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RE: Request for Immediate Action on Behalf of Individuals Detained at Baker County Detention Center Due to Systemic Medical Neglect

Dear Dr. Rivera, *et al.*:

We write to alert ICE Health Services Corps ("IHSC") and the Department of Homeland Security ("DHS") of ongoing, systemic, and dangerous patterns of medical neglect at Baker County Detention Center ("Baker") in Macclenny, Florida. Baker is operated by the Baker County Sheriff's Office ("BCSO") and Baker County Corrections Management Corporation ("BCCMC"). BCSO entered into an Intergovernmental Services Agreement ("IGSA") with Immigration Customs Enforcement ("ICE") on August 3, 2009, to detain individuals in immigration custody. Under the terms of the IGSA, Baker operations must comply with ICE's 2019 National Detention Standards ("2019 NDS").[1] The IGSA also sets forth specific contractual obligations, including health care requirements, and specifies that IHSC has supervisory authority over health care provided at the Baker facility.[2] [3]

Based on IHSC's responsibility and authority to ensure the proper medical and mental health care for immigrants in ICE detention, we write to ask that you intervene at Baker to address reports of systemic and life-threatening medical neglect.

Baker entered into a subcontract with Armor Correctional Health Services ("Armor") to provide medical care to both people in ICE custody and people in criminal custody. Armor has a well-documented history of failing to provide appropriate medical care at ICE detention facilities, including the Glades County Detention Center, which ICE is currently not using due to concerns of systemic medical neglect.[4] Based on our interviews of detained individuals, review of medical records to date, and consultation with medical experts, this pattern continues at Baker.

[1] Ex. 1, IGSA between ICE and Baker County Sheriff's Office ("IGSA") at 5, 72.
[2] *Id*. at 7-9.
[3] The IGSA also references the authority of DIHS (Department of Immigration Health Services), which upon information and belief is part of IHSC. *See* IGSA at 7, § K.
[4] *See, e.g.*, ACLU of Florida, *Immigrant Rights Advocates Submit Civil Rights Complaint to Shut Down Glades County Detention Center, Amidst Reckless COVID-19 Response*, Feb. 22, 2021, https://www.aclufl.org/en/press-releases/immigrant-rights-advocates-submit-civil-rights-complaint-shut-down-glades-county; Cary Barbor, *ICE to pause use of Glades Detention Center*, Mar. 25, 2022, https://news.wgcu.org/2022-03-25/ice-to-limit-use-of-glades-detention-center.

As Dr. Amy Zeidan, Assistant Professor of Emergency Medicine at Emory University School of Medicine, explains based on her review of Baker medical records, there is grave concern that this "facility does not have the necessary medical resources to appropriately manage individuals with multiple medical problems or serious medical problems." Ex. 2, Letter from Dr. Amy Zeidan, April 12, 2023. Armor demonstrates a dangerous pattern of undertreatment, failure to timely follow up on serious medical conditions and concerns, and neglecting to provide appropriate or correct treatment, for both physical and mental health conditions. *See id*.

BCSO and Armor (with BCCMC's oversight) also appear to engage in a pattern of inappropriate and unsafe use of solitary confinement (disciplinary or administrative segregation). As detailed in the examples below, there is a pattern of excessive and unwarranted confinement, lack of adherence to IHSC Policies on Therapeutic Isolation[5] when employing solitary confinement, and disregard for individuals' mental health diagnoses and deterioration when employing and continuing the use of solitary confinement. These abuses have caused lasting damage and are dangerous practices that require your immediate attention and intervention.

Dr. Zeidan's team has reviewed medical records for several of our clients currently or recently detained at Baker, and their review has identified significant concerns that are evidently emblematic of the facility's systemic inability to provide appropriate medical treatment to the immigrants detained at Baker.[6]

Per the 2019 NDS, individuals detained at Baker must receive timely, thorough, and appropriate medical care.[7] BCSO is required to provide: (2) "[m]edically necessary and appropriate medical, dental and mental health care and pharmaceutical services at no cost to the detainee;" (5) "[s]pecialty healthcare;" and (6) "[t]imely responses to medical complaints."[8] Likewise, the Supreme Court has found that the government has an obligation to provide medical care to incarcerated individuals under the Constitution.[9] BCSO has failed to meet its obligations under the NDS and the Constitution. The examples detailed below illustrate a pattern of neglect that, upon review, warrants the immediate release of individuals detained at Baker, especially those with medical conditions, and the termination of the IGSA. Additionally, the reports from the

[5] IHSC Operations Memorandum, Medical Restraint and Therapeutic Seclusion/ Administrative Segregation, OM-16-024, March 24, 2016.
[6] To date, Dr. Zeidan and her team have reviewed the medical records for David Musa, Harriette Beck, Danielle Gaul, and Charles Smith. The ACLU of Florida has a number of additional clients that report medical neglect at Baker. We have described some of these cases herein and hope to have further medical expert analysis in the near future. We would welcome the opportunity to discuss information about additional clients and events substantiating serious medical neglect at Baker. The individuals included in this letter by no means make up the entirety of individuals who have reported complaints of medical neglect at Baker. Please review the Florida Detention Database for more details regarding the pattern of medical neglect at Baker.
[7] 2019 ICE National Detention Standards, § 4.3(I).
[8] *Id*. at (II)(A)(2), (5), (6).
[9] *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

individuals detained at Baker merit an immediate investigation into medical care practices at Baker.

As set forth below, our interviews and review of available records substantiate a pattern of serious and life-threatening medical neglect and other disregard by local authorities at Baker for the wellbeing of individuals in their custody, placing the latter in grave danger. The cases detailed in this letter are a small sample of a widespread problem and include the following instances of medical neglect:[10]

- Emergency hospitalizations due to misdiagnosis and failure to follow standards of care;
- Failure to identify and treat serious medical conditions;
- Undertreatment of serious medical conditions;
- Significant and life-threatening delays in providing treatment;
- Improper discontinuation of medical devices;
- Failure to communicate medical information to patient;
- Denial of medical records;
- Improper use of solitary confinement/administrative segregation; and
- Failure to provide mental health treatment.

We urge you to review the examples detailed below, release immigrants detained at Baker, initiate an immediate investigation into the medical care provided at Baker, and call for the termination of the IGSA.

A. Danielle Gaul

Ms. Danielle Gaul is a 56-year-old woman with multiple life-threatening conditions that require constant care, including HIV and hypertension. Ms. Gaul was detained at Baker from December of 2022 to March of 2023, with brief absences due to an emergency hospitalization and a failed deportation attempt resulting in a medical emergency. Ms. Gaul's records also contain diagnostic testing results indicative of diabetes, congestive heart failure, hyperlipidemia, and a disc protrusion, all of which went unaddressed or untreated during her time at Baker. *See* Letter from Dr. Patrick Rizk and Amy Zeidan regarding Ms. Danielle Gaul, March 21, 2023, attached hereto as Ex. 3.

[10] The ACLU of Florida's Immigration Detention Database has documented 110 instances where individuals in detention have reported being denied medical care since 2020. *See* ACLU of Florida, Florida Immigration Detention Database Tableau available at https://public.tableau.com/app/profile/aclu.fl/viz/FLDetentionDatabase/u.

a. Hospitalization Due to Poorly Managed Hypertension

When Ms. Gaul walked into Baker, she was not in acute medical distress. A week later, she had to be hospitalized and required a wheelchair for mobility. On December 30, 2022, Ms. Gaul collapsed due to poorly controlled hypertension. She was initially taken to a local hospital, Ed Fraser Memorial Hospital ("Ed Fraser") in Macclenny, Florida.[11] She was subsequently transferred to HCA Florida Memorial Hospital ("HCA") in Jacksonville, Florida where she remained for four days.[12] Her hospital records reveal that when she first arrived at HCA she was in a "severe altered mental status," and was "unresponsive" and unable to provide basic information about her medical history.[13]

Ms. Gaul reports that when she was initially taken into ICE custody, she notified an officer that she must take medication daily to control her blood pressure. She also disclosed this information to BCSO and Armor staff upon arrival on December 22, 2022.[14] Despite her repeated requests to receive her blood pressure medication during her transit to and arrival at Baker, the first dose of any antihypertensive medication was given to her more than 24 hours after arriving.[15] Even then, Dr. Rizk and Dr. Zeidan note in their analysis of Ms. Gaul's medical records that the medication provided was not a "first line agent[]" for hypertension management and, as a result, her hypertension was poorly controlled.[16]

Armor's records indicate that Ms. Gaul collapsed as a result of a seizure that they later diagnosed as epilepsy.[17] As noted by Dr. Rizk and Dr. Zeidan in their analysis of Ms. Gaul's medical records, however:

> Ms. Gaul was noted to have new onset seizure activity in the setting of poorly controlled hypertension. This was subsequently diagnosed as epilepsy which would be exceedingly uncommon for a new diagnosis of epilepsy in a 56-year-old woman with no past neurologic history.[18]

Dr. Rizk and Dr. Zeidan further express that her collapse was very likely caused by her poorly controlled hypertension, and "raises concern for hypertensive emergency and or Posterior Reversible Encephalopathy syndrome (PRES) which would necessitate a broader workup for other signs of end organ dysfunction, including but not limited to cardiac enzymes, renal function,

[11] Danielle Gaul-Full Baker Medical History, attached hereto as Ex. 4, at 24 of 285.
[12] *Id.* at 148 of 285.
[13] *Id.* at 220 and 230 of 285.
[14] *Id.* at 7 of 285.
[15] *Id.* at 95 and 220 of 285.
[16] Rizk and Zeidan Letter at 1.
[17] Danielle Gaul-Full Baker Medical History at 40 of 285.
[18] Rizk and Zeidan Letter at 2.

ophthalmologic exam. Ms. Gaul did not receive any of this workup."[19] The doctors that treated Ms. Gaul at HCA shared this hypothesis. As noted in Ms. Gaul's hospital records, when she was transferred from Ed Fraser her blood pressure was "extremely high," which led the doctors at HCA to "highly" suspect PRES syndrome, which "can cause seizures."[20] Still, upon returning to Baker, Ms. Gaul retained Armor's very unlikely diagnosis of epilepsy.[21]

During her time in the hospital, Ms. Gaul's husband, Mr. Dolcen Pierre, received a call from other detained individuals at Baker informing him that Ms. Gaul had collapsed and been transported to a hospital. Mr. Pierre, who is listed as Ms. Gaul's emergency contact in her medical records,[22] attempted to contact Baker to get more information and was incorrectly told that his wife was at Baker, in good health and not hospitalized. He was not able to reach her or know of her whereabouts and health status until almost a week later when she was returned to Baker and was able to contact him.

i. Improper Discontinuation of a Medical Device

Following her return from the hospital, Ms. Gaul required a wheelchair and was unable to safely move around without it.[23] After months of utilizing the wheelchair, Armor abruptly discontinued her permission to use any wheelchair, without giving her the support of physical therapy or the benefit of specialist's medical opinion. Ms. Gaul was told to use a walker moving forward.[24] On February 18, 2022, the day after Ms. Gaul's wheelchair use was discontinued, Ms. Gaul fell trying to carry a cup of water and walk with the assistance of the walker.[25] She spent several days in the medical unit because Armor provided her an impossible ultimatum: leave with no wheelchair or remain in medical observation.[26] Ms. Gaul did not feel capable of using the walker to get around after her fall so she remained in the medical unit.[27] Armor's actions are particularly egregious in light of the fact that Ms. Gaul's difficulty walking could be attributed to a disc protrusion and possible pinched nerve, a diagnosis made by Armor's own staff on January 5, 2023 and discussed further below.[28]

[19] *Id.*
[20] Danielle Gaul-Full Baker Medical History at 219-246 of 285.
[21] *Id*. at 18-19, 40, 52, 55, 61, 148, 184 of 285.
[22] *Id*. at 7 of 285.
[23] *Id*. at 39 of 285.
[24] *Id.* at 183 of 285.
[25] *Id.* at 43 of 285.
[26] *Id.*
[27] *Id.*
[28] *Id.* at 182 of 285.

ii. Improperly Cleared for Travel

Despite Ms. Gaul's pending appeal, and thirty years of residence in the United States, ICE seemed determined to quickly remove Ms. Gaul at all costs. Directly following her second fall and stay in the medical unit in February of 2023, ICE attempted to deport Ms. Gaul despite her precarious state at the time.

Armor's records indicate that medical staff cleared Ms. Gaul for travel without so much as taking her blood pressure.[29] There are notations that she was screened for COVID; however, there is no record of a blood pressure screening to ensure her blood pressure was stable prior to clearing her for travel.[30] This is alarming considering Ms. Gaul was previously hospitalized for this very condition less than two months prior to the date of transfer, and was just recovering from a second fall. The Medical Summary for Transport dated February 21, 2023, is also troubling. It states that Ms. Gaul may be "in travel status" for an unrestricted amount of time and does not require "any medical equipment while in transport status."[31] While the form lists some of Ms. Gaul's diagnoses, it leaves off others such as her untreated diabetes, disc protrusion, and potential heart condition, and falls woefully short of alerting the reader to Ms. Gaul's fragile health.

In fact, the very kind of danger that use of the Medical Summary Transport form is meant to prevent, occurred during Ms. Gaul's transport on that date. She reports that upon arriving at the Miami International Airport on or about February 21, 2023, she collapsed a third time since coming into ICE custody after not being provided her medication despite being in transit for almost three days.[32] After her return to Baker following the failed attempt by ICE to transport her for deportation, she described the event during an initial Behavioral Health evaluation on February 23, 2023:

> I was having severe headaches on the bus at the airport and next thing I knew I passed out. They had to call 911 and they gave me one pill but my blood pressure was still high so they could not take me. That's why they brought me back here. I spent 6 days with my family not knowing where I was…I fell when I was in ICE custody and they are suppose to pay for me therapy but they don't want to pay for me to get therapy. They want to send me to Haiti in a wheelchair.[33]

This incident, like so many others described herein, was avoidable, unnecessarily risky and further demonstrates the lack of care for the wellbeing of those detained at Baker. Ms. Gaul was still in recovery, had just sustained a second fall after having her wheelchair use

[29] *See* generally, Danielle Gaul-Full Baker Medical History.
[30] *Id.* at 46 of 285.
[31] *Id.* at 251 of 285.
[32] *Id.* at 67 of 285.
[33] *Id*.

discontinued and, based on the recommendations of the doctors who treated her at HCA, still required significant follow-up.[34] Despite all this, she was cleared for travel without question.

b. HIV

Though it appears Ms. Gaul was receiving medication for her HIV diagnosis, it does not appear that she was evaluated by an infectious disease specialist which, according to Dr. Rizk and Dr. Zeidan, is "critical given the seriousness of this condition and need for routine monitoring."[35] It appears that Armor made two requests for consultations with an Infectious Disease Specialist, the earliest of which was over a month after Ms. Gaul arrived.[36] It is not apparent from Ms. Gaul's records that she was ever actually seen.

c. Undertreated and Undiagnosed Medical Conditions

i. Hyperlipidemia and Diabetes

Ms. Gaul was previously diagnosed with hyperlipidemia which, Dr. Rizk and Dr. Zeidan point out, is further confirmed in lipid studies that show an elevated LDL cholesterol.[37] According to Dr. Rizk and Dr. Zeidan, the recommended course of treatment would have been to place Ms. Gaul on a "cholesterol lowering medication, namely a statin."[38] Ms. Gaul was given only 10mg of simvastatin by Armor, which Dr. Rizk and Dr. Zeidan further state is "considered 'low-intensity' statin therapy and would not be appropriate."[39] Because Ms. Gaul's condition, if left undertreated, places her at significant risk for heart attack and stroke, she should have been prescribed "high intensity statin use which includes Atorvastatin 40-80mg and Rosuvastatin 20-40mg."[40]

It is also important to note that Ms. Gaul's blood work revealed levels of hemoglobin A1C of 7.1, "which is consistent with diabetes."[41] Her medical records do not reflect that she was being treated for or advised of her diabetes.

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[34] *Id.* at 219-246 of 285.
[35] Rizk and Zeidan letter at 3.
[36] Danielle Gaul-Full Baker Medical History at 247 and 253 of 285.
[37] *Id.* at 19, 41, 56, 61, 68, and 210 of 285.
[38] Rizk and Zeidan letter at 2.
[39] *Id.*
[40] *Id.*
[41] *Id.; see also* Danielle Gaul-Full Baker Medical History at 208 of 285.

ii. Suspected Heart Failure and Possible Damage to Spinal Cord

Diagnostic testing also revealed that Ms. Gaul should have been further evaluated for possible congestive heart failure and damage to her spinal cord.[42] Following her first collapse due to uncontrolled hypertension (*see supra* at 4-6), Ms. Gaul was admitted to Ed Fraser. There, she received a chest x-ray for shortness of breath, which revealed enlargement of her heart with concerning findings of fluid building up in her lungs.[43] As observed by Dr. Rizk and Dr. Zeidan, this is indicative of a diagnosis of congestive heart failure,[44] which would have called for "additional laboratory testing, an echocardiogram, referral to a cardiologist and the prompt initiation of medicines such as diuretics to decrease the fluid in her body."[45] The recommended tests or interventions were either not done at all or not done timely, "putting [Ms. Gaul] at high risk for a myriad of heart failure-related complications."[46]

Of similar concern is Ms. Gaul's back condition, which went unaddressed and in fact may have been exacerbated by Armor's negligence. At the beginning of January of 2023, Ms. Gaul was diagnosed by Armor medical staff as having an "L5/S1 large central and right subarticular disc protrusion and canal stenosis with probable impingement to R S1 nerve root."[47] This is concerning because it indicates there is a "disc protrusion that is likely causing or soon will cause damage to the spinal cord and is compressing/pinching the S1 nerve."[48] As Dr. Rizk and Dr. Zeidan recommend, Ms. Gaul should have been evaluated by a neurosurgeon urgently.[49] Instead, she was not referred to a neurosurgeon or physical therapy until February 27, 2023, after Armor staff discontinued Ms. Gaul's permission to use a wheelchair and she suffered a second fall and nearly two months after first being diagnosed.[50]

d. PREA violations

Ms. Gaul reported two separate PREA ("Prison Rape Elimination Act") incidents that occurred while she was detained at Baker, one of which occurred while she was housed in the medical unit. The first incident happened shortly after she returned to Baker following her hospitalization at HCA in January of 2023. On January 6, 2023, a BCSO officer opened the door to her cell unannounced when she was coming out of the shower, exposing her naked body to other

[42] Rizk and Zeidan letter at 3.
[43] Danielle Gaul-Full Baker Medical History at 202 of 285.
[44] Rizk and Zeidan letter at 3.
[45] *Id.*
[46] *Id.*; *see also* Danielle Gaul-Full Baker Medical History.
[47] Danielle Gaul-Full Baker Medical History at 182 of 285.
[48] Rizk and Zeidan letter at 3.
[49] *Id.*
[50] Danielle Gaul-Full Baker Medical History at 254-255 of 285.

individuals present in the female housing unit, including male workers conducting maintenance.[51] Ms. Gaul said of the event: "They could see me. I was so humiliated."[52]

The second incident took place on or about February 19, 2023, when Ms. Gaul was housed in the medical unit after having fallen while trying to get a cup of water. At that time, Ms. Gaul was unable to get around on her own and required assistance to get to and from the toilet. At one point during her stay, the nurse was not available to assist her, and she was forced to urinate on herself. She was told by a guard that the shower in the medical unit was not working, and she would not be able to shower. Desperate to clean herself, she tried washing herself while sitting on the toilet. She describes that a male officer pulled back a curtain and observed her naked on the toilet. Ms. Gaul told the officer she was trying to bathe herself and to please announce his presence. A few minutes later, the officer returned and stared at her exposed body.[53] Ms. Gaul reports that there were other male detained individuals just outside of the room and she was fearful they could also see her. These incidents not only violate PREA, but also Ms. Gaul's dignity and wellbeing as a patient and human being.

These are not isolated incidents. There have been reports of PREA violations including incidents of sexual assault and voyeurism at Baker dating back to 2019. In November of 2022, our office filed a complaint with the Department of Homeland Security Office of Civil Right and Civil Liberties ("CRCL") detailing multiple PREA incidents experienced by individuals, including the case of Ms. Harriette Beck, discussed *infra*, detained in the female housing unit at Baker. We subsequently received a response substantiating those complaints.[54] There is also an ongoing criminal matter relating to an allegation of sexual battery on a former detained individual by a former BCSO officer.[55]

B. Charles Smith

Charles Smith is a 38-year-old man from X who suffered severe physical and mental decline while detained at Baker from November 2, 2020 to July 25, 2021 that was nearly fatal and resulted in his transfer to a hospital. Mr. Smith reports that his treating physician at the hospital found his lack of treatment so egregious that he would not authorize his return to Baker.

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[51] *Id*. at 62 of 285.
[52] *Id*.
[53] *Id.*
[54] ACLU of Florida, PREA Complaint, November 2, 2023, found at https://www.aclufl.org/en/prison-rape-elimination-act-prea-complaint-baker-county-detention-center.
[55] *See* Baker County Circuit Court Case No. 02-2019-CF-000382-A available at https://www.civitekflorida.com/ocrs/app/caseinformation.xhtml?query=KJB9xknlGNxRBNGMzib1WctYttCtrnjNWGEyqBy3C0w&from=caseSearchTab.

a. Untreated Diabetes Mellitus

While detained at Baker, Mr. Smith developed pre-diabetes that went untreated and progressed to the point where he was in a diabetic coma and had to be life-flighted out of Baker. Throughout the six months between Mr. Smith's prediabetic diagnosis in January of 2021 and his emergency hospitalization in July of 2021, Mr. Smith consistently complained of diabetes-related symptoms. These symptoms were largely ignored, and medical staff failed to order any post-diagnosis labs or the necessary treatment and dietary adjustments to ensure Mr. Smith's safety. The medical neglect Mr. Smith experienced at Baker nearly cost him his life.

Labcorp results from as early as January 23, 2021 show Mr. Smith's glucose levels were high and his Hemoglobin A1C marker fell into the prediabetic range.[56] At this point, as stated by Doctors Jiang and Zeidan, dietary modifications alone *should* have been sufficient absent the development of additional symptoms, provided levels were rechecked in 6-12 months.[57] However, Mr. Smith reports he never received a modified diet. His medical records substantiate this, as they fail to show any directives for dietary changes. While Baker medical staff classified Mr. Smith as "prediabetic" during his February 23, 2021 Chronic Care Clinic visit,[58] subsequent monthly follow-ups do not acknowledge this condition, citing only hypertension.[59] Despite this oversight, Baker staff sent an email from Ashley Harris to Mr. Smith's wife dated May 5, 2021 listing hypertension, obesity, and *pre-diabetes* as Mr. Smith's diagnoses and stating that he was receiving treatment for the same.[60] Mr. Smith's medical records do not support these statements. Ms. Harris' email also demonstrates a concerning acknowledgement that BCSO and Armor were aware of Mr. Smith's pre-diabetes and yet still did not provide sufficient treatment, even while promising his family members they were doing just that.

Baker's medical neglect culminated with Mr. Smith presenting serious symptoms associated with diabetes which deteriorated into diabetic ketoacidosis ("DKA") on July 20, 2021.[61] Doctors Jiang and Zeidan note that, rather than performing basic blood work to rule out DKA, which would have been the proper response to Mr. Smith's symptoms, Baker medical staff delayed emergency care for five near-fatal days.[62] As Doctors Jiang and Zeidan explained, DKA is a life-threatening condition that could have been prevented by properly diagnosing and treating Mr.

[56] Charles Smith-Full Baker Medical History, attached hereto as Ex. 5, at 536-537 of 740. (LabCorp Results dated 1/23/2021).
[57] Letter from Dr. Amy Zeidan and Dr. Alice Jiang regarding Mr. Charles Smith, March 20, 2023, attached hereto as Ex. 6, at 1.
[58] Charles Smith-Full Baker Medical History at 49 of 740.
[59] *Id.* at 51, 63, 66, 75 of 740.
[60] Email from Ashley Harris, Administrator Assistant at Baker County Detention Center, to Judith Smith, Mr. Smith's wife, attached hereto as Ex. 7.
[61] Charles Smith-Full Baker Medical History at 76 of 740; Zeidan and Jiang letter at 1-2.
[62] Zeidan and Jiang letter at 1-2.

Smith's diabetes months prior to the incident.[63] Likewise, Mr. Smith may have avoided this critical condition had BCSO and Armor adhered to the IHSC protocols in the face of an emergency.[64]

Not only did Mr. Smith's medical records and lab results confirm the need for pre-diabetes treatment and diabetic prevention, Mr. Smith submitted numerous requests for medical assistance due to increasingly serious symptoms that can indicate diabetic concerns. Mr. Smith submitted over ten separate sick call complaints documenting "constant" headaches and dizziness.[65] Second, Mr. Smith submitted multiple sick call complaints citing back pain.[66] Third, Mr. Smith's vision drastically declined from 20/30 when he first requested glasses in February 2021 to 20/100 when he was finally referred to optometry in June 2021, four months later.[67] Finally, ten days prior to his emergency hospitalization, Mr. Smith submitted a sick call request pleading to see a doctor (rather than a nurse practitioner) because he was "very worried" about side effects of his medications.[68] This same day, during a behavioral health appointment, he expressed his fear that the inadequate healthcare at Baker was "destroying [his] body."[69] He was "encouraged to speak with a medical provider regarding his concerns" and told to "work on deep breathing techniques."[70]

Mr. Smith's condition grew deadly serious in July 2021. On July 21, 2021, he was brought to the medical unit in a wheelchair with an "acute medical condition."[71] He reported shortness of breath, nausea, and a headache.[72] He was returned to his housing unit.[73] On July 22, 2021, Mr. Smith was again brought to the medical unit in a wheelchair, after reporting feeling "short of breath" for three days.[74] He was again returned to his housing unit.[75] On July 23, 2021, he was relocated to medical housing for observation.[76] On July 25, 2021, when he was finally air-lifted to an outside hospital in an "altered mental state," he was diagnosed with DKA and acute kidney injury.[77] Armor and BCSO failed to provide appropriate treatment for seven months and wasted valuable time when Mr. Smith's condition was clearly deteriorating. Mr. Smith's diabetic ketoacidosis was avoidable. Dr. Zeidan and Dr. Jiang found that the delay in evaluating Mr. Smith for DKA may have "resulted in him *developing* severe DKA."[78]

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[63] *Id.*
[64] IHSC Policy, All Hazards Emergency Preparedness and Response, December 30, 2016 at 5 ("staff must be prepared to respond to emergencies with a four minute response time").
[65] Charles Smith-Full Baker Medical History at 531, 552, 595, 599, 600, 609, 614, 616, 617, 623 of 740.
[66] *Id.* at 540, 575, 588, 589, 620 of 740.
[67] *Id.* at 50 and 69 of 740.
[68] *Id.* at 642 of 740.
[69] *Id.* at 100 of 740.
[70] *Id.* at 102 of 740.
[71] *Id.* at 76 of 740.
[72] *Id.*
[73] *Id.*
[74] *Id.* at 77 of 740.
[75] *Id.* at 78 of 740.
[76] *Id.*
[77] *Id.* at 14 and 106 of 740.
[78] Zeidan and Jiang letter at 3.

Baker's remote location may have exacerbated delays in providing Mr. Smith the life-saving treatment he needed as a result of the gross medical negligence he experienced at Baker. Medical records indicate Mr. Smith was first taken to Ed Fraser leaving the detention center at 7:33am.[79] Inexplicably, BCSO officers took Mr. Smith to a hospital over 100 miles away in Tallahassee, Florida where he was not admitted to Tallahassee Memorial Hospital until 10:47 pm, over fifteen hours later.[80] Dr. Joo, the attending physician at Tallahassee Memorial Health, found the transfer to Tallahassee to be reckless, characterizing it as attributable to some "unknown poorly thought-out reason" considering Mr. Smith's critical condition.[81] Mr. Smith was hospitalized for four days before briefly returning to Baker on July 29, 2021.[82] On July 30, 2021, he was transferred to Krome North Processing Center.[83] In September 2021, he was deported to X.

b. Poorly Managed Hypertension

Mr. Smith was diagnosed with hypertension during his detention at Baker. On December 10, 2020, a nurse practitioner at the facility referred Mr. Smith to the Chronic Care Clinic for "new onset" hypertension.[84] Mr. Smith was prescribed medium doses of amlodipine and lisinopril, but continued to experience blood pressure levels falling within hypertension Stage 2 and Stage 3 (hypertensive crisis) throughout his detention.[85] He was relocated to medical housing due to his elevated blood pressure from March 25 - April 1, 2021.[86] As Doctors Jiang and Zeidan explain, rather than increasing his daily medications, which is the standard of care, Baker medical staff introduced as-needed clonidine.[87] Clonidine is a blood pressure medication that "can actually cause rebound hypertension if not taken consistently."[88] Baker medical staff also implemented multiple changes to his treatment plan without any clear explanation of their reasoning.[89] Blood pressure control is "crucial," because "chronically elevated blood pressure can increase an individual's risk of chronic kidney disease, stroke, and adverse cardiac events."[90]

[79] Charles Smith-Full Baker Medical History at 14 and 106 of 740. ("Spoke with Tiffany at ED Frasiers called Pt. Dx with DKA and acute kidney injury. Pt will be sent to Tallahassee Memorial for further tx.")
[80] Charles Smith-Full Baker Medical History at 668 of 740.
[81] *Id.* at 730 of 740.
[82] *Id.* at 729 of 740.
[83] *Id.* at 723-724 of 740.
[84] *Id*. at 29 of 740.
[85] *Id.* at 181-242 of 740 (Medication Administration Record Notes for as-needed Clonidine from 2/16/21, 2/17/21, 2/20/21, 2/22/21, 6/4/21, 6/23/21, 6/27/21, 6/28/21, 7/1/21, 7/7/21, and 7/15/21).
[86] *Id.* at 55-63 of 740.
[87] Zeidan and Jiang letter at 2.
[88] *Id*.
[89] *Id.*
[90] *Id*.

c. Delays in Providing Dental Care

Baker medical staff identified Mr. Smith's broken molar on February 13, 2021.[91] His treatment consisted of a recommendation to "eat soft foods" before the molar was finally extracted, nearly a month later, on March 11, 2021.[92] Mr. Smith submitted sick call requests pleading for the tooth to be removed, noting "the pain [was] unbearable" during the weeks he waited for dental care.[93] Even after the extraction, Mr. Smith was in considerable pain, noting his gums were so swollen he could not eat.[94] This pain continued for weeks.[95] He submitted multiple Sick Call Requests, pleading "can someone please help me," and documenting "outrageous" and "serious" pain he feared could be due to infection or exposed nerves.[96] Mr. Smith never received proper medical attention or treatment for his chronic pain.

d. Denial of Medical Records

Mr. Smith submitted nearly 10 requests for his medical records to be released to his wife and attorney between January 6, 2021 and May 17, 2021,[97] and yet none of these requests were even acknowledged. The only signed Release of Information form to Mr. Smith's wife is dated December 21, 2020, prior to Mr. Smith's rapid, preventable deterioration and near demise.[98] This is directly contrary to the 2019 NDS which state, "[d]etainees and their representatives shall be allowed to request and receive medical records."[99]

Finally, despite multiple requests, Baker has yet to release medical records from Mr. Smith's initial emergency hospitalization at Ed Fraser prior to his transfer to Tallahassee Memorial Health.

C. Harriette Beck

Harriette Beck is a 60-year-old woman who was transferred to Baker from the Federal Detention Center ("FDC") in Miami in April of 2022. Ms. Beck has several known medical conditions, including high cholesterol and a compression fracture in her back, that require consistent care and monitoring.[100] Additionally, Ms. Beck has a history of dental infections that were largely undertreated, causing her extreme pain. Finally, Ms. Beck developed symptoms

[91] Charles Smith-Full Baker Medical History at 47 of 740.
[92] *Id.* at 48, 583 of 740.
[93] *Id.* at 576 of 740.
[94] *Id.* at 585 of 740.
[95] *Id.* at 58 of 740.
[96] *Id.* at 586, 587, 588 of 740.
[97] *Id.* at 526, 529, 535, 546, 548, 549, 550, 556, 614, 615 of 740.
[98] *Id.* at 521-522 of 740.
[99] 2019 NDS, *supra* note 1, at § 4.3(P).
[100] Harriette Beck-Full Baker Medical History, attached hereto as Ex. 8, at 10, 12, 36 of 552.

during her time in detention that have gone undiagnosed or unaddressed such as rectal bleeding, an umbilical hernia, and pre-diabetic hemoglobin A1C levels.[101]

a. Untreated Compressed Back Fracture

Ms. Beck fractured her back in 2021.[102] When she arrived at Baker, she used a back brace and reported chronic pain associated with the injury.[103] Her medical records reveal that she was seen sixteen times for back pain, at times reporting difficulty sleeping, walking and excruciating pain.[104] Despite having been referred to the Chronic Care Clinic, she did not see a neurosurgeon or receive x-rays until June of 2022 and did not see a specialist until August of 2022, four months after her arrival.[105] Following the visit with the specialist, it was recommended that additional imaging be conducted, and that Ms. Beck be weaned off her brace and prescribed physical therapy.[106] Despite this recommendation, Ms. Beck was not referred to physical therapy to assist her with strengthening her back and weaning off the back brace. Instead, her back brace was taken and she was advised to "increase exercise and stretching exercises," without the supervision and guidance of a physical therapist as previously recommended.[107] On October 11, 2022, two weeks after her brace was taken, Ms. Beck injured her back so severely that she could not walk, resulting in a "medical emergency," per Armor's records.[108]

In July, Ms. Beck requested an extra mattress to alleviate her back pain.[109] She was denied any accommodation, evidently because Baker's medical unit does not issue extra mattresses or pillows, and she was advised to contact security.[110] Between July and August of 2022, Ms. Beck sent multiple sick call requests indicating that after speaking with a BCSO officer inside Baker, she was told "only medical can approve" an extra mattress or pillow and again requested an extra mattress to no avail.[111]

In March of 2023, Ms. Beck saw another neurosurgery provider, who recommended a "muscle relaxant as needed for the back pain and stiffness," and "physical therapy for gait training and for low back pain to strengthen muscles."[112] After nearly a year of first learning of Ms. Beck's

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[101] Letter from Dr. Joshua Volin and Dr. Amy Zeidan regarding Ms. Harriette Beck, March 31, 2023, attached hereto as Ex. 9.
[102] Harriette Beck-Full Baker Medical History at 10 of 552.
[103] *Id*. at 10, 11, 14, 15 of 552
[104] Volin and Zeidan letter at 1; *see also* Harriette Beck-Full Baker Medical History at 48, 52, 54, 57, 63, 79, 80, 88, 90, 93, 107 of 552.
[105] Harriette Beck-Full Baker Medical History at 186 and 271 of 552.
[106] *Id.* at 463-465 of 552.
[107] *Id.* at 247 of 552.
[108] *Id.* at 247-248 of 552.
[109] *Id.* at 54, 106, 192, 196, 210, 287, 307, 326, 377-378 of 552.
[110] *Id.* at 106 and 246 of 552.
[111] *Id.* at 206-207, 287, 307, 326 of 552.
[112] *Id.* at 515-525 of 552.

injury and eight months after physical therapy was first prescribed as a course of treatment, Armor medical staff submitted a request for a physical therapy consult.[113] As of the date of this letter, Ms. Beck has not seen a physical therapist or received the recommended muscle relaxers.

b. PREA Violation

Not only has Ms. Beck suffered terribly from medical neglect at Baker, she has also been the victim of multiple Prison Rape Elimination Act violations. Ms. Beck, who is a survivor of sexual violence, reported an initial PREA violation in which a male guard watched her using the restroom and refused to close the door.[114] When Ms. Beck bravely reported this incident, she was met with accusations of having lied and pressured to close her complaint.[115] Ms. Beck describes feeling dehumanized and traumatized by the incident: "He made me feel so low. He made me feel like I am nothing. In my past I got raped so that made me feel real bad."[116] As Dr. Volin and Dr. Zeidan raise in their letter, this incident and the way it was subsequently handled raises serious concern about the health and safety of those detained at Baker.[117] This is especially concerning if the BCSO officer in question remains employed at Baker, placing Ms. Beck at risk of continued exposure to the perpetrator.

c. Dental abscesses

Ms. Beck's medical records indicate that a week after arriving she was experiencing toothaches and was taking ibuprofen for the pain.[118] Despite her medical records from FDC stating that Ms. Beck had been recommended for a tooth extraction due to a residual root of her #16 tooth, she was not referred to a dental care provider.[119] Days later, on May 11, 2022, she was seen again by medical staff after reporting that ibuprofen was no longer effective at managing her pain.[120] The nurse at that time indicated Ms. Beck had a "dental abscess."[121] Ms. Beck was not referred to a dental care provider at that time and was instead prescribed antibiotics and told to return for a follow-up.[122] Almost two months passed until she was finally referred to a dentist who performed an extraction.[123] Following that extraction Ms. Beck was seen another seven times for tooth pain related to recurrent infections or abscesses and only referred to a dentist once.[124]

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[113] *Id.* at 526 of 552.
[114] *Id.* at 95-96 of 552.
[115] *Id.* at 95-96 and 103 of 552.
[116] *Id.* at 95 of 552.
[117] Volin and Zeidan letter at 3-4.
[118] Harriette Beck-Full Baker Medical History at 34-35 of 552.
[119] *Id*. at 319 of 552.
[120] *Id*. at 36 of 552.
[121] *Id*. at 37 of 552.
[122] *Id.*
[123] *Id*. at 261 of 552.
[124] *Id*. at 55, 59, 61, 67, 70, 76, 93 of 552.

IHSC Directive 09-01, relating to Dental Services, specifically states that "urgent care should be provided" to detained individuals to "relieve pain, treat acute infection or help correct caloric intake."[125] Ms. Beck experienced severe dental pain for seven months without receiving proper care, in direct conflict with IHSC's own policies.

D. David Musa

David Musa is a 32-year-old man from X. Mr. Musa has several serious medical conditions, including cardiovascular concerns, chronic pain and lack of mobility due to a gunshot wound in his shoulder, and mental health diagnoses including schizophrenia. Mr. Musa has not received the medical care or medication necessary to treat his medical conditions, and as a result these conditions have worsened and/or continue to go untreated. *See* Letter from Dr. Amy Zeidan and Ms. Nicole Lue regarding Mr. David Musa, March 11, 2023, attached hereto as Ex. 10. Mr. Musa's condition continues to deteriorate.

a. Brachial Plexus Injury

Before entering immigration detention, Mr. Musa was shot in his left shoulder and abdomen. Bullet fragments remain in Mr. Musa's left shoulder, causing significant pain and mobility impediments.

BCSO[126] and Armor were alerted to this injury upon his arrival in February of 2022. Mr. Musa reported acute, "constant," pain and Armor medical staff noted that a bullet "shatter[ed] his scapula per Shands / Memorial hospital."[127] Despite notice of Mr. Musa's acute injury and his report of extreme pain, Armor medical staff did not schedule further evaluation or treatment, and instead prescribed two acetaminophen for five days.[128]

Following this visit, a pattern of undertreatment emerged which continues to this day. Mr. Musa has put in numerous sick calls requesting help for his shoulder injury.[129] He describes his pain as "unbearable," "extreme," "severe," and reported the pain makes it impossible for him to sleep.[130] Armor medical staff responded much as they did in February 2022, prescribing over the counter pain medication, declining further treatment, and refusing to provide Mr. Musa an arm sling when he reported that his condition was worsened by "walking around and letting my arm dangle" and that he had been provided an arm sling, which was helpful, at his previous facility.[131]

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[125] IHSC Directive 09-01, Dental Services, March 4, 2016, at 3.
[126] Pursuant to an agreement between BCCMC and BCSO, BCSO is responsible for the administration and operation of Baker subject to BCCMC oversight.
[127] David Musa-Full Baker Medical History, attached hereto as Ex. 11, at 33 of 156.
[128] *Id*. at 34 of 156.
[129] David Musa-Sick Calls, attached hereto as Ex. 12, at 1, 3-6, 8-10, 16, 18-19 of 19.
[130] *Id*.
[131] David Musa-Full Baker Medical History at 51-52 of 156.

In April 2022, Mr. Musa was finally able to see a physician at Shands Jacksonville Correctional Facility Clinic. Dr. Lawra noted that Mr. Musa's pain was "poorly controlled on current medical regime[n]" and noted decreased sensitization and weakness in his left shoulder.[132] Dr. Lawra prescribed physical and occupational therapy, along with pain medication. Although Armor has been aware of Mr. Musa's prescribed need for physical and occupational therapy, and despite Mr. Musa's continued pleas for help, neither Armor nor BCSO has provided or referred Mr. Musa for this treatment. Failing to do so violates IHSC protocol, which requires that recommendations from specialty consultations to be "acted upon by the medical provider in a timely manner."[133]

Mr. Musa reports that when he pleaded with BCSO and Armor staff for a surgery consultation, he was told that surgery would only be an option if Mr. Musa paid for it himself. Such a statement would be in direct violation of the 2019 NDS, which state that "[e]very facility shall directly or contractually provide . . . [m]edically necessary and appropriate medical, dental and mental health care and pharmaceutical services at no cost to the detainee[.]"[134]

b. Lower Extremity Edema

In September of 2022, Mr. Musa reported swelling in his arms and legs. Armor recommended various diagnostic tests, such as an EKG, echocardiogram, and a Holter heart monitor.[135] However, it is unclear if any of these tests occurred, as any results are absent from Mr. Musa's medical record.

Further, as Dr. Zeidan and Ms. Lue explain in their analysis of Mr. Musa's treatment at Baker, Armor also recommended contravening treatments that could be harmful to Mr. Musa. They note that not only is it critical to identify the cause of the swelling, which could indicate serious and life-threatening heart failure, but "the provider in detention started him on Lasix, a medication that helps with decreasing swelling in patients who have congestive heart failure. The same provider also recommended he increase his water intake, which would be contraindicated in someone with congestive heart failure who is taking Lasix. The inconsistencies in the note and incomplete workup thus far are concerning and Mr. Musa should obtain a complete workup and follow up with cardiology as soon as possible."[136]

Despite the seriousness and life-threatening risk of congestive heart failure, Armor reverted to a pattern of undertreatment and delay. Records indicate that in January and February of 2023,

[132] David Musa-Ortho Docs, attached hereto as Ex. 13, at 20 of 23.
[133] IHSC Policy Care of Chronic Conditions at 3.
[134] 2019 NDS, supra note 1, at § 4.3(II)(A).
[135] David Musa-CorEMR Records, attached hereto as Ex. 14, at 272, 285-86, 300, 331, 335 of 338.
[136] Zeidan and Lue letter at 3.

Mr. Musa's "cardiology referral" was still "pending"[137] and Mr. Musa's swelling and discomfort continue without explanation.

c. Mental Health Conditions

Mr. Musa has been diagnosed with depression, bipolar disorder, and schizophrenia.[138] BCSO and Armor were aware of these serious conditions upon Mr. Musa's arrival at Baker.[139]Mr. Musa has also suffered several psychotic episodes at Baker. For example, Musa reported hearing voices, worsening depression and anxiety and was placed on medical watch.[140]

In August 2022, Mr. Musa was placed on suicide watch.[141] He reported that he was suicidal, and suicide watch commenced at 6:29 pm on August 9, 2022. His records are absent any Initial Suicide Risk Assessment or Follow-Up Suicide Risk Assessment, as required under IHSC protocols, and it appears that other protocols set forth in the IHSC standards were also not followed.[142] Despite Mr. Musa's specific statement confirming suicidal ideation, his "Suicide observation [was] discontinued" three hours later, at 9:30 pm.

Despite Mr. Musa's diagnosis of schizophrenia and bipolar disorder and reports of mental decompensation, BCSO and Armor failed to adequately treat Mr. Musa and it appears he was never screened or further assessed for mental competency.[143] As Dr. Zeidan explains, bipolar depression is one of the "leading causes of disability."[144] Yet Mr. Musa remains without appropriate treatment and evaluation, placing Mr. Musa at significant risk of suicide or self-harm and undermining his ability to adequately engage in his immigration case.[145]

Armor appears to have also failed to properly prescribe medication to treat Mr. Musa's conditions. Dr. Zeidan and Ms. Lue found that:

> Mr. Musa is not on any appropriate medications or receiving any consistent psychiatric treatment for his mental health conditions. In the past, he has received mirtazapine and hydroxyzine intermittently. It should be noted that neither of these medications are recommended as first-line therapeutics for any of his mental health

[137] David Musa-CorEMR Records at 336 of 338.
[138] David Musa-Full Baker Medical History at 1 and 12 of 156.
[139] *Id*.
[140] *Id*. at 62-63, 70, 72 of 156.
[141] David Musa-CorEMR Records at 58-59, 266-67, 299 of 338.
[142] *See* IHSC Operations Memorandum Significant Self Harm and Suicide Prevention and Intervention, March 28, 2016, at p. 4-6.
[143] *See* https://www.ice.gov/doclib/news/releases/2022/11063-2.pdf.
[144] Zeidan and Lue letter at 1.
[145] *Id.* at 2.

> diagnoses. His mental health crisis and suicide risk upon arriving at Baker were not followed up with the appropriate workup.[146]

Armor's nursing notes from February 18, 2022 illustrate Armor's dangerous pattern of undertreatment and mistreatment. Despite knowledge that Mr. Musa was diagnosed with schizophrenia, bipolar disorder, and depression, and had a gunshot wound injury causing acute distress, Armor nursing staff noted "[n]o significant health conditions identified at present."[147] That was not the case then and it is certainly not the case now. It is critical that Mr. Musa not only be provided appropriate medical and mental health treatment and medication, but that he be released from a detention environment that is incapable of addressing his serious needs.

E. Greg Sanchez

Greg Sanchez is a 24-year-old man who was detained at Baker from October of 2021 until he was deported in June of 2022. Mr. Sanchez has a well-documented history of mental health issues, including an "unspecified psychotic disorder" and history of hallucinations.[148]

a. Assault and Resulting Untreated Physical Injury

In December of 2021, Mr. Sanchez was physically assaulted by two Baker officers.[149] During the assault, one of the officers slammed his fist against Mr. Sanchez's head which caused his ear to bleed.[150] Mr. Sanchez reported:

> I didn't do what they said I did on that DR. I was singing last night and officer Caleb Collins came to my door and said that 'don't nobody want to hear me sing.' So I said it's okay and I started singing lower and then he opened the door and Sergeant Gainey was standing at the door when he came in and Officer Collins tried to intimidate me. He said that 'I came from the prison and if I wanted to I could beat you right now' and he stood in my face and looked in my eyes and intimated me with bad words. He kept talking in my face and then I said 'I'm not scared of you. I'm scared of God, not you!' I was sitting on my bed all the time and when I turned around to talk to Sergeant Gainey, he hit me on the side of my face in my ear and my head hit the wall and then Sergeant was looking like what happened. Then I told Collins 'that all you wanted' and then he got madder. He left my room

[146] *Id*.
[147] David Musa-Full Baker Medical History at 22 of 156.
[148] Greg Sanchez-Baker Patient History, attached hereto as Ex. 15, at 7, 29, 31-33 of 117.
[149] *Id.* at 39 of 117.
[150] *Id*.

and then came back and got my tablet. I ask to go to medical because my ear was bleeding but they won't let me go."[151]

Mr. Sanchez's medical records do not reflect any medical attention or treatment following this assault, even though Mr. Sanchez put in sick call requests because he could not hear out of his left ear as a result of the assault.[152]

b. Lack of Mental Health Treatment

Mr. Sanchez's medication records reflect that he never received mental health medication while detained at Baker, despite documented mental health conditions, evidence of declining mental health, and hallucinations.[153] It also appears that Mr. Sanchez was not identified at any time during his confinement at Baker for further mental health evaluation, competency, or whether he was an appropriate referral for the National Qualified Representative Program.[154]

c. Harm Inflicted from Prolonged Isolation in Solitary Confinement

Mr. Sanchez also experienced significant mental health injury due to his prolonged detention in solitary confinement. Mr. Sanchez was held in solitary confinement from October 29, 2021 to January 24, 2022 and again from May 25, 2022 until he was transferred for deportation on June 3, 2022.[155] Mr. Sanchez's records do not contain any justification for his prolonged detention in confinement, but are replete with his asserted concerns that he was held in confinement to pressure him to sign deportation papers.[156] Mr. Sanchez reports that approximately every two days during his confinement, a BCSO officer would approach his cell and ask if he was "ready to be deported," while Mr. Sanchez was represented by counsel and his case was still ongoing.

Similarly to Mr. Musa, his records also do not show that any Initial Suicide Risk Assessment or Follow-Up Suicide Risk Assessment was conducted, as required under IHSC protocols, and it appears that other protocols set forth in the IHSC standards were also not followed.[157] He also made repeated complaints documenting his declining mental health in

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[151] *Id*.
[152] *Id.* at 116 of 117.
[153] *Id.* at 74-79 of 117.
[154] The "National Qualified Representative Program (NQRP),[is] a nationwide program to provide Qualified Representatives (QRs) to certain unrepresented and detained respondents who are found by an Immigration Judge or the BIA to be mentally incompetent to represent themselves in immigration proceeding," available at https://www.justice.gov/eoir/national-qualified-representative-program-nqrp.
[155] Greg Sanchez-Baker Patient History at 49-71 of 117.
[156] *See e.g., id.* at 29, 34-37, 41, of 117.
[157] *See* IHSC Operations Memorandum Significant Self Harm and Suicide Prevention and Intervention, at pp. 4-6 and Appendix C, available at: https://www.documentcloud.org/documents/6025484-IHSC-Operations-Memorandum-Significant-Self-Harm.

confinement, including hallucinations and severe depression.[158] He received no assistance and was forced to remain in solitary confinement for months.

d. Lack of Translation and Language Assistance throughout Medical Treatment

It is also noteworthy that Mr. Sanchez does not speak English and requires Spanish translation. The ACLU of Florida met and spoke with Mr. Sanchez on multiple occasions, and it was immediately apparent that Spanish is his best and native language. His medical records reflect this fact.[159] However, there is a concerning absence of documented use of translation services in his records and his medical records even note at one point that he "speaks english fluently and spanish."[160] This is demonstrably false and undermines any medical encounter conducted solely in English. It is also a clear violation of IHSC standards, requiring that "[h]ealth care professionals screen detainees in their primary language . . . If an interpreter is used, the nurse will document this . . . Unless there is an emergency, the use of other detainees as interpreters is prohibited."[161]

F. Michelle Johnson

Michelle Johnson is a 22-year-old woman who has a history of asthma, seizures, pneumonia, depression, anxiety, and chondrocostal junction syndrome.[162]

a. Untreated Asthma

Ms. Johnson had an inhaler at her previous facility to treat her asthma and breathing difficulties,[163] but reports that Baker staff confiscated the inhaler upon her arrival. When Ms. Johnson requested an inhaler on January 13, 2022, she was refused.[164] Ms. Johnson continued requesting an inhaler, but it was not until after she contracted COVID-19 and had to be housed in a "negative airflow medical cell [for] observation" because she was having substantial trouble breathing that she was finally prescribed an inhaler.[165] While she had COVID-19, Ms. Johnson was taken to medical isolation for eleven days.[166] Ms. Johnson reports that during isolation, she felt as if she were going to faint and tried to get medical attention. She states that she was ignored until a Baker officer walked by and found her unconscious on the floor.

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[158] *See e.g.,* Greg Sanchez-Baker Patient History at 29, 31, 34-37, 41, 75 of 117.
[159] *Id.* at 2, 11, 47 of 117.
[160] *Id.* at 116 of 117.
[161] *See* IHSC Policy Intake Screening and Intake Reviews, 4.1(e).
[162] Michelle Johnson-CorEMR Records, attached hereto as Ex. 16, at 9-10 of 277.
[163] Michelle Johnson-Full Baker Patient History, attached hereto as Ex. 17, at 36 of 232.
[164] *Id*. at 36 and 145 of 232.
[165] *Id.* at 37 of 232.
[166] *Id.* at 232 of 232.

b. Exposure to Contaminated Food

Ms. Johnson also had to request medical assistance after she consumed black worms in her food.[167] Ms. Johnson's medical records reference an unnamed sergeant who "stated that there appeared to be tiny black worm like objects on the left over patty."[168] It is unclear whether BCSO or Armor took any steps to ameliorate the presence of worms in the food provided to detained individuals; instead Ms. Johnson's records merely suggest she make "lifestyle changes" and "look at food prior to eating."[169]

c. Untreated Seizure Disorder and Subsequent Seizure Activity

Ms. Johnson also has a history of seizures and her initial medical intake records note a hospitalization for seizure activity as recently as February 2018.[170] During her detention at Baker, Ms. Johnson requested seizure medications multiple times after fearing she may suffer another seizure.[171] The anticonvulsant medication, Keppra, was provided for approximately one month and then inexplicably discontinued.[172] Ms. Johnson continued to express fear of having a seizure and submitted requests for her medication to be restarted.[173] On August 2, 2022, Ms. Johnson requested medical assistance and medication, stating "I need my seizure meds back, I feel like I've been having seizure symptoms for the past month, I'll all of a sudden start drooling, my side will start feeling numb."[174] Ms. Johnson's request for medication was denied.[175]

Only three days later, on August 5, 2022, Ms. Johnson indeed suffered a seizure as she and her family had feared.[176] Ms. Johnson was found lying on her right side, "unresponsive to verbal stimuli."[177] When Ms. Johnson awoke in the medical bay, she reports that medical staff denied that she had a seizure and instead claimed she had experienced a panic attack. Minutes after waking up, Ms. Johnson states that the medical staff sent her back to the housing unit dorm without further observation or monitoring or providing her anticonvulsant medication. Her medical records confirm the lack of follow up for seizure activity and show that the incident was referred for mental health without further diagnostic testing, medication, or follow-up.[178]

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[167] *Id*. at 47 of 232.
[168] *Id*.
[169] Michelle Johnson-CorEMR Records at 274 of 277.
[170] Michelle Johnson-Full Baker Patient History at 12 and 30 of 232.
[171] *Id*. at 196 and 230 of 232.
[172] *Id.* at 104-114 of 232.
[173] Michelle Johnson-CorEMR Records at 274 of 277.
[174] *Id*. at 49 and 214 of 277.
[175] *See id*. and full medication chart included in Ms. Johnson's medical records.
[176] *Id*. at 49 of 277.
[177] *Id*.
[178] *Id*.

Ms. Johnson did not receive Keppra, despite requests for her medication due to fear of additional seizure activity, for fifteen days after she suffered a seizure on August 5th.[179] Ms. Johnson reports that she submitted a complaint of medical neglect to ICE. Ms. Johnson states that ICE informed her that she was taken off her Keppra prescription based on her own wishes. She explained that this was not true, urged ICE to review her medical records, and asked ICE to immediately instruct Baker to provide necessary medical care. On August 5, 2022, Ms. Johnson's immigration counsel inquired about the incident. Ms. Johnson's counsel reports that ICE responded by denying that Ms. Johnson had ever suffered a seizure, despite failing to administer a test that could rule it out. This (and Ms. Johnson's continued lack of treatment) is especially troubling given her well-documented seizure disorder and repeated requests for assistance and medication due to symptoms indicating impending seizure activity.

G. Rebecca Cortez

Rebecca Cortez is a 44-year-old woman who has a history of hypertension, abnormal pap smears, and intestinal issues due to a previous accident.[180] Upon her arrival at Baker in April 2022, she was also experiencing unintentional and rapid weight loss.[181] In May 2022, Ms. Cortez had a cardiovascular incident and was taken to the medical unit in a wheelchair as her heart was racing.[182] Ms. Cortez complained that Armor had failed to check her blood pressure following her cardiac incident.[183] A few days later, she also reported chronic, prolonged menstrual bleeding.[184] She informed Armor medical staff that she had been bleeding for nine months and that "it makes me feel dizzy sometimes."[185] In response, Armor medical staff prescribed acetaminophen and noted that Ms. Cortez could receive additional menstrual pads, toilet paper, and two extra pairs of underwear.[186] There does not appear to be any further investigation of Ms. Cortez's chronic bleeding. In fact, Ms. Cortez's medical concerns about her chronic menstrual bleeding was met with skepticism. A month later, for example, Armor medical staff provided Ms. Cortez a menstrual pad and had her remain in medical for one hour to check Ms. Cortez's pad to demonstrate she was really bleeding.[187]

In June 2022, ACLU of Florida toured the Baker facility and met with Ms. Cortez. During the tour, Baker staff informed the ACLU of Florida team of a policy limiting women's access to sanitary napkins to thirty per month. Ms. Cortez reported to counsel that she was not in fact provided additional menstrual pads above this cap, despite her documented need, and instead was

[179] *Id*. at 139 of 277.
[180] Rebecca Cortez-Full Baker Medical History, attached hereto as Ex. 18, at 8, 11, 12, 29 of 100.
[181] *Id*. at 26 of 100.
[182] *Id*. at 36 of 100.
[183] *Id*. at 41 of 100.
[184] *Id*. at 37 of 100.
[185] *Id*.
[186] *Id*. at 38 of 100.
[187] *Id*. at 81 of 100.

forced to free bleed and sleep in blood-soaked clothes and sheets. Forcing individuals to free bleed rather than provide sufficient feminine hygiene products carries significant risk of exposure to bloodborne pathogens such as HIV and hepatitis and violates IHSC policy.[188] These issues were previously reported to DHS in a multi-individual complaint submitted on September 13, 2022.[189]

BCSO and Armor's responses to Ms. Cortez's documented medical conditions and requests for medical assistance were dehumanizing and detrimental to her physical and mental health and they are, tragically, emblematic of how detained individuals at Baker are treated, even in their most vulnerable moments.

H. Mario Mendoza

Mr. Mendoza is a 41-year-old man who has a history of anxiety, PTSD, insomnia, and major depressive disorder.[190] Upon arrival at Baker on January 10, 2022, Mr. Mendoza was sentenced to isolation for an extended period of time – thirty days – despite his delicate mental health.[191] Further, the justification for this isolation appears to have been lacking. While officers claimed he was "belligerent," notes from Mr. Mendoza's subsequent mental health evaluation show Mr. Mendoza had simply knocked on a locked bathroom door to get an officer's attention to release him.[192] He reports that BCSO officers threw him to the floor, pinned him to the ground by placing their knees on his neck, and then put him in solitary confinement. He further reports that he requested to be seen by medical staff following the incident and instead only received ibuprofen.

Though confinement log records show that Mr. Mendoza was in confinement for a period of twelve days, the threat of additional time in isolation is particularly cruel and distressing for individuals who have active mental health symptoms. On January 12, 2022, Mr. Mendoza reported isolation made him feel "alone, helpless, and depressed."[193] He also reported Armor medical staff had inexplicably decreased his medications from the three different types he was prescribed while at Krome to just one.[194] On January 20, 2022, while still in isolation, Mr. Mendoza requested to increase this medication, Vistaril, "because the isolation [was] making him more anxious."[195] His request for follow-up treatment and medication appears to have been ignored.

[188] IHSC Bloodborne Pathogens and Other Potentially Infectious Materials Guide, October 9, 2015 at 6.
[189] *See* https://www.aclufl.org/en/crcl-complaint-baker-county-detention-center.
[190] Mario Mendoza-Full Baker Medical History, attached hereto as Ex. 19, at 6-7 of 96.
[191] *Id.* at 22-23 of 96.
[192] *Id.* at 20 and 22-23 of 96.
[193] *Id.* at 23 of 96.
[194] *Id.*
[195] *Id.* at 29 of 96.

I. Reggie Grant

Reggie Grant is a 44-year-old man who has been detained at Baker since July 13, 2022. Despite informing Baker staff of several chronic medical conditions,[196] as well as providing a medication list to control these painful and life-threatening illnesses, Mr. Grant has yet to receive adequate care.

a. Crohn's Disease

Mr. Grant was diagnosed with Crohn's disease over a decade ago and was previously able to manage his condition with medication and a low-fiber diet. Immediately upon arrival at Baker during his initial intake screening, Mr. Grant reports that he provided his full medication list which included Pentasa, Loperamide, Folic acid, and multipurpose vitamins. Yet for months in detention, he was only prescribed folic acid.[197] Mr. Grant experienced multiple flare-ups with symptoms ranging from discomfort, fatigue, weakness, and anxiety to blood in his stool.[198]

On October 5, 2022, Mr. Grant saw an external GI doctor at Jacksonville Shands Hospital.[199] The GI doctor created a treatment plan including a steroid taper followed by a daily dose of budesonide for maintenance.[200] Though the steroid taper was administered by Armor, Mr. Grant was never prescribed budesonide, continuing the trend failing to adequately treat his chronic medical condition at the facility.[201] Additionally, Armor medical staff directly contradicted IHSC protocol, which requires recommendations from specialty consultations to be "acted upon" in a "timely manner."[202] Mr. Grant's Medication Administration Record demonstrates at least a 10-week delay in action.[203] This is not timely, especially considering the known severity of his condition.

IHSC protocol additionally mandates that any deviation from protocol be "clinically justif[ied]" and that this information be shared with the detained individual.[204] The record does not reflect any clinical justification, and Mr. Grant reports no one communicated any reason for the deviation from the standard of care was ever discussed with him.

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[196] *See* IHSC Policy Care of Chronic Conditions ("a chronic disease is an illness or a condition that affects an individual's well-being for an extended interval, usually at least six months, and generally is not curable but can be managed to provide optimum functioning within any limitations the condition imposes on the individual.")
[197] Reggie Grant-Full Baker Medical History, attached hereto as Ex. 20, at 47-58 of 168.
[198] *Id.* at 32, 47, 88, 108 of 168.
[199] *Id.* at 112 of 168.
[200] *Id.* at 116 of 168.
[201] *Id.* at 47-58 of 168.
[202] IHSC Policy Care of Chronic Conditions
[203] Reggie Grant-Full Baker Medical History at 47-58 of 168. (No record of Budesonide being prescribed through receipt of Medical Records on 12/20/2022.)
[204] IHSC Policy Care of Chronic Conditions

b. Untreated Mental Health Conditions

Mr. Grant is diagnosed with antisocial personality disorder and has a history of major depressive disorder, leading to multiple suicide attempts in his youth.[205] While he was urgently referred to the behavioral health unit upon arrival to Baker, no follow-up appointments were scheduled beyond his initial screening.[206] Mr. Grant reports he has attempted to request mental health follow-up appointments and has been told that he is ineligible because he is not on any psychiatric medications. He also reports that while incarcerated at a previous facility, he was seeing a psychologist on a regular basis and found talk therapy very helpful. Given the increased anxiety caused by detention and his untreated Crohn's symptoms, this lack of treatment is irresponsible and dangerous.

J. Conclusions and Recommendations

The individual accounts described herein demonstrate but a few examples of the pervasive pattern of medical neglect that has already come dangerously close to being fatal to individuals detained at Baker. Our investigations, which are ongoing, have confirmed that Armor, BCSO, and BCCMC cannot safely or responsibly provide medical care for the individuals in their custody. The foregoing cases are examples of a widespread failure at Baker to adhere to the detention standards, IHSC policies, medical standards of care, and the United States Constitution. For these reasons, we urge IHSC to recommend immediate and permanent termination of the IGSA that allows Baker County to operate as an ICE facility.

For the health and safety of those in detention at Baker, we urge ICE to immediately release all immigrants detained at Baker, as the evidence included herein reveals that all immigrants detained at Baker are at risk for suffering abusive and inhumane conditions at Baker, particularly those with serious health conditions or of advanced age. The continued detention of these individuals at Baker is neither necessary nor safe and could prove fatal.

Independent of the dangers related to the lack of adequate medical care, Baker also has a history of retaliating against detained immigrants who speak out about the mistreatment they suffer.[207] For these reasons, the ACLU of Florida is concerned for the safety and wellbeing of the above-named individuals. Therefore, we also respectfully request that, for the protection of these individuals, DHS issue and halt the deportation of any individual named above that is still present in the United States by issuing a Z hold to prevent their removal while an investigation is ongoing.

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[205] Reggie Grant-Full Baker Medical History at 4 of 168.
[206] *Id.* at 5 of 168 (considered "high risk" for an "active condition").
[207] ACLU of Florida, Multi-Individual Complaint Regarding Inhumane Conditions and Unlawful Treatment at Baker County Detention Center, Including Retaliation, Physical Assault, Medical Neglect, and Unsanitary Conditions, September 13, 2022, available at https://www.aclufl.org/en/crcl-complaint-baker-county-detention-center.

Finally, we ask that CRCL, the Office of the Immigration Detention Ombudsman and the Office of Inspector General conduct a comprehensive investigation of the medical neglect and abuses at Baker raised in this letter to ensure the patterns and practices that led to the events described herein are not repeated at any detention facility. Immigrants detained at Baker are not safe. We ask you to intervene and recommend an end to this inappropriate contractual relationship with BCSO and BCCMC to bring immediate relief and protection to those suffering inside Baker.

Sincerely,

s/Katie Blankenship
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s/Maite Garcia
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