison-like solitary confinement, whether for disciplinary or administrative reasons."[440]

445. In fact, those confined to administrative segregation do not receive greater protections from prolonged isolated confinement. For example, a 2017 DHS OIG report "identified detainees who were held in administrative segregation for extended periods of time without documented, periodic reviews that are required to justify continued segregation."[441]

446. For example, Plaintiff Alex Hernandez was placed in segregation for over two weeks while he was detained at Mesa Verde for safety reasons. While he was in isolation, he was not allowed out of his cell for any recreation. He did not receive an opportunity to visit the law library or use the telephone to contact his family or attorney. He was allowed out of his cell only to shower three times a week. This isolation exacerbated Mr. Hernandez's PTSD; he experienced nightmares and was paranoid and hypervigilant while in isolation. He did not see a mental health professional while in segregation.

447. Plaintiff Hamida Ali was placed in effective segregation for approximately nine months when security staff at Aurora placed her alone in a dorm designed for dozens of women. Ms. Ali has a documented history of schizophrenia and suicidal ideation and attempts, all of which were exacerbated by

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[439] Human Rights First, *Ailing Justice: New Jersey Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, at 5 (Feb. 2018), https://www.humanrightsfirst.org/sites/default/files/Ailing-Justice-NJ.pdf.

[440] Disability Rights Cal., *supra* note 36, at 18.

[441] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG-18-32*, *supra* note 152, at 6.

this placement. No steps were taken to ensure that this placement was appropriate for someone with her mental health disability, and both mental health staff and ICE officers informed Ms. Ali that there was nothing they could do about it, even after she had attempted suicide.

448. Defendants' abdication of any meaningful oversight of segregation practices has allowed the operators of Detention Facilities to act with impunity in imposing segregation. For example, the June 2019, DHS OIG report found that at Adelanto and Essex, "detainees are placed in disciplinary segregation before the disciplinary hearing panel finds the detainee guilty of the charged offense," and that the facilities erroneously recorded those placements as administrative segregation placements.[442]

449. In a 2019 report detailing unannounced inspections at four detention facilities, OIG raised concerns about overly restrictive segregation practices.[443] At Adelanto, Essex, and Aurora, individuals in disciplinary segregation were placed in restraints when they were outside of their cells, despite ICE standards stating that disciplinary segregation alone does not constitute a valid basis for the use of restraints.[444] At Essex, segregated individuals were strip-searched without documented justification and without reasonable suspicion.[445] Both Adelanto and Essex failed to give segregated individuals proper recreation or out-of-cell time, and individuals in disciplinary segregation at Adelanto were not permitted to

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[442] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG 19-47*, *supra* note 97, at 5–6; Performance-Based National Detention Standards: Special Management Units, Section 2.12.II (U.S. Immigr. & Customs Enf't 2011) (Revised Dec. 2016).
[443] Office of Inspector Gen., U.S. Dep't of Homeland Sec., *OIG 19-47*, *supra* note 97, at 3.
[444] *Id.* at 5.
[445] *Id.* at 5–6.

shower.[446] Overall, OIG concluded that these practices "violated standards and infringed on detainee rights."[447]

450. DRC's 2019 Adelanto report found that female disciplinary segregation cells are located in the same physical unit as the administrative segregation cells, and that Adelanto staff placed one detained individual who had been sent from suicide watch to disciplinary segregation because administrative segregation was full.[448]

451. Defendants are on notice of, but have failed to address, the use of punitive conditions in segregation.

452. Far from anomalous, such punitive conditions in both forms of segregation exist throughout the Detention Facilities. For example, a Penn State Law School study of Stewart and Irwin[449] found that detained immigrants in segregation at Stewart "cannot tell if it is day or night. There is no access to commissary or showers, and limited or prohibited access to phones, medical attention, and recreation."[450] At Irwin, individuals in the "segregated unit spend twenty-three hours in their cells, with limited recreation, shower, and phone access, and no access to the law library or commissary."[451] As at Essex, staff at Stewart shackle detained individuals in segregation whenever they leave their cells and allow them only one hour a day of non-lockdown time, during which detained individuals must choose between recreation or phone use.[452]

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[446] *Id.* at 6.
[447] *Id.* at 3.
[448] Disability Rights Cal., *supra* note 36, at 30.
[449] Penn State Law, *Imprisoned Justice: Inside Two Georgia Immigrant Detention Centers*, at 36 (May 2017) https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf.
[450] *Id.* at 36.
[451] *Id.* at 49.
[452] *Id.* at 36–37.

453. Similarly, OIG's 2017 unannounced inspection report of Theo Lacy in California documented several violations of ICE detention standards for disciplinary segregation, including that:

> [D]isciplinary segregation at [Theo Lacy] means a person is isolated for 24 hours a day in a cell with no access to visitors, recreation, or group religious services. The detainees are released briefly every other day to shower. In contrast, ICE detention standards require that detainees placed in disciplinary segregation receive a minimum of 1 hour of recreation five times per week, opportunities for general visitation, religious guidance, and limited access to telephones and reading material. However, through observation and interviews, we determined that detainees are not allowed any recreation time, visitation, religious guidance, or telephone access. They were permitted to access one book from the library for the duration of their stay in solitary, lasting up to 30 days.[453]

454. The California Department of Justice's 2019 report on immigration detention in California also found "multiple facilities that fail to follow national standards that require one hour of recreation five days a week for detainees in disciplinary segregation."[454]

455. It is not necessary for ICE to subject detained individuals to such horrors. Indeed, the 2011 Performance Based National Detention Standards ("PBNDS")—standards developed and approved by ICE—require that facilities provide a host of protections that are not implemented in practice.

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[453] Office of Inspector Gen., Office of Homeland Sec., OIG-17-43-MA: Management Alert on Issues Requiring Immediate Action at the Theo Lacy Facility in Orange, California (2017), https://www.oig.dhs.gov/sites/default/files/assets/2017/OIG-mga-030617.pdf.

[454] Becerra, *supra* note 19, at 123.

456. Moreover, Defendants can proffer no legitimate rationale for imposing conditions in segregation that so closely mirror the conditions of segregation in prison. Defendants' failure in this regard reflects their systemic overreliance on punitive models to effectuate civil detention. Yet, as explained above, the Fifth Amendment prohibits imposition of such punitive conditions in civil detention.[455]

1. **Defendants Subject Plaintiffs to a Substantial Risk of Serious Harm Through Their Failure to Monitor and Prevent Needless and Arbitrary Segregation.**

457. Defendants' failure to monitor and oversee segregation practices in Detention Facilities results in a serious risk of substantial harm to members of the Segregation Subclass.

458. Confining a person to a cell alone for 22 or more hours a day has an extremely negative effect on psychological health. Segregation places those with preexisting medical or mental health conditions at elevated risk for exacerbating those conditions and those without conditions at elevated risk for developing them.[456] Psychological effects of the isolation brought about by segregation include anxiety, depression, insomnia, confusion, withdrawal, emotional flatness, cognitive dysfunction, hallucinations, paranoia, and suicidality.[457] Approximately fifty percent of all prison suicides happen among the two to eight percent of incarcerated individuals held in solitary confinement.[458] According to a 2014 report, detained

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[455] *Jones*, 393 F.3d at 933.

[456] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol'y 325, 333–38 (2006), https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law_journal_law_policy.

[457] Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 Crime & Delinq. 124, 130–31, 133–34 (2003), https://www.gwern.net/docs/psychology/2003-haney.pdf.

[458] 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-

individuals held in segregation in New York City jails were nearly seven times more likely to harm themselves than were those in the general population.[459]

459. ICE has been on notice for years of the deleterious health effects of segregation.

460. For example, the 2011 OIG Mental Health Management Report recited mental health care providers at Detention Facilities as stating that: "[s]egregation is never an appropriate setting for long-term placement of mentally ill detainees"; "[s]egregation often exacerbates mental illness and is counterproductive to the goal of stabilizing a detainee"; "[s]egregation is not a good environment for those with mental health concerns because detainees reported increased levels of depression and anxiety when held in a short stay unit"; "[i]t is not possible to make segregation into a therapeutic setting in which a mentally ill detainee's condition would improve"; and "[s]pecial management units should only be used at the detainee's request, or for short periods when these units are the only option."[460]

461. Nevertheless, Defendants have failed to ensure that Detention Facilities do not improperly use segregation or place detained individuals in

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reports/416638.The_Colorado_Study_vs_the_Reality_of_Supermax_Confinement; *see also* Jennifer R. Wynn & Alisa Szatrowski, *Hidden Prisons: Twenty-Three-Hour Lockdown Units in New York State Correctional Facilities*, 24 Pace L. Rev. 497, 516 (2004), 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 twenty-three-hour lockdown units, although less than 10 percent of the inmate population is housed in them.").

[459] Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 Am. J. Pub. Health 442, 444–46 (2014), https://ajph.aphapublications.org/doi/10.2105/AJPH.2013.301742.

[460] 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.

segregation in lieu of providing them with proper mental health care or accommodations.

462. Indeed, ICE's own policies authorize the placement in segregation of detained individuals with "special vulnerabilities" when "no other viable housing options exist."[461] This includes detained individuals "who are known to be suffering from mental illness or serious medical illness; who have a disability or are elderly, pregnant, or nursing; who would be susceptible to harm in general population due in part to their sexual orientation or gender identity; or who have been victims—in or out of ICE custody—of sexual assault, torture, trafficking, or abuse."[462]

463. Not surprisingly, many detained individuals with mental health disabilities are placed in segregation, rather than provided with appropriate mental health services. For example, according to data from the International Consortium of Investigative Journalists, nearly one-third of segregation placements consisted of detained individuals who were described as being "mentally ill."[463]

464. The "vulnerable" populations ICE identified in its 2013 Segregation Directive[464] are subjected to an even higher risk of harm. The Division of Immigration Health Services—the agency responsible for detained individuals' medical care in 2008—estimated that, at that time, 15% of individuals detained by

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[461] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 2 (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

[462] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 3.3 (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

[463] Antonio Cucho & Karrie Kehoe, *Solitary Voices: How US Immigration Authorities Use Solitary Confinement* (May 20, 2019), https://www.icij.org/investigations/solitary-voices/how-us-immigration-authorities-use-solitary-confinement/.

[464] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, *supra* note 462, at ¶ 2.

ICE had at least one mental health disability.[465] The New York City study found that detained individuals with serious mental health disabilities who were confined to segregation were almost ten times more likely to engage in potentially fatal self-harm.[466] One federal court, summarizing the literature in 1995, likened confining inmates with mental health disabilities in isolation to "the mental equivalent of putting an asthmatic in a place with little air."[467]

465. Ellen Gallagher, former policy advisor at DHS's Office for Civil Rights and Civil Liberties, raised the alarm about abuse of segregation for people in ICE custody.[468] Gallagher found that many people who were listed as having a "serious mental illness" were assigned to extended periods of segregation. ICE's widespread use of segregation, particularly with regard to individuals with special vulnerabilities, such as those with serious mental health disabilities, violated the

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[465] Dana Priest & Amy Goldstein, *Suicides Point to Gaps in Treatment*, The Washington Post, May 13, 2008, http://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html?noredirect=on.

[466] Homer Venters et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 Am. J. Pub. Health 442, 445 (2014); *see also* Human Rights Watch, *Callous and Cruel: Use of Force against Inmates with Mental Disabilities in US Jails and Prisons* (May 2015), https://www.hrw.org/report/2015/05/12/callous-and-cruel/use-force-against-inmates-mental-disabilities-us-jails-and (Finding that isolation may worsen and intensify pre-existing mental health related symptoms such as depression, paranoia, psychosis, and anxiety, and can cause severe impairment in isolated individuals' ability to function).

[467] *Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

[468] Maryam Saleh & Spencer Woodman, *A Homeland Security Whistleblower Goes Public About Ice Abuse of Solitary Confinement*, The Intercept (May 20, 2019) https://theintercept.com/2019/05/21/ice-solitary-confinement-whistleblower/?utm_source=The+Marshall+Project+Newsletter&utm_campaign=baf0e9f0%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-solitary-confinement-u-s-detention-centers-n1007881.

agency's policies and procedures. She found that segregation, meant to be used as a last resort in many cases, was often the first and only option in Detention Facilities.

466. There have been numerous examples of detained individuals with physical or mental disabilities that have been put at significant risk of substantial harm by being placed in segregation. For example, in 2017, an individual in the Aurora facility was placed in solitary confinement for almost a month due to frequent seizures.[469] According to the detained individual, "They told me it was to monitor my seizures. I felt like they were treating me like an animal by putting me in a room by myself for weeks. They ignored me and treated me horribly."[470]

467. This person's experience echoes the experiences of many of the Plaintiffs in this case, who have likewise been subjected to prolonged segregation, notwithstanding having conditions that make such placement dangerous.

468. Plaintiff Jimmy Sudney was placed in segregation for about a week after a verbal altercation with officers who were harassing him. He filed a grievance and was placed in segregation about two days after he submitted his complaint. Though Adelanto medical staff knew that Mr. Sudney had mental health disabilities including PTSD, the mental health assessment conducted prior to his placement in isolation was cursory—he was asked only if he would harm or kill himself. There was no other inquiry into his mental health or other possible symptoms of deterioration and exacerbation of symptoms related to his PTSD. The noise in segregation triggered a PTSD flashback in which he relived the earthquake in Haiti where his house collapsed around him.

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[469] Letter from American Immigration Council & American Immigration Lawyers Association to Thomas Homan, Acting Dir., Immigration & Customs Enf't, Dep't 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.

[470] *Id.*

469. For example, Plaintiff Hamida Ali, who has a mental health disability and a history of suicidal ideation and attempts, was effectively placed in segregation when she was housed alone at Aurora for approximately nine months. During one of the brief periods in which Ms. Ali was not alone in the dorm, the other detained woman with her told security staff that they should not leave Ms. Ali alone because she had a mental health disability. Ms. Ali heard security staff say that it was none of their business.

470. As a result of her housing placement, Ms. Ali experienced several episodes of extreme psychological distress and suicidal ideation. Despite this, and despite her repeated insistence that her placement in the dorm was the cause, mental health staff took no action, deferring to security staff classification and housing placements. Ms. Ali's repeated requests to her ICE Deportation Officer to move dorms also went unheeded. Ms. Ali was placed on suicide watch in April 2019 after hearing voices, crying uncontrollably, and wrapping a sweater around her neck. She was placed back in the dorm by herself when she was taken off of suicide watch. The conditions exacerbated her mental health difficulties.

471. Plaintiff Marco Montoya Amaya has been living with an untreated likely brain parasite for over a year. This brain parasite, left untreated, can cause severe and life-threatening symptoms, including irreversible cognitive and psychiatric symptoms, some of which Mr. Montoya Amaya already appears to be experiencing. Despite this known diagnosis, and despite his other diagnoses for PTSD and major depressive disorder, Mr. Montoya Amaya was placed in segregation for approximately one week in May 2019 for accidentally eating an extra tray he was given by an officer. He did not understand the officer's instructions—likely due to his cognitive impairment—that the tray was for other detained individuals who were fasting for Ramadan. He did not receive any opportunity to appeal or challenge his segregation. Further, Mr. Montoya Amaya

was confused as to whether the segregation was disciplinary, or instead for his health or protection, as he was housed in medical isolation.

472. While in segregation, Mr. Montoya Amaya did not receive daily mental health or physical health evaluations, and it appears he instead had a total of only two mental health evaluations. To the extent he received any health evaluation before he entered segregation, that health evaluation was incomplete and incorrect; for example, despite indicating that the health professional had completed a chart review, a note in his medical record related to his segregation falsely indicated that Mr. Montoya Amaya did not have any headaches or dizziness, despite having those symptoms regularly documented in his medical records for over a year.

473. The risk of harm suffered by Plaintiffs and the Class as a result of Defendants' failure to sufficiently monitor and oversee Detention Facilities so as to prevent the Segregation Practices is neither remote nor minimal, but rather substantial and irreparable. Indeed, the tragic—and preventable—deaths of numerous detained individuals subjected to Segregation Practices demonstrate both the gravity and urgency of harm stemming from these practices. For example, in July 2018, Efrain De la Rosa died by suicide at Stewart.[471] Despite having schizophrenia, and despite IHSC's receipt of 12 separate notifications depicting suicidal ideation and psychosis, Mr. De la Rosa was not treated with psychotropic medication; instead, he was remanded to segregation for 23 hours a day for the entire three-week period leading up to his death.[472] On the day of his death,

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[471] CoreCivic General Counsel Office of Investigations, *Investigation Report Form: Stewart Detention Center – FSC Case # 2018-2505-087-1: Efrain De La Rosa* (August 6, 2018). *See also* Robin Urevich, *Newly released documents reveal mounting chaos and abuse at a troubled ICE detention center*, Fast Company (Jan. 29, 2019), https://www.fastcompany.com/90298739/newly-released-documents-reveal-mounting-chaos-and-abuse-at-a-troubled-ice-detention-center.

[472] Ken Klippenstein, *ICE Detainee Deaths Were Preventable: Document*, The Young Turks (June 3, 2019),

detention officers repeatedly failed to perform required thirty-minute checks, and failed to check on Mr. De la Rosa for nearly two hours before finding him unresponsive in his cell.[473] The Georgia Bureau of Investigation's report found a series of mistakes in Mr. De la Rosa's care, including that he was held in prolonged segregation despite serious mental health disability.[474]

474. Likewise, on October 23, 2013, Tiombe Kimana Carlos died by suicide while detained at York County in Pennsylvania.[475] Ms. Carlos was diagnosed with schizophrenia prior to her arrival at the facility.[476] Ms. Carlos showed symptoms of an acute mental health condition from the start of her two-and-a-half-year detention at York County.[477] In April 2011, a Licensed Professional Counselor documented that Ms. Carlos had a mental health history and took Haldol by injection every two weeks.[478] Over the next two and a half years, she was placed on suicide watch five times and attempted suicide once, and held in segregation for at least nine months over 12 separate instances due to "behavioral issues and associated mental health concerns."[479]

475. After an attempted suicide on August 13, 2013, Ms. Carlos remained in segregation.[480] The DDR states that Ms. Carlos' record contains "no

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https://tyt.com/stories/4vZLCHuQrYE4uKagy0oyMA/688s1LbTKvQKNCv2E9bu7h; Robin Urevich, *supra* note 471.

[473] CoreCivic General Counsel Office of Investigations, *supra* note 471. *See also* Robin Urevich, *supra* note 471.

[474] Robin Urevich, *supra* note 471.

[475] Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review – Tiombe Kimana Carlos*, at 1, https://www.ice.gov/doclib/foia/reports/ddr-carlos.pdf.

[476] *Id.* at 5.

[477] *Id.* at 3.

[478] *Id.*

[479] *Id.* at 6, 8–9, 10–11, 23.

[480] *Id.* at 10–12.

documentation [facility] mental health staff pursued alternative placement with [ICE Enforcement and Removal Operations]."[481]

476. Two independent experts reviewed Ms. Carlos' medical records on behalf of HRW and found that the substantial amount of time Ms. Carlos was held in segregation was "counter to accepted norms for treating mental illness whereby segregation and use of restraints are temporizing measures for use in emergencies and as a last resort-rather than a routine response."[482]

477. Clemente Ntangola Mponda died in September 2013 by apparent suicide while at the Houston Contract Detention Center in Texas.[483] Mr. Mponda was identified as having significant mental health needs early in his detention, when facility medical staff diagnosed him with "depression or schizophrenia."[484] For eight months of his 15-month detention at the facility, Mr. Mponda was in segregation, including administrative segregation, disciplinary segregation, and three days on suicide watch.[485] A doctor interviewed for the DDR "stated he ordinarily does not recommend segregation because it is often a 'destabilizing environment.'"[486] Mr. Mponda attempted suicide twice.[487] The DDR found numerous violations of standards for placing someone in segregation and for reviewing whether continued segregation was justified, including failure to medically clear him for segregation and failure to include the input of mental health professionals.[488]

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[481] *Id.* at 27.
[482] Human Rights Watch & CIVIC, *supra* note 181, at 34.
[483] Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review – Clemente Ntangola Mponda*, https://www.ice.gov/doclib/foia/reports/ddr-mponda.pdf.
[484] *Id.* at 4.
[485] *Id.* at 24.
[486] *Id.* at 34.
[487] *Id.* at 5, 6.
[488] *Id.* at 25–30.

478. The second time Mr. Mponda attempted suicide, staff placed him in segregation upon his return from the hospital and did not create a mental health treatment or management plan for him.[489] Two experts reviewing this case on behalf of HRW identified substandard care.[490] One expert concluded that this case "might be the poster child for misuse of isolation for mental health patients." The other noted that "standard psychiatric care is to utilize segregation and restraints as temporizing measures for short-term use and only urgent situations, rather than as a routine means of addressing psychiatric illness," and that in Mr. Mponda's case, "the repeated overuse of segregation without considering other options may well have contributed to an unstable individual becoming even more unstable and ultimately contributed to his death."[491]

479. Defendants' failure to monitor and prevent improper and exaggerated use of segregation at Detention Facilities also extends to other vulnerable populations, including pregnant women and the elderly.

480. Placing pregnant and nursing women in segregation has a host of negative health consequences and is prohibited by the United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders.[492] People with physical disabilities are also at heightened risk of harm in

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[489] *Id.* at 6, 31.

[490] Human Rights Watch & CIVIC, *supra* note 181, at 42.

[491] *Id.*

[492] *See Hearing on Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences Before the Subcomm. on Constitution, Civil Rights and Human Rights of the S. Comm. on the Judiciary*, 112th Cong. (2012) (statement of the Correctional Association of New York), 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.

segregation, as they are "often denied access to the very physical and pharmacological therapies that will help them maintain their health or prevent physical deconditioning."[493]

481. Segregation of elderly individuals increases the risk that they will develop or exacerbate chronic health conditions, as sensory deprivation from prolonged confinement in an empty room can worsen mental health and lead to memory loss; limited space hinders mobility, which is crucial for maintaining health through exercise; and a lack of sunlight can cause vitamin D deficiencies and greater risk of fractured bones.[494] Likewise, people with serious and chronic medical conditions may suffer from exacerbations of their symptoms due to the stress, lack of exercise, reduced access to healthcare, and inability of staff to detect and quickly respond to medical emergencies.[495]

482. However, despite the well-known harm that segregation wreaks on detained individuals, ICE continues to explicitly allow its contractors to use it

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Similarly, women in isolation may be dissuaded from requesting care related to sensitive gynecological issues because they are required to inform correction officers about details of their medical problem, may have serious difficulty accessing appropriate medical staff when they do reach out, may be shackled during gynecological appointments that do occur, and will often interact with medical providers in full view of correction officers and/or receive superficial evaluations through closed cell doors.").

[493] Am. Civil Liberties Union, *Caged In: Solitary Confinement's Devastating Harm on Prisoners with Physical Disabilities*, at 27 (Jan. 2017), https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf.

[494] Brie Williams, *Older Prisoners and the Physical Health Effects of Solitary Confinement*, 106 Am. J. Pub. Health 2126 (2016), https://escholarship.org/uc/item/64n248wp.

[495] Am. Civil Liberties Union, *Caged In: Solitary Confinement's Devastating Harm on Prisoners with Physical Disabilities*, at 24–32 (Jan. 2017), https://www.aclu.org/sites/default/files/field_document/010916-aclu-solitarydisabilityreport-single.pdf.

liberally for its general population and as long as "no other viable housing options exist" for those it deems especially vulnerable.[496]

483. These risks are not limited to those who currently have special vulnerabilities. Indeed, all individuals are at risk for developing mental health conditions when placed in segregation, especially for prolonged periods. The danger is well-known: "severe and prolonged restriction of environmental stimulation in solitary confinement is toxic to brain functioning."[497] The United Nations Special Rapporteur on Torture, citing multiple studies regarding the harmful effects of even short period of isolation, has said that isolation can amount to "torture or cruel, inhuman or degrading treatment," and that isolation for more than 15 days should be absolutely prohibited.[498]

484. Despite this overwhelming evidence, ICE policy allows extended placement in segregation "when necessary, after engaging in an individualized assessment of the case."[499] A DHS OIG 2016 report recommended that ICE "[e]stablish time limits for holding mentally ill detainees in segregation outside of medical units, and identify recourses for Detention Facilities when segregated

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[496] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 2 (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

[497] Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol'y 325, 349 (2006), https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1362&context=law_journal_law_policy.

[498] *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-confinement-should-be-banned-most-cases-un-expert-says.

[499] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 7 (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

detainees are approaching set time limits."[500] However, on information and belief, ICE did not adopt that recommendation.

485. Therefore, although those ICE has identified as having "special vulnerabilities" are at greatest risk of harm as a result of segregation, any detained individual is at risk for being sent to segregation for prolonged periods—and then, in turn, being at a heightened risk for developing mental or physical disabilities.

2. **Defendants Fail to Monitor and Oversee Segregation Practices on a Systemic Scale.**

486. ICE's 2013 Segregation Directive established centralized policies and procedures governing placement of detained individuals in segregation.[501] These policies ostensibly mandate centralized review of many segregation placements. However, ICE fails to ensure implementation of these policies.[502]

487. Insufficient though the ICE policies are to protect against a serious risk of harm, ICE fails even to follow its own policies. For example, a 2017 DHS OIG report found that ICE Field Offices "did not record and promptly report all instances of segregation to ICE headquarters, nor did their system properly reflect all required reviews of ongoing segregation cases per ICE guidance."[503] Nor does

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[500] Office of Inspector Gen., Office of Homeland Sec., OIG-16-113-VR: *ICE Still Struggles to Hire and Retain Staff for Mental Health Cases in Immigration Detention*, at 6 (July 21, 2016), https://www.oig.dhs.gov/assets/VR/FY16/OIG-16-113-VR-Jul16.pdf.

[501] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶ 2 (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

[502] Office of Inspector Gen., Office of Homeland Sec., OIG-17-119: *ICE Field Offices Need to Improve Compliance with Oversight Requirements for Segregation 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.

[503] Office of Inspector Gen., Office of Homeland Sec., OIG-17-119: *ICE Field Offices Need to Improve Compliance with Oversight Requirements for Segregation 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.

ICE "regularly compare segregation data in the electronic management system with information at Detention Facilities to assess the accuracy and reliability of data in the system."[504] Thirty-nine percent of placements were reported to ICE's Custody Management Division after the three days mandated by the Segregation Directive.[505] OIG's file reviews found that 74 percent of reviews were either missing or incomplete in ICE's online case management system ("SMRS").[506] Because ICE headquarters uses the SRMS to review detained individuals' placements in segregation, these failures preclude any centralized review of those placements. The report gives one example of a detained individual who was placed in disciplinary segregation on four separate occasions, none of which was documented in the SRMS.[507]

488. On information and belief, the "Detention Inspection Form Worksheet" (the "Inspection Worksheet") that is used in connection with many inspections of Detention Facilities includes a section concerning segregation units that omits or gets wrong several parts of the Segregation Directive. Whereas the Directive requires that the ICE Field Office Director be notified whenever a detained individual has been held in segregation continuously for 21 days, or for 14 days out of a 21-day- period,[508] the Inspection Worksheet requires only that the ICE Field Office Director be notified when a detained individual's confinement in segregation exceeds 30 days. In addition, the Inspection Worksheet omits any mention of the Directive's requirement that the Field Office Director be notified within 72 hours when a detained individual has been placed in administrative

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[504] *Id.*
[505] *Id.* at 5.
[506] *Id.* at 6.
[507] *Id.* at 5.
[508] 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.

segregation on the basis of a medical or mental health condition, disability, or other special vulnerability, as well as any mention of the notification requirement any time a detained individual with a mental condition, serious mental health disability, or physical disability is placed in segregation.

489. Predictably, ICE's insistence on letting its contractors confine detained individuals to segregation and lack of interest in monitoring conditions has led to disastrous results systemwide. Rather than providing a therapeutic environment for those most at risk for lasting damage from segregation, contractors use segregation as a panacea for all manner of perceived inconveniences.

490. A June 2019 OIG report summarizing unannounced inspections of Adelanto, Essex, Aurora, and LaSalle found that overly restrictive segregation practices were used.[509] For example, detained individuals at Adelanto and Essex are placed in disciplinary segregation before a disciplinary hearing finds them guilty of a charged offense. Facility forms also incorrectly state that individuals are in administrative segregation, when they are actually in disciplinary segregation.[510]

491. A May 2019 NBC News report found, after reviewing 8,488 cases, that half of segregation placements were not for disciplinary reasons but instead "involve the mentally ill, the disabled or others who were sent to solitary largely for what ICE described as safety reasons."[511] In those cases, former CRCL policy analyst Ellen Gallagher explained that at facilities, "[s]olitary confinement was being used as the first resort, not the last resort."[512] A third of the segregation placement reviews involved detained individuals who "were determined by ICE to

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[509] Office of Inspector Gen., Office of Homeland Sec., *OIG-19-47*, *supra* note 97.
[510] *Id.* at 5.
[511] 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-solitary-confinement-u-s-detention-centers-n1007881.
[512] *Id.*

have a mental illness," and some were placed in disciplinary segregation "for offenses that stem from mental illness, such as acts of self-harm."[513] Some records show individuals with mental health disabilities confined to segregation shuttle "chronically back and forth from the general population to administrative or disciplinary segregation, with periodic, crisis-oriented admissions to psychiatric hospitals punctuating their return to the same disturbing cycle."[514] Records showed that more than 60 detained individuals were confined in segregation "solely because they required a wheelchair or some other aid."[515] Though ICE's Segregation Directive requires it to document what alternatives to segregation were considered, Ms. Gallagher "often found no evidence that ICE had done so."[516]

492. Ms. Gallagher raised these concerns for five years, and circulated memos about them within DHS and then to the US Office of Special Counsel, but neither OIG nor CRCL has published any reports addressing the systemic use of either prolonged segregation or segregation of those with special vulnerabilities.[517] Nor have the abuses abated.

493. Disability Rights California's March 2019 report found that facility staff at Adelanto held detained individuals in segregation on the basis of disability.[518] Unit rosters identify "mental illness or medical condition" as the reason for many placements.[519] In its investigation, DRC found multiple examples of facility staff knowingly sending detained individuals with mental health disabilities to segregation, only to have those individuals attempt suicide.[520]

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[513] *Id.*
[514] *Id.*
[515] *Id.*
[516] *Id.*
[517] *Id.*
[518] Disability Rights Cal., *supra* note 36, at 29.
[519] *Id.* at 48.
[520] *Id.* at 8, 27, 32.

494. A 2017 investigation by The Verge of over 300 segregation logs at Stewart, Eloy, and Pearsall also found many examples of abuse, including one on June 8, 2016, when facility staff placed a detained individual in segregation for "standing up on his open bay bed and urinating in a cup followed by [the detainee] drinking the same urine."[521] Staff, with ICE's approval, placed this detained individual in solitary confinement for nearly a month, not for mental health treatment, but to discipline him for drinking his urine.[522] Detained individuals at Irwin also report staff regularly using prolonged periods of isolation, strapping those with mental health conditions in straitjackets, and involuntarily confining those with mental health conditions to segregation.[523] ICE itself has acknowledged that "[d]ue to housing limitations at various facilities, segregation use for suicide observation is a necessity."[524]

495. ICE's own death reviews also demonstrate the complete lack of accountability in its segregation system. Inspectors found failures to monitor individuals in segregation in a number of the publicly available DDRs.

496. Before his death on December 2, 2017, Kamyar Samimi spent the entirety of his 16-day detention at Aurora in medical observation and suicide

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[521] Spencer Woodman, *ICE Detainees are Asking to Be Put in Solitary Confinement for Their Own Safety*, The Verge (2017), https://www.theverge.com/2017/3/10/14873244/ice-immigrant-detention-solitary-trump-corecivic-geo.

[522] Id.

[523] Ctr. for Immigrants' Rights Clinic, PennState Law, *Imprisoned Justice: Inside Two Georgia Immigrant Detention Centers*, at 49 (May 2017), https://projectsouth.org/wp-content/uploads/2017/06/Imprisoned_Justice_Report-1.pdf.

[524] 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-in-us-solitary-confinement/.

watch.[525] The DDR found that nursing staff failed to conduct a welfare check during the 14 hours he spent on suicide watch.[526] Additionally, the facility doctor did not renew his orders for Mr. Samimi's placement in medical housing, as required by GEO policy.[527]

497. On March 28, 2017, Osmar Epifanio Gonzalez-Gadba died by suicide while detained at Adelanto.[528] Though facility staff sent Gonzalez-Gadba to an outside doctor for mental health treatment, staff placed Mr. Gonzalez-Gadba in segregation upon his return to Adelanto.[529] Because staff knew of Mr. Gonzalez-Gadba's diagnosed mental health conditions and repeated medication refusals, they placed him on psychiatric observation status.[530] However, staff failed to consistently check on him every 30 minutes as required, including during the period that he hanged himself.[531]

498. Two independent experts who reviewed Mr. Gonzalez-Gadba's DDR found that facility staff were on notice that he had serious mental health conditions and had stopped taking his medicine, and that he should not have been placed in segregation because of the likelihood of inadequate coping mechanisms due to stress, resulting in personality disturbance or disintegration.[532]

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[525] Samimi DDR, *supra* note 220, at 60–62.
[526] *Id.* at 66.
[527] *Id.*
[528] 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.
[529] *Id.* at 11.
[530] *Id.*
[531] *Id.* at 11–15.
[532] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 155, at 53.

499. On May 15, 2017, Jean Carlos Alfonso Jimenez-Joseph died by suicide while in solitary confinement at Stewart.[533] The Georgia Bureau of Investigation reviewed his death and found that Mr. Jimenez-Joseph had been prescribed medication at a mental health facility before he was detained by ICE, but Stewart staff did not give him the full dosage.[534] Despite knowledge that Mr. Jimenez-Joseph was diagnosed with schizophrenia, staff placed him in segregation as punishment for attempting suicide by jumping from the top tier of his housing unit.[535] On the night of his death, Mr. Jimenez was seen jumping rope with his bedsheets and had written "Hallelujah the Grave Cometh" in large dark letters on his cell wall. After 19 days in isolation, he died by suicide.[536]

500. Despite being identified as a suicide risk, he was never placed on suicide watch, nor was he provided the upward adjustment of his anti-psychotic medication he begged for in the days before his death.[537] He was also placed in a cell that contained a known suicide hazard, a ceiling sprinkler head, upon which he affixed his makeshift noose.[538]

501. In sum, evidence from facilities across the country makes clear that segregation is overused, misused, and not properly tracked or reported, leaving detained individuals who may be subjected to the practice at substantial risk of harm. Despite extensive documentation of these problems, ICE has taken no effective steps to prevent these abuses.

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[533] *Id.*

[534] *Id.* at 40. *See also* Robin Urevich, *Private prison giant under fire for pressuring Georgia to keep immigrant detainee's death report sealed*, FAST COMPANY (Dec. 10, 2018) https://www.fastcompany.com/90279208/private-prison-giant-under-fire-for-pressuring-georgia-to-keep-immigrant-detainees-death-report-sealed.

[535] Human Rights Watch, Am. Civil Liberties Union, National Immigrant Justice Center & Detention Watch Network, *supra* note 155, at 40.

[536] *Id.* at 53.

[537] *Id.* at 40.

[538] *Id.*

VIII. As a Result of Defendants' Failure to Monitor and Oversee Disability-Related Practices in Detention Facilities, Plaintiffs with Disabilities and Members of the Disability Subclass Are Subjected to Violations of the Fifth Amendment and Section 504 of the Rehabilitation Act.

A. Section 504 of the Rehabilitation Act Prohibits Discrimination on the Basis of Disability by Executive Agencies.

502. Plaintiffs Sergio Salazar Artaga, José Baca Hernández, Raul Alcocer Chavez, Jimmy Sudney, Jose Segovia Benitez, Marco Montoya Amaya, Faour Abdallah Fraihat, Ruben Darío Mencías Soto, Aristoteles Sanchez Martinez, Alex Hernandez, Melvin Murillo Hernandez, Luis Manuel Rodriguez Delgadillo, and Hamida Ali (collectively the "Disability Plaintiffs") and the Disability Subclass challenge ICE's failure to ensure Detention Facilities comply with the requirements of Section 504 of the Rehabilitation Act ("Section 504"), 29 U.S.C. § 794.

503. Section 504 prohibits discrimination on the basis of disability in programs or activities conducted by executive agencies of the United States. Defendants DHS and ICE are executive agencies, and the Detention Facilities program they operate, whether directly or through contractual, licensing, or other arrangements, constitutes a covered program or activity conducted by executive agencies.

504. Defendants have an affirmative obligation to operate their Detention Facilities program so that it is readily accessible to and usable by individuals with disabilities, does not discriminate on the basis of disability, and is otherwise in compliance with Section 504 and its implementing regulations, 6 C.F.R. § 15.1 *et seq.*

505. Defendants have failed and continue to fail to comply with this affirmative obligation in the following ways (referred to herein as "the Disability Practices"): (1) failing to ensure that their programs are readily accessible to and usable by detained individuals with disabilities; (2) to the extent structural changes or other measures are necessary to make such facilities readily accessible to and

usable by detained individuals with disabilities, failing to ensure that such structural changes are made or other measures taken; (3) failing to conduct an adequate self-evaluation or prepare and implement an adequate Transition Plan to bring Detention Facilities into compliance with Section 504; (4) failing to ensure that Detention Facilities maintain and implement adequate screening to identify, track, and accommodate the needs of detained individuals with disabilities; (5) failing to ensure that Detention Facilities do not improperly place persons with disabilities in segregation and administrative segregation in Detention Facilities; (6) failing to ensure that Detention Facilities have an effective system in place to provide detained individuals with disabilities with reasonable accommodations necessary for meaningful access to the benefits available at Detention Facilities, as well as to provide auxiliary aids necessary for detained individuals with sensory impairments to have access to effective communication; (7) making determinations concerning the location of detention facilities that have the purpose or effect of discriminating on the basis of disability; (8) using criteria in the selection of contractors to operate detention facilities that subject members of the Disability Subclass to discrimination on the basis of disability; (9) failing to administer programs and activities in the most integrated setting appropriate to the needs of individuals with disabilities; and (10) using criteria or methods of administration that have the purpose or effect of discriminating on the basis of disability.

506. Organizational Plaintiffs ICIJ and Al Otro Lado have had to divert resources, and have had their missions frustrated, as a result of the Disability Practices.

507. The policies and practices described herein place members of the Disability Subclass at particular risk of infringement or denial of the rights secured by Section 504.

1. **Defendants Exercise Centralized Control Regarding Conditions Impacting Persons with Disabilities at Detention Facilities Nationwide.**

508. Defendants have the sole authority to select and contract with the facilities in which Disability Subclass members are detained. Further, as all members of the Disability Subclass are in ICE custody, Defendants maintain centralized control of the standards, policies, practices, and procedures applicable to detained individuals with disabilities, discussed in detail below. Defendants have in place centralized directives regarding program accessibility, reasonable accommodations, and effective communications.

509. For example, in 2013, DHS issued Directive 065-01, requiring ICE and other parts of DHS to, among other things, conduct a self-evaluation, develop a plan that addresses any barriers identified in the self-evaluation, and document the policies and procedures for providing reasonable accommodations and modifications to persons with disabilities.[539]

510. DHS followed up with a 2015 instruction, Instruction #065-01-001, requiring ICE and other DHS components to designate a lead Disability Access Coordinator with "the ability and authority to reach across the Component's divisions and offices," and to serve "as the central resource for Component compliance with Section 504."[540]

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[539] U.S. Dep't. of Homeland Sec., *Nondiscrimination for Individuals with Disabilities in DHS-Conducted Programs and Activities (Non-Employment)* (Sep. 2013), https://www.dhs.gov/sites/default/files/publications/dhs-management-directive-disability-access_0.pdf.

[540] U.S. Dep't. of Homeland Sec., *Instruction on Nondiscrimination for Individuals with Disabilities in DHS-Conducted Programs and Activities (Non-Employment)* (March 2015), https://www.dhs.gov/sites/default/files/publications/dhs-instruction-nondiscrimination-individuals-disabilities_03-07-15.pdf.

511. Defendants also have in place a policy entitled "Assessment and Accommodations for Detainees with Disabilities."[541] On information and belief, pursuant to this and other policies, detained individuals with communication and mobility disabilities are subjected to reviews by staff at ICE headquarters, in part to make recommendations on accommodations.

512. Despite the existence of these system-wide directives and policies, Defendants have failed to take the affirmative steps necessary to enforce them, to otherwise ensure that Detention Facilities have appropriate systems in place to ensure that detained individuals with disabilities have meaningful access to ICE programs and services, and to ensure that detained individuals with disabilities are not denied necessary accommodations or otherwise subject to the discriminatory Disability Practices described below.

2. Defendants Systemically Fail to Ensure Access to ICE Programs and Services for Detained Individuals with Disabilities.

513. Defendants have failed to ensure that their Detention Facilities Program is readily accessible to and usable by persons with disabilities (referred to as "Program Access"), including but not limited to failing to engage in alterations to existing facilities, construction of new facilities, redesigning equipment, or reassignment of services to accessible buildings. For example, several Detention Facilities contain architectural barriers and need facilities or program modifications for members of the Disability Subclass to have meaningful access to the benefits of those facilities. Yet Defendants have not adequately evaluated those barriers, much less implemented the changes needed to remedy them.

514. Defendants have further failed to conduct an adequate self-evaluation, including opportunities for meaningful input from the disability community in that

[541] U.S. Immigration & Customs Enforcement, Enforcement and Removal Operations, *Assessment and Accommodations for Detainees with Disabilities* (Dec. 2016).

process, despite their own directives and federal regulations requiring such self-evaluation.

515. Defendants have also failed to ensure that Detention Facilities make modifications to their policies and practices where needed to avoid discrimination on the basis of disability and denial of access to programs and activities.

516. Despite their failure to ensure Program Access, Defendants have nonetheless housed thousands of members of the Disability Subclass in inaccessible facilities. On information and belief, many Detention Facilities lack accessible paths of travel, sufficient accessible restroom and shower facilities, and accessible recreational facilities for detainees with mobility disabilities, among other barriers. Detained individuals with disabilities are denied access to a range of benefits, from access to basic hygiene, recreation and visitation, among others, and face an increased risk of harm, as well as the denial of personal autonomy.

517. Examples of architectural barriers and other failures of Program Access at Detention Facilities include a lack of sufficient accessible shower facilities at La Salle, requiring at least one detained individual who uses a wheelchair to rely on the assistance of other detainees to shower; a lack of accessible paths of travel at Stewart, including barriers making it difficult for detained individuals who use wheelchairs to access the medical unit; and overcrowding that blocks accessible paths of travel and provides no access to accessible housing facilities for detained individuals who use wheelchairs at Krome, among many other issues.

518. Another example is Florence Correctional Center's lack of accessibility to persons with mobility impairments like Plaintiff Sergio Salazar Artaga. Because of his cerebral palsy, Mr. Salzar Artaga has difficulty standing, ambulating, and using the right side of his body. The shower to accommodate people with disabilities at Florence has been nonfunctional for the duration of Mr. Salazar Artaga's time at the facility. As a result, he has been nervous to take a

shower in the standard showers without slipping, falling, and hurting himself. While he made a request for a shower chair so that he would be less likely to fall, he was in the facility for nearly three months before he received the shower chair.

519. Defendants' failure to ensure access to adequate medical and mental heath care, as alleged earlier in this Complaint, often has the effect of depriving Disability Subclass members of access to Detention Facility programs and services.

520. For example, instead of providing Plaintiff Melvin Murillo Hernandez timely consultation with an allergist and ready access to an EpiPen, LaSalle staff isolated him. This, and his repeated, avoidable bouts of anaphylactic shock, deny him access to the programs and activities accessible to other detained individuals.

521. As another example, while detained at Adelanto, Plaintiff Luis Manuel Rodriguez Delgadillo has not been provided therapy or all of the psychotropic medication he took prior to detention, causing him to repeatedly have acute mental health episodes that have denied him access to the programs and activities accessible to non-disabled detained individuals.

3. Defendants Systemically Fail to Ensure Adequate Screening to Identify, Track, and Accommodate Detained Individuals with Disabilities.

522. Defendants' Detention Facilities across the country fail to adequately identify, track, and provide accommodations for detained individuals with disabilities as required by Section 504.

523. Defendants' inadequate screening procedures, as alleged earlier this Complaint, also result in the failure to identify individuals with disabilities, track their needs, and provide accommodations required by their disabilities.

524. Defendants have sole authority to transfer and move detained individuals throughout their network of Detention Facilities. Class members are regularly shuffled from facility to facility with little to no regard for whether they have a disability that requires a particular placement, and Defendants fail to ensure

that facilities in which Detained individuals with disabilities are housed provide access to the same essential services and programs as in all other facilities.

525. Upon transfer, information regarding any prior identification of disability is often not communicated, resulting in inadequate tracking of individuals with disabilities. Further, accommodations that have been approved and provided by Defendants are often discontinued or removed without cause when a person is transferred to a new facility. Individuals with disabilities must restart the process of requesting reasonable accommodations at each new facility, resulting in delay and denial of receiving those accommodations to meaningfully access programs and services.

526. The Plaintiffs' experiences are illustrative of Detention Facilities' failure to perform adequate screening and tracking of the needs of individuals with disabilities.

527. For example, Plaintiff José Baca Hernández is blind and has been detained at Theo Lacy and Adelanto, neither of which conducted an intake that included a discussion of reasonable accommodations. At Adelanto, it took more than one year for an Americans with Disabilities Act ("ADA") Coordinator to meet with Mr. Baca.

528. Plaintiff Alcocer Chavez is Deaf and communicates in ASL, but he was not provided ASL interpretation during medical intake. Accordingly, he was unable to communicate effectively with medical staff, among many other issues.

529. When Plaintiff Jimmy Sudney arrived at Adelanto, it took over a week to see a doctor for an intake meeting, and that doctor asked only about his mental health. When he arrived at Eloy, it took almost a month to have an intake meeting. Meanwhile, upon arrival at Eloy, he went without medication that he requires daily to stabilize his medical and mental health needs.

530. Plaintiff Alex Hernandez's rotator cuff and inflammation and pain in his back, legs, hip and feet impede his mobility and range of motion. When Mr.

Hernandez was transferred to Etowah, he was given a bottom bunk profile based on his disability, but he was assigned to a top bunk. He was told that no bottom bunks were available at that time.

531. As a result, for a month and half Mr. Hernandez was required to sleep on the top bunk. There was no ladder to get up to the top bunk, and no railing or other device to use for support. Mr. Hernandez relied on assistance from other detained individuals assigned to his cell to lift him so he could get into bed and also help support him as he was getting out of bed. He was fearful of falling or sustaining further injury to his shoulder, back, hip, and legs.

532. Plaintiff Sergio Salazar Artaga's initial screenings at Florence indicated that he had no mental health disability. As a result, he did not timely receive psychotropic medication, and he ended up on suicide watch twice over the next month for banging his head on the wall and auditory and visual hallucinations.

533. At Adelanto, Plaintiff Luis Manuel Rodriguez Delgadillo's intake was deficient, relying on his incomplete self-reporting of his psychotropic medication, declining to coordinate with his prior treating doctor even when provided that doctor's contact information by his family, and failing to gather records from that treatment. As a result, Mr. Rodriguez Delgadillo has become unstable and has had repeated episodes of acute mental health distress.

534. Further, Disability Rights California's 2019 report highlighted numerous examples of deficiencies in the intake screening process at Adelanto that resulted in discrimination against individuals with disabilities.[542]

535. For example, Adelanto's list of recognized disabilities in its screening protocol is arbitrary and incomplete.[543] Many common disabilities are missing entirely, such as those related to vision, hearing, and communication.[544] Physical

[542] Disability Rights California, *supra* note 36.
[543] *Id.* at 41.
[544] *Id.*

disabilities are inappropriately limited to "para/quadriplegia," "stroke," "amputation," and "cardiac condition."[545] There is no screening for housing accommodation needs, such as a placement in a lower bunk or accessible cell for detained individuals with mobility impairments.[546] The facility's screening also lacks a reliable or valid tool to identify detained individuals with intellectual or developmental disabilities.[547]

536. The DRC Adelanto report further documented the risk and, in some instances, actual harm that results from Defendants' failure to adequately identify and track individuals with disabilities. For example, a deaf asylum seeker at Adelanto was not provided sign language interpretation and had to go months with no way to communicate with staff, including during medical appointments.[548] Because of this, "[h]e had to point at the area of his body that was hurting and hope medical staff understood."[549]

537. Harm to people with disabilities also includes members of the Disability Subclass being subjected to punitive and counter-therapeutic responses when they engage in behavior that is a manifestation of their disability. [550] For example, a detained individual at Adelanto reported that he was pepper sprayed after staff saw him attempting suicide.[551]

4. **Defendants Systemically Fail to Prevent Improper Use of Segregation for Detained Individuals with Disabilities.**

538. As alleged earlier in this Complaint, Defendants repeatedly place detained individuals with disabilities in segregation, despite their own experts

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[545] *Id.*
[546] *Id.*
[547] *Id.*
[548] *Id.* at 42.
[549] *Id.*
[550] *Id.* at 27.
[551] *Id.*

having found that segregation is inappropriate and potentially harmful to detained individuals with disabilities, particularly to detained individuals with mental health disabilities.[552]

539. Indeed, Defendants' Segregation Directive recognizes that segregation of detainees with disabilities and other vulnerable detainees "should be used only as a last resort and when no other viable housing options exist."[553]

540. Detainee Death Reviews document improper placement and monitoring of individuals with disabilities as a contributing factor to a number of the deaths in Defendants' custody, including at Houston,[554] Hudson County,[555] and Farmville,[556] among others.

541. Additionally, in a 2017 report, OIG found numerous instances in which ICE failed to comply with its duties to oversee and monitor the segregation of detained individuals with mental health conditions.[557]

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[552] U.S. Immigration & Customs Enf't, *Directive No. 11065.1: Review of the Use of Segregation for ICE Detainees*, at ¶¶ 3.3, 5.2(5) (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.

[553] *Id.* at ¶ 2.

[554] *See, e.g.*, Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review – Clemente Ntangola Mponda*, https://www.ice.gov/doclib/foia/reports/ddr-mponda.pdf.

[555] *See, e.g.*, Office of Professional Responsibility, Office of Detention Oversight, *Detainee Death Review – Santo Carela*, https://www.ice.gov/doclib/foia/reports/ddr-Carela.pdf.

[556] *See, e.g.*, U.S. Dep't. of Homeland Sec., *Report of Investigation: RAMIREZ-Ramirez, Anibal/Unknown/0109 Detainee/Alien – Death (Known Cause – Terminal Illness)/FARMVILLE, PRINCE EDWARD, VA*, https://www.documentcloud.org/documents/2695511- Ramirez-Ramirez-Anibal.html#document/.

[557] Office of Inspector Gen., Office of Homeland Sec., OIG-17-119: *ICE Field Offices Need to Improve Compliance with Oversight Requirements for Segregation 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.

542. Defendants also fail to oversee and monitor detention facilities that utilize segregation to house detained individuals with disabilities due to inaccessible facilities or a lack of accommodations or auxiliary aids and services. For example, incident reports obtained and evaluated by The International Consortium of Investigative Journalists depict dozens of cases between 2012 and 2017 of detained individuals in segregation because of a disability that required use of an aid, such as a wheelchair, cane, or crutches, or because of a mental health disability.[558]

543. Plaintiff Jimmy Sudney was never placed in segregation while in county jail or state prison, but he has been placed in disciplinary segregation while in ICE custody. Mr. Sudney was placed in disciplinary segregation at Adelanto because he filed a grievance against an officer who was harassing him and her fiancée—another guard—who had joined in that conduct. They had a verbal altercation and Mr. Sudney was put in segregation for one week. There was no hearing before Adelanto put Mr. Sudney in segregation and the mental health clearance was cursory—when Mr. Sudney reported that he would not hurt or kill himself in segregation, they cleared him to be segregated. While he was in segregation, the guards knocked loudly on the door, and the people above him made noise that triggered a PTSD flashback. Mr. Sudney jumped under the bed and relived the earthquake in Haiti with his house coming down over him.

544. Plaintiff Jose Segovia Benitez has been placed in disciplinary segregation for three to five days on several occasions. During some of those segregation stays, on information and belief, he often did not receive daily medical

[558] Spencer Woodman, et al., *Solitary Voices: Thousands of Immigrants Suffer in Solitary Confinement in ICE Detention*, THE INTERCEPT (May 20, 2019), https://theintercept.com/2019/05/21/ice-solitary-confinement-immigration-detention/.

or mental health check-ins, despite Adelanto's records documenting his physical and mental health conditions.

545. Plaintiff Marco Montoya Amaya not only has PTSD and major depressive disorder, but has also been living with a likely untreated brain parasite for over a year. This brain parasite, left untreated, can cause severe and life-threatening symptoms, including irreversible cognitive and psychiatric symptoms. Mr. Montoya Amaya was placed in disciplinary segregation for approximately one week in May 2019 for accidentally eating an extra tray of food based on his failure to understand the officer's instructions. While in segregation, Mr. Montoya Amaya did not receive daily mental health or physical health evaluations, instead receiving only two mental health evaluations overall. To the extent he may have received some health evaluation before he entered segregation, that health evaluation was incomplete and incorrect; for example, despite indicating that the health professional had completed a chart review, a note in his medical record regarding segregation falsely indicated that Mr. Montoya Amaya did not have any headaches or dizziness, despite having those symptoms regularly documented throughout his medical records for over a year.

546. Plaintiff Faour Abdallah Fraihat has been placed in medical segregation for medical reasons four times while detained at Adelanto, including for around one week each of the two times he returned to Adelanto from the hospital. A doctor would check on him for at most ten minutes per day, and nurses came twice per day to check his vitals and bring him medication. Each of the four times Mr. Fraihat was in medical segregation he was not allowed out of his cell at any time, though he asked to be let out.

547. LaSalle staff has confined Plaintiff Melvin Murillo Hernandez to medical segregation since arriving at LaSalle on May 8, 2019, based on his severe allergies. Though he relied on other detained individuals to bring him to facility staff during previous anaphylactic shocks in which he lost consciousness, he is now

confined alone in a cell 24 hours a day. Facility staff now bring all of his meals, which consist mostly of eggs and rice, to his cell.

548. Plaintiff Hamida Ali, who has schizophrenia, was segregated and placed in a dorm by herself for approximately nine months, causing her to experience extreme psychological distress and suicidal ideation.

5. Defendants Systemically Fail to Provide People with Disabilities with Reasonable Accommodations, Auxiliary Aids, and Effective Communication.

549. Despite the supposed existence of the centralized systems described above, as a matter of practice, Defendants systemically fail to ensure that Detention Facilities provide detained individuals with disabilities with necessary accommodations, including mobility devices or other aids necessary for detained individuals with mobility disabilities to engage in activities of daily living; auxiliary aids, such as video phones, ASL interpretation, or effective means of communication for persons who are deaf or hard of hearing; and materials in Braille, large print, or other alternate formats for persons who are blind or have low vision. As a result, Defendants systemically fail to ensure detained individuals with disabilities have meaningful access to the benefits of Defendants' Detention Facilities Program.

550. As an initial matter, Defendants do not ensure Detention Facilities provide information during intake about the facility's reasonable accommodation and modification process and and otherwise fail to make available information regarding Section 504, its implemention regulations, and its applicability to Defendants' programs or activities in such a manner as is necessary to apprise detained individuals of the protections against discrimination assured them by Section 504 and its implemention regulations. For example, there is often no formal process in place to request, review, or respond to such requests.

551. Defendants also fail to ensure that, upon intake, Detention Facilities provide information to detained indiviudals regarding their rights under Section 504, including ensuring in an accessible format how to file a complaint under Section 504 and ensuring that such information is available in common areas in a manner that is accessible to indiviudals who have disabilities.

552. Further, Defendants fail to ensure that detention staff are trained in Section 504 obligations and related interactions with detained individuals with disabilities. For example, in Adelanto the Disability Compliance Manager disclosed he did not have prior disability-related training and received only a four-hour online training to fulfill the role requirement.[559]

553. The result of these failures is a broken system in which disability-based needs are routinely ignored, denying members of the Disability Subclass access to needed services and excluding them from critical benefits of Defendants' Detention Facilities Program.

554. Defendants fail to ensure that Detention Facilities provide deaf and hard of hearing detained individuals with auxiliary aids and services necessary to ensure effective communication. For example, Defendants fail to ensure that qualified interpreters are available for such interactions as medical appointments and disciplinary proceedings.

555. In many Detention Facilities, detained individuals who are deaf or hard of hearing must rely on peers, hand guestures, or lip reading to attempt to communication with staff because Defendants fail to ensure they have access to a qualified interpreter.

556. Further, many Detention Facilities lack timely processes to obtain devices and services needed to achieve effective communication. The processes to

[559] Disability Rights California, *supra* note 36, at 47.

request such devices are also discriminatory in themselves, because individuals are often required to submit a written request that does not come in accessible formats.

557. For example, Plaintiff Alcocer Chavez is Deaf and communicates in ASL. He has repeatedly been denied effective communication at Adelanto, which hinders his ability to communicate with ICE officials and medical staff. During Mr. Alcocer Chavez's time at Adelanto, he has never been provided with an ASL interpreter. Mr. Alcocer Chavez has had multiple interactions with ICE and medical staff without interpretation. There were several occasions during which he communicated with a doctor by writing notes back and forth. Due to his limited English, he did not understand much of the vocabulary the doctor used. Additionally, ICE officials have tried to convince Mr. Alcocer Chavez to sign documents without effectively communicating what the documents say.

558. Though Mr. Alcocer Chavez had access to a videophone when he was incarcerated in Riverside, California, he has not had access to a videophone in ICE detention at the Nevada Southern Detention Center or at Adelanto. Mr. Alcocer Chavez has requested a videophone at Adelanto, but a supervisor denied his request; instead, he was given limited access to Skype for short periods of time, and he is no longer allowed to even use Skype. He has also been granted TTY access for short periods of time. Yet the TTY is an antiquated communication system largely replaced in the deaf community by videophone. TTYs requires typing, which is difficult for most deaf people, including Mr. Alcocer Chavez, because of limited reading and writing skills in English. When Mr. Alcocer Chavez uses the TTY, guards take him to the intake area and lock him in a holding tank for hours before and after the call, measures not required of hearing detained individuals who wish to use a conventional telephone. As a result of ICE's failure to reasonably accommodate Mr. Alcocer Chavez, he has not been able to effectively communicate with his lawyers by phone while in detention.

559. Defendants also fail to ensure effective communication for detained individuals with vision disabilities.

560. For example, Plaintiff José Baca Hernández is blind. Neither Theo Lacy, where he had been detained, nor Adelanto, where he is currently detained, provided Mr. Baca a means of reading documents about his immigration case or medical care privately and independently, such as with a screen reader. At both facilities, Mr. Baca has been forced to rely on others—his cell mates, attorneys, and, at times, guards—to read documents for him. When he has needed to submit something in writing, such as a request to meet with an ICE officer, he has had to rely on others to write it for him.

561. Additionally, Detention Facilities routinely fail to provide inmates with mobility and other physical disabilities access to mobility devices, auxiliary aids, or other reasonable accommodations for their disability related-needs, and they often lack adequate processes to ensure that such accommodations are provided when needed.

562. For example, Plaintiff Faour Abdallah Fraihat has knee and back pain and a disc problem in his lower back that require the use of a wheelchair for mobility; his legs become numb when he tries to walk more than 10 to 15 feet. Though Adelanto provided Mr. Fraihat with a temporary wheelchair when he arrived in December 2016, staff took it away after one month and did not return the wheelchair to him until February 2019, two days after he filed a grievance because he had been making daily requests for months. For the more than one year in between, Mr. Fraihat was unable to get to the yard or to the cafeteria to eat. When officers did not bring him food, he ate whatever he was able to purchase from the commissary. His friends were not allowed to bring food from the cafeteria to him.

563. Staff also assigned Mr. Fraihat to the top bunk in his cell, though it is not accessible to him. The few times he made it up into the top bunk, it was very painful for him and he could not get down to use the bathroom. One time, he

slipped on the floor because he could not climb up. Mr. Fraihat has never met with an ADA Coordinator at Adelanto, and several of his requests for reasonable accommodations have been denied or delayed.

564. Plaintiff Aristoteles Sanchez Martinez has an expanding hernia, neuropathy, and a foot injury that has caused a bone spur and bone deterioration. As a result, Mr. Martinez has pain and uses a wheelchair for mobility. When Mr. Sanchez Martinez was transferred to the Stewart facility, he was placed in full restraints and could not use his wheelchair—leaving him no choice but to walk, despite his documented medical conditions that impair his mobility Three days after he arrived at Stewart, he was given a "provisional" wheelchair that was too small and uncomfortable. Over two weeks after arriving at Stewart, he was given a used, heavy wheelchair that strained his hernia every time he pushed it. A month after arriving at Stewart, Mr. Sanchez Martinez was finally given a suitable wheelchair when another detained individual who used a wheelchair left. At Stewart, Mr. Sanchez Martinez also sometimes has difficulty going through doorways without assistance from others. He was never offered a cane or crutches to help him walk shorter distances. There is one accessible shower, but the shower seat appears broken and not properly affixed and Mr. Sanchez Martinez fears using it. Instead, he has to use the wall to try to support himself when he showers.

565. When Mr. Sanchez Martinez arrived at Stewart, he was also forced to choose between his hernia belt and his back brace, despite the two accommodations serving different purposes from one another. Mr. Sanchez Martinez unwillingly relinquished his back brace. Despite requiring a cane or crutches to improve circulation throughout his feet, Mr. Sanchez Martinez has not been provided with either to help him move short distances.

566. Plaintiff Ruben Darío Mencías Soto has required multiple mobility aids after a fall in the shower while in detention severely reduced his mobility. At one time, Adelanto staff took away his crutches and told him he could have

crutches or a wheelchair, but not both. At the beginning of June, Adelanto took his wheelchair away, even though it is too painful for him to walk to the doctor or the cafeteria every time he needs to. Thus, for over a month, Mr. Mencías Soto ate only one meal a day at the cafeteria and tried to cobble together enough food from the commissary for the rest of the day. Rather than provide him with a mobility device, staff had suggested Mr. Mencías Soto live in the medical unit, where he will not have access to socialization or recreation activities. Mr. Mencías Soto only recently got his wheelchair back after sustained advocacy by an attorney.

567. Plaintiff Jimmy Sudney received reasonable accommodations in prison that are denied in ICE detention. For example, he had a wedge in prison to allow him to sleep with his head up so that his eye would drain, but the Adelanto ADA Coordinator denied his request because ICE has a "different standard." In prison, Mr. Sudney had special shoes for his flat feet, but Adelanto denied his request because the shoes have laces. In prison, Mr. Sudney had prescription tinted glasses, but ICE would not pay for what the doctor prescribed so he has lower-quality glasses. An officer at Adelanto calls out "blind man walking" when she sees Mr. Sudney walk by with his tinted glasses, and one time, she tried to take them away. Mr. Sudney spoke with the ADA Coordinator about this harassment and he said, "Can't do nothing about it. They bully you here."

568. Because of the acute pain stemming from his right hip, legs, and feet, Plaintiff Alex Hernandez cannot stay standing for more than 15 to 20 minutes at a time. Mr. Hernandez would benefit from a cane or walking stick.

569. Further, Mr. Hernandez requested an additional chair for his designated-accessible cell after experiencing increased pain with prolonged sitting or standing. He was told that the medical unit does not provide special chairs and to instead change positions when he was in pain, despite Mr. Hernandez already having received oral confirmation from Etowah staff that he could receive a medical request pass for the chair. Because of his back and hip pain, it is painful for

him to sit on a stool because it offers no support. Further, although Mr. Hernandez, was told his cell is accessible, it does not have a handrail by his toilet and it is difficult for him to support himself as he gets up. Mr. Hernandez was not housed in a cell that has a handrail by the toilet to assist with support.

570. Similarly, Mr. Hernandez does not have access to a handicapped shower properly equipped with a shower seat. He is terrified of falling and further injuring himself in the shower.

571. Mr. Hernandez had to wait over a month for a bottom bunk to open up, despite having a medical pass for that bunk approved on December 21, 2018. During the time he was waiting, he was forced to climb to a top bunk without a ladder. He had to use tremendous effort on his right shoulder to climb up and down the top bunk.

572. Plaintiff Sergio Salazar Artaga has been delayed and denied reasonable accommodations for his cerebral palsy, a mobility disability that makes it difficult for him to walk and to use the right side of his body. His metal cane was confiscated when he entered Florence, and he did not receive a wooden replacement until a day or two later. Because the accessible shower was broken, Mr. Salzar Artaga also requested a shower chair multiple times to avoid falling. He received it only after he had been at Florence for nearly three months.

573. Mr. Salazar Artaga also requested shoes and braces for his legs and knee so that he can walk more stably in the facility. He had two falls inside Florence, only after which he was provided more stable shoes. After receiving his shoes, he still had a third fall on his way to immigration court on April 23, 2019, but he still has not been provided with leg or knee braces. The first medical provider he requested them from at Florence was unfamiliar with these braces, and the second made a request for Mr. Salazar Artaga to receive the braces, provided that they did not interfere with safety or security at the facility. However, when Mr. Salazar Artaga went to an outside clinic for prosthetics and orthotics, he was told

that he would not receive the braces until ICE authorized payment for them. No such authorization has happened to date, so Mr. Salazar Artaga walks unsteadily without the aid of leg or knee braces, in constant fear that he will fall again.

574. Further, Defendants select Detention Facilities that are located in remote, rural areas that do not have access to internal or off-site care providers, with the effect that detained individuals with disabilities do not receive the care and treatment necessary for them to have meaningful access to the privileges and advantages of these Facilities provided to nondisabled detainees.

575. Defendants' practice of detaining people in remotely located facilities also causes a shortage in resources available to accommodate people with disabilities. For example, the area around LaSalle is devoid of Mexican Sign Language and other rarer sign language interpreters, so Defendants cannot accommodate individuals who are deaf or hard of hearing. In addition, a shortage of qualified mental health professionals in these areas leads to mental health conditions going untreated and cognitive disabilities going unaccommodated.

576. Many of the Detention Facilities are also not accessible for persons with mobility impairments, and often are not equipped with videophone or video relay technology, further preventing Defendants from providing reasonable accommodations to detained individuals who are deaf or hard of hearing. Similarly, Defendants fail to ensure that Detention Facilities have screen readers and other accommodations to assist those who are blind or have low vision.

577. Defendants' decision to contract with facilities without ensuring they have necessary services available is a significant contributing factor to their inability to provide adequate care and program access for members of the Disability Subclass.

578. For example, Plaintiff Raul Alcocer Chavez is Deaf and communicates in ASL, but has never been provided ASL interpretation at Adelanto. When Mr. Alcocer Chavez requested to use a videophone at Adelanto, which would have

enabled him to call his hearing lawyer with the use of an interpreter, a supervisor denied his request. Additionally, ICE officials have tried to convince Mr. Alcocer Chavez to sign documents without providing effective communication regarding what the documents say.

579. As another example, in Folkston, the medical unit that Plaintiff Aristoteles Sanchez Martinez visited twice a day to receive his insulin shots was in a different building. He would either have other detained individuals help him to the medical unit or he would strain his hernia and push himself there in his wheelchair. His wheelchair did not easily fit through the doorways and there were ramps and other walkways that required assistance for him to navigate. At Folkston, whenever he had a legal visit, he had to use a non-accessible van to go to the visit. Lifting himself in and out of the non-accessible van would cause him to strain his hernia and risk falling due to his Charcot's foot, neuropathy, and other conditions that impact his balance and mobility.

6. **Defendants Systemically Fail to Ensure Contractors do Not Subject Detained Individuals with Disabilities to Discrimination on the Basis of Their Disability**.

580. The criteria used by Defendants to enter into, expand, and renew contracts with contractors do not take into consideration whether the contractors have engaged in disability discrimination or whether they have effective systems in place to ensure that detained individuals with disabilities are afforded rights secured under Section 504.

581. This failure directly conflicts with the Defendants' Section 504 implementing regulations, which require Defendants to ensure that contract facilities and programs are readily accessible to and usable by detained individuals with disabilities. 6 C.F.R. §§ 15.10, 15.51.

582. Many contractors used by Defendants to operate Detention Facilities have a well-documented track record of failing to comply with disability statutes, including Section 504.

583. For example, one of Defendant's largest contractors, CoreCivic, fails to provide assistive devices, such as corrective lenses, to detained individuals with disabilities.[560]

584. Additionally, as set forth above, GEO-operated Adelanto has been the subject of numerous investigations, reports, and complaints documenting disability discrimination.[561]

585. GEO also operates the Aurora and South Texas Detention Facilities, and detained individuals with disabilities have been subjected to documented discrimination in both of those facilities.[562]

586. Nevertheless, ICE recently expanded its contract with GEO to increase the capacity of the Aurora facility,[563] and also awarded a direct contract to GEO to

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[560] Detainee Allies, *Testimony from Migrants and Refugees in the Otay Mesa Detention Center*, at 13 (Jan. 2019), http://www.detaineeallies.org/wp-content/uploads/2019/01/FINAL_Detainee-Allies-2019-0131b.pdf.

[561] *See, e.g.*, Disability Rights California, *supra* note 36.

[562] *See, e.g.*, Letter from American Immigration Council & American Immigration Lawyers Association to Thomas Homan, Acting Dir., Immigration & Customs Enf't, Dep't 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 (Aurora); Human Rights First, *Ailing Justice: Texas* (June 2018), https://www.humanrightsfirst.org/sites/default/files/Ailing_Justice_Texas.pdf (South Texas).

[563] *Extension of Use for Surge Beds at Aurora CDF*, Federal Business Opportunities, https://www.fbo.gov/index.php?s=opportunity&mode=form&id=24bf5af8f106d92a3abc7bc98fb8a51f&tab=core&_cview=0.

continue operating Mesa Verde in California after the municipality with which ICE originally contracted withdrew from the contract.[564]

587. Plaintiff Hamida Ali had a GEO-employed security guard inform her that she should stop saying that she was suicidal—so Ms. Ali declined to seek medical help at a moment when she was actively expressing suicidal ideation, even though she had a history of suicidal ideation and attempts.

588. Plaintiff Aristoteles Sanchez Martinez has experienced several instances where he has been forced by contractors to abandon his accommodations. For example, when he was transferred from Folkston to Stewart, Mr. Sanchez Martinez was placed in full restraints, and staff did not allow him to use his wheelchair. He was forced to walk throughout the entire day of transport in constant fear of falling and suffering from potentially fatal consequences. In addition, upon arriving at Stewart, the medical staff forced him to choose between his back brace and hernia belt.

589. In addition to repeatedly being denied effective communication in the form of ASL interpretation and videophone access, Plaintiff Raul Alcocer Chavez has experienced several instances of harassment by staff at Adelanto. Mr. Alcocer Chavez is Deaf and communicates in ASL. Staff at Adelanto mock him for that fact; they respond to his signing with gang signs, and they refuse to write back when he attempts to communicate with them in writing with his limited English. On one occasion, a staff member used his foot to get Mr. Alcocer Chavez's attention.

590. On information and belief, the criteria used by Defendants to enter into, expand, and renew contracts with contractors do not take into consideration whether the contractors have engaged in disability discrimination, or whether they

[564] Joseph Luiz, *Mesa Verde center will stay open with new contract*, The Bakersfield Californian, https://www.bakersfield.com/news/mesa-verde-center-will-stay-open-with-new-contract/article_29aef992-410b-11e9-a913-c75ff002d758.html.

have effective systems in place to ensure that detained individuals with disabilities are afforded rights secured under Section 504.

591. This failure directly conflicts with Defendants' Section 504 implementing regulations. Those regulations direct Detention Facilities to afford persons with disabilities equal opportunity to participate in or benefit from facilities' aids, benefits, or services, and to administer programs and activities in the most integrated setting appropriate. 6 C.F.R. § 15.30(b)(1).

592. As a result, members of the Disability Subclass have been denied such rights and are at significant risk of being denied those rights in the future.

B. The Fifth Amendment Prohibits the Federal Government from Subjecting Members of the Disability Subclass to Conditions That Rise to the Level of Punishment.

593. The Disability Plaintiffs and the Disability Subclass challenge ICE's failure to ensure that Detention Facilities do not subject civil detainees with disabilities to conditions that rise to the level of punishment.

594. Defendants fail to adequately monitor and oversee disability-related practices in Detention Facilities.

595. As a result, detained individuals with disabilities are subjected to the Disability Practices, which individually and collectively constitute punishment because they are expressly intended to punish, are not reasonably related to a legitimate governmental objective, and/or are excessive in relation to that objective.

596. In addition, due process requires that conditions in civil Detention Facilities may not be the same as or worse than those in a prison. *See King v. Cty. of Los Angeles*, 885 F.3d 548, 556–57 (9th Cir. 2018). However, as described in detail earlier in this Complaint, Defendants fail to ensure that detained individuals with disabilities are held in conditions that are not the same as or worse than those for persons with disabilities in criminal detention.

597. For example, Plaintiff Jimmy Sudney received reasonable accommodations in prison that were denied to him in ICE detention. Though Mr. Sudney had a wedge in prison to allow him to sleep with his head up so that his eye would drain, Eloy and Adelanto denied his request, both stating that ICE has a "different standard." In prison, Mr. Sudney had special shoes for his flat feet, but Adelanto denied his request because the shoes have laces. In prison, Mr. Sudney had prescription tinted glasses, but ICE would not pay for what the doctor prescribed so he has to make do with lower-quality glasses that his family purchased for him.

598. As another example, Plaintiff Raul Alcocer Chavez is Deaf and, though he had access to a videophone while he was in Riverside County Jail, he has not had access to a videophone in ICE detention. Mr. Alcocer Chavez has requested a videophone at Adelanto, but a supervisor denied his request, implying that he was a liar and had already used it. He has only been granted occasional Skype calls to his family, and TTY access for short periods of time. Yet TTY is an outdated technology that requires typing, which is difficult for Mr. Alcocer Chavez because he has limited reading and writing skills in English. A videophone would allow him to communicate in his primary language, ASL. Mr. Alcocer Chavez had better communication because of the videophone in the Riverside County Jail.

599. Plaintiff José Baca Hernández is blind and, when he was in jail, an ADA Coordinator checked in with him monthly regarding his need for accommodations and other disability-related needs. In ICE detention, neither Theo Lacy nor Adelanto conducted an intake that included a discussion of reasonable accommodations. At Adelanto, it took more than one year from the time he arrived at the facility for an ADA Coordinator to meet with him.

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,[565] 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;

[565] 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.

c. 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 at substantial risk of serious harm in violation of the Due Process Clause of the Fifth Amendment;

d. Whether Defendants have been deliberately indifferent to the serious health care and other needs of Class members; and

e. Whether Defendants have systemically abdicated their constitutional and statutory duty to monitor conditions in the Detention Facilities.

603. Defendants are expected to raise common defenses to these claims, including denying that their actions violate the law.

604. The claims of the Plaintiffs are typical of those of the Class, as their claims arise from the same policies, practices, omissions, or courses of conduct, and their claims are based on the same theory of law as the Class's claims.

605. Plaintiffs are capable of fairly and adequately protecting the interests of the Class because Plaintiffs do not have any interests antagonistic to the Class. Plaintiffs, as well as the Class members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, Plaintiffs are represented by counsel experienced in civil rights litigation, litigation regarding the rights of detained individuals, and complex class action litigation.

606. This action is maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(1) because there are more than 50,000 class members, and the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn could establish conflicting and incompatible standards of conduct for Defendants. Additionally, the prosecution of separate actions by individual members could result in adjudications

with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

607. This action is also maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(2) because Defendants' policies, practices, actions, and omissions that form the basis of this Complaint are common to and apply generally to all members of the Class, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the Class. Defendants' monitoring and oversight practices and policies are centrally promulgated, disseminated, and enforced. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Class.

X. Segregation Subclass

608. The Segregation 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 subclass (the "Segregation Subclass") consisting 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 Segregation Practices as a result of Defendants' failure to adequately administer, monitor, or oversee conditions at Detention Facilities.

609. The Segregation Subclass is so numerous that joinder of all members is impracticable. For example, a 2017 OIG report looked at segregation placements at just seven facilities from October 1, 2015, to June 30, 2016. During that time, there were 713 segregation placements for detained individuals with mental health conditions.[566] In addition, members of the Segregation Subclass are geographically dispersed at Detention Facilities throughout the country.

[566] Office of Inspector Gen., Dep't of Homeland Sec., *OIG-17-119: ICE Field Offices Need to Improve Compliance with Oversight Requirements for Segregation 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.

610. There are questions of law and fact common to the members of the Segregation Subclass. Such questions include, but are not limited to:

a. Whether Defendants violate the Due Process Clause of the Fifth Amendment by failing to ensure that placement of detained individuals in administrative and disciplinary segregation at Detention Facilities is consistent with constitutional requirements;

b. Whether Defendants have been deliberately indifferent to the Subclass members' serious risk of substantial injury from the debilitating isolation and inhumane conditions to which they are subjected; and

c. Whether the Segregation Practices constitute punishment in violation of the Due Process Clause of the Fifth Amendment.

611. Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

612. The claims of the Segregation Plaintiffs are typical of those of the Segregation Subclass, as their claims arise from the same policies, practices, or courses of conduct, and their claims are based on the same theory of law as the Segregation Subclass's claims.

613. The Segregation Plaintiffs are capable of fairly and adequately protecting the interests of the Segregation Subclass because these Plaintiffs do not have any interests antagonistic to the Subclass. The Segregation Plaintiffs, as well as the Segregation Class members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, the Segregation Plaintiffs are represented by counsel experienced in civil rights litigation, litigation regarding the rights of detained individuals, and complex class action litigation.

614. This action is maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(1) because the Segregation Subclass exceeds 1,000

members, and the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn could establish incompatible standards of conduct for Defendants. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

615. This action is also maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(2) because Defendants' monitoring and oversight policies and practices regarding segregation are common to and apply generally to all members of the Segregation Subclass, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the Segregation Subclass. Defendants' monitoring and oversight practices and policies regarding segregation are centrally promulgated, disseminated, and enforced. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Segregation Subclass.

XI. Disability Subclass

616. The Disability 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 subclass (the "Disability Subclass") consisting of all qualified individuals with a disability, as that term is defined in 29 U.S.C. § 705(9), who are now, or will in the future be, subjected to the Disability Practices as a result of Defendants' failure to adequately administer, monitor, and oversee conditions at Detention Facilities.

617. The Disability Subclass is so numerous that joinder of all members is impracticable. For example, according to a 2008 Washington Post report, internal ICE memos estimate that about 15% of the detained population (which would be in excess of 8,000 detained individuals with today's detention population) have

mental health disabilities.[567] The total number of detained individuals with any disability exceeds this number. In addition, the Disability Subclass is geographically dispersed at Detention Facilities throughout the country.

618. There are questions of law and fact common to the members of the Disability Subclass. Such questions include, but are not limited to:

a. Whether Defendants' failure to ensure that Detention Facilities have in place systems that identify detained individuals with disabilities, and provide for reasonable accommodations for detained individuals with disabilities, violates Section 504;

b. Whether Defendants' failure to ensure that Detention Facilities have in place systems to provide auxiliary aids and services to ensure effective communications with detained individuals with disabilities violates Section 504;

c. Whether Defendants' failure to ensure that Detention Facilities do not use segregation in lieu of proper mental health treatment violates Section 504;

d. Whether the discriminatory effect on detained individuals with disabilities of Defendants' selection of Detention Facilities and contractors violates Section 504; and

e. Whether the Disability Practices constitute punishment in violation of the Due Process Clause of the Fifth Amendment.

619. Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

[567][567] Dana Priest et al., *Suicides Point to Gaps in Treatment: Errors in Psychiatric Diagnoses and Drugs Plague Strained Immigration System*, Wash. Post (May 13, 2008), https://www.washingtonpost.com/wp-srv/nation/specials/immigration/cwc_d3p1.html?noredirect=on.

620. The claims of the Disability Plaintiffs are typical of those of the Disability Subclass, as their claims arise from the same policies, practices, or courses of conduct, and their claims are based on the same theory of law as the Disability Subclass's claims.

621. Plaintiffs are capable of fairly and adequately protecting the interests of the Disability Subclass because the Disability Plaintiffs do not have any interests antagonistic to the class. The Disability Plaintiffs, as well as the Disability Subclass members, seek to enjoin the unlawful acts and omissions of Defendants. Finally, the Disability Plaintiffs are represented by counsel experienced in civil rights litigation, litigation regarding the rights of detained individuals, and complex class action litigation.

622. This action is maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(1) because the Disability Subclass exceeds 8,000 members, and the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn could establish incompatible standards of conduct for Defendants. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

623. This action is also maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(2) because Defendants' monitoring and oversight policies and practices relevant to detained individuals with disabilities are common to and apply generally to all members of the Disability Subclass, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the Disability Subclass. Defendants' disability policies are centrally promulgated, disseminated, and enforced. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Disability Subclass.

CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF

XII. Violation of the Due Process Clause of the Fifth Amendment: Failing to Monitor and Prevent the Challenged Practices (All Plaintiffs and the Class Against All Defendants).

624. Plaintiffs reallege and incorporate the allegations set forth in the preceding paragraphs as though fully set forth herein.

625. By their policies, omissions, and practices described herein, Defendants fail to adequately monitor, oversee, and administer Detention Facilities, and as a result, Plaintiffs and the Class are subjected to the Challenged Practices.

626. The Challenged Practices, alone or in combination, constitute punishment and subject Individual Plaintiffs and the Class to a significant risk of serious harm.

627. As a result of the Challenged Practices, the Organizational Plaintiffs have had to divert resources, and have had their missions frustrated.

628. Defendants have a nondelegable duty to ensure that the conditions of confinement in the facilities operated by ICE's employees and contractors are constitutionally adequate.

629. 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 Plaintiffs' and the Class's ongoing deprivation of rights secured by the United States Constitution under the Fifth Amendment.

630. Defendants have been and are aware of all the deprivations complained of herein and have condoned or been deliberately indifferent to such conduct.

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.

636. Defendants have been and are aware of all the deprivations complained of herein and have condoned or been deliberately indifferent to such conduct.

THIRD CLAIM FOR RELIEF

XIV. Violation of Due Process Clause of the Fifth Amendment: Failing to Monitor and Prevent Disability-Related Practices That Constitute Punishment (Organizational Plaintiffs, Disability Plaintiffs, and Members of the Disability Subclass Against All Defendants).

637. Plaintiffs reallege and incorporate the allegations set forth in the preceding paragraphs as though fully set forth herein.

638. By their policies, omissions, and practices described herein, Defendants fail to adequately monitor, oversee, and administer Detention Facilities. As a result, the Disability Plaintiffs and the Disability Subclass are subject to conditions of confinement that constitute punishment.

639. As a result of these policies, omissions, and practices, the Organizational Plaintiffs have had to divert resources, and have had their missions frustrated.

640. 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, Disability Plaintiffs' and the Disability Subclass's ongoing deprivation of rights secured by the United States Constitution under the Fifth Amendment.

641. Defendants have a nondelegable duty to ensure that members of the Disability Subclass are not held in conditions that are punitive in violation of the Due Process Clause.

642. The conditions described above for members of the Disability Subclass, alone or in combination, are identical to, similar to, or more restrictive

than those under which persons accused or convicted of crimes are confined in jails or prisons; are expressly intended to punish civil detainees; are not reasonably related to legitimate governmental objective; and/or are excessive in relation to any proffered objective and more restrictive than necessary. This violates the Due Process Clause.

643. Defendants have been and are aware of all the deprivations complained of herein and have condoned or been deliberately indifferent to such conduct.

FOURTH CLAIM FOR RELIEF

XV. Violation of Section 504 of the Rehabilitation Act, 29 U.S.C. § 794 (Organizational Plaintiffs, Disability Plaintiffs, and the Disability Subclass Against Defendants DHS, ICE, and IHSC).

644. Plaintiffs reallege and incorporate the allegations set forth in the preceding paragraphs as though fully set forth herein.

645. At all times relevant to this action, Defendants are federal executive agencies within the meaning of the Rehabilitation Act. As such, they are required to comply with the provisions of Section 504.

646. Defendants are legally responsible for all violations of Section 504 committed by their contractors arising from their operation of Detention Facilities. 6 C.F.R. § 15.30(b)(1).

647. Defendants are also directly responsible for their systemic use of deficient monitoring and oversight practices and policies that result in the denial of detained individuals with disabilities' rights under Section 504. *Id.*

648. Detention Facilities are required to reasonably accommodate detained individuals with disabilities, to provide them with auxiliary aids and services, and to ensure effective communication, so that those detained individuals can avail themselves of and participate in all programs and activities offered at the Detention Facilities.

649. As described above, Defendants have failed to ensure that Detention Facilities reasonably accommodate the Disability Plaintiffs and members of the Disability Subclass, provide them with auxiliary aids and services, and provide them with effective communication.

650. Detention Facilities must also comply with regulations promulgated by DHS implementing Section 504. *See* 6 C.F.R. Part 15. Detention Facilities are in violation of many of these regulations, including without limitation by:

a. Denying the Disability Plaintiffs and members of the Disability Subclass "the opportunity to participate in or benefit from the aid, benefit, or service." 6 C.F.R. § 15.30(b)(1)(i).

b. Affording the Disability Plaintiffs and members of the Disability Subclass with "an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others." 6 C.F.R. § 15.30(b)(1)(ii).

c. Providing the Disability Plaintiffs and members of the Disability Subclass "with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others." 6 C.F.R. § 15.30(b)(1)(iii).

d. Providing the Disability Plaintiffs and members of the Disability Subclass with "different or separate aid, benefits or services . . . than is provided to others unless such action is necessary to provide qualified individuals with a disability with aid, benefits or services that are as effective as those provided to others." 6 C.F.R. § 15.30(b)(1)(iv).

e. Otherwise denying the Disability Plaintiffs and members of the Disability Subclass "the enjoyment of any right, privilege,

advantage, or opportunity enjoyed by others receiving the aid, benefit, or service." 6 C.F.R. § 15.30(b)(1)(vi).

f. Using "criteria or methods of administration," "directly or through contractual or other arrangements," "the purpose or effect of which" is to subject the Disability Plaintiffs and members of the Disability Subclass to "discrimination on the basis of disability." 6 C.F.R. § 15.30(b)(4), (b)(4)(i).

g. Using "criteria or methods of administration," "directly or through contractual or other arrangements," "the purpose or effect of which" is to "[d]efeat or substantially impair accomplishment of the objectives of a program or activity with respect to" the Disability Plaintiffs and members of the Disability Subclass. 6 C.F.R. § 15.30(b)(4)(ii).

h. Making determinations "concerning the site or location" of Detention Facilities, "the purpose or effect of which" as to the Disability Plaintiffs and members of the Disability Subclass is to "[e]xclude individuals with disabilities from, deny them the benefits of, or otherwise subject them to discrimination under any program or activity conducted by the Department." 6 C.F.R. § 15.30(b)(5)(i).

i. Making determinations concerning "the site or location" of Detention Facilities, "the purpose or effect of which" is to "[d]efeat or substantially impair the accomplishment of the objectives of a program or activity" with respect to the Disability Plaintiffs and members of the Disability Subclass. 6 C.F.R. § 15.30(b)(5), (b)(5)(ii).

j. Using "criteria" "in the selection of procurement contractors" that as to the Disability Plaintiffs and members of the Disability

Subclass "subject qualified individuals with a disability to discrimination on the basis of disability." 6 C.F.R. § 15.30(b)(6).

k. Failing to "administer programs and activities in the most integrated setting appropriate to the needs of" the Disability Plaintiffs and members of the Disability Subclass. 6 C.F.R. § 15.30(d).

l. Failing to conduct an adequate self-evaluation to identify modifications to policies and practices at Detention Facilities needed to ensure the programs and services at such facilities are readily accessible to and usable by detained individuals with disabilities, and to provide opportunity for input from the disability community in this process. 6 C.F.R. § 15.10; *see generally* 6. C.F.R. § 15.1 *et seq.*

m. Failing to conduct adequate transition planning to identify structural or other changes needed to achieve program accessibility at Detention Facilities. 6 C.F.R. § 15.50(d).

651. The Disability Plaintiffs and the Disability Subclass they represent are qualified individuals with disabilities as defined in the Rehabilitation Act.

652. Because of Defendants' Disability Practices, and systemic policy and practice of failing to adequately monitor, oversee, and administer Detention Facilities, members of the Disability Subclass are subject to violations of Section 504, including the Disability Practices, at Detention Facilities, and these violations are continuing and recurring.

653. As a result, the Disability Plaintiffs and the members of the Disability Subclass are discriminated against, not reasonably accommodated, do not have equal access to detention center activities, programs, and services for which they are otherwise qualified, and otherwise suffer violations of Section 504 by Defendants.

654. Further, as a result of these policies and practices, the Organizational Plaintiffs have had to divert resources, and have had their missions frustrated.

655. Accordingly, Defendants have violated rights secured under the Rehabilitation Act to the Organizational Plaintiffs, the Disability Plaintiffs and the Disability Subclass.

PRAYER FOR RELIEF

656. Plaintiffs and the Class and Subclasses they represent have no adequate remedy at law to redress the wrongs alleged in this complaint. Plaintiffs and the Class and Subclasses they represent have suffered and will continue to suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of defendants, as alleged herein, unless Plaintiffs and the Class and Subclasses they represent are granted the relief they request. The need for relief is critical because the rights at issue are paramount under the United States Constitution and the laws of the United States.

657. WHEREFORE, the Plaintiffs and the Class and Subclasses they represent request that this Court grant them the following relief:

a. Declare that the suit is maintainable as a class action pursuant to Federal Rules of Civil Procedure 23(a), 23(b)(1), and 23(b)(2), and appoint the undersigned as Class Counsel;

b. Declare that the conditions, acts, omissions, policies, and practices described above are in violation of the rights of Plaintiffs and the Class and Subclasses they represent under the Fifth Amendment to the United States Constitution, and the Rehabilitation Act;

c. Permanently enjoin Defendants, their agents, employees, and officials, from subjecting Plaintiffs and the Class and Subclasses

to the illegal and unconstitutional conditions, acts, omissions, policies, and practices set forth above;

d. Order Defendants and their agents, employees, and officials to develop and implement, as soon as practicable, a plan to eliminate the substantial risk of serious harm, discrimination, and statutory violations that Plaintiffs and members of the Class and Subclasses they represent suffer due to the unlawful acts, omissions, conditions and practices described in this Complaint. Defendants' plan shall include at a minimum taking all necessary steps to ensure the following conditions at immigration Detention Facilities:

i. Access: Ensure that Individual Plaintiffs and the Class have timely access to healthcare;

ii. Specialty and chronic care: Ensure that Individual Plaintiffs and the Class have timely access to competent specialty care and care for chronic conditions;

iii. Training and qualifications: Ensure that Detention Facility staff and medical providers that provide healthcare to Individual Plaintiffs or the Class are adequately qualified and trained to carry out their duties;

iv. Emergency care: Ensure timely and competent responses to healthcare emergencies suffered by Individual Plaintiffs or the Class;

v. Screening: Ensure reliable screening for medical or mental health conditions of Individual Plaintiffs or the Class that need treatment;

vi. Staffing: Ensure staffing that is sufficient to provide Individual Plaintiffs and the Class with timely access to

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

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;

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,

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