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COMPLAINT DETAILING ABUSIVE OVERUSE OF SOLITARY CONFINEMENT AND MISTREATMENT THAT DISPROPORTIONATELY IMPACTS PERSONS WITH DISABILITIES AT THE AURORA CONTRACT DETENTION FACILITY

******This complaint includes violations of the Rehabilitation Act of 1973. Please submit to the Section 504 division pursuant to 6 C.F.R. § 15.70.**

Dear Ms. Sivaprasad Wadhia, Mr. Klein, Mr. Gersten, and Mr. Cuffari,

American Immigration Council ("AIC"), National Immigration Project ("NIPNLG"), and Rocky Mountain Immigrant Advocacy Network ("RMIAN") file this complaint on behalf of a group of individuals currently or recently detained at the Aurora Contract Detention Facility ("Aurora facility"), a prison owned and operated by GEO Group Inc. ("GEO") where Immigration & Customs Enforcement ("ICE") incarcerates people who have pending or recently concluded immigration matters.

Despite a clear record of abuse and repeated deaths of people detained at the Aurora facility in Colorado, the facility and ICE continue to fail to keep people safe. Complainants' experiences highlight the myriad ways in which systemic abuses occur within the facility, with a particular focus on the increased misuse of solitary confinement. The examples provided in this complaint align with broader findings of mistreatment of people in ICE custody across the country.[1]

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[1] U.S. Dept. of Homeland Sec., Office of Inspector Gen., OIG-22-01 "ICE Needs to Improve Its Oversight of Segregation Use in Detention Facilities" (Oct. 13, 2021), https://www.oig.dhs.gov/sites/default/files/assets/2021-10/OIG-22-01-Oct21.pdf; Joseph Nwadiuko et al., *Solitary Confinement Use in Immigration Detention Before and After the Beginning of the SARS-CoV-2 Pandemic*, J. Gen. Intern. Med. (2023), https://link.springer.com/article/10.1007/s11606-023-08055-0.

This complaint raises violations of: (1) ICE Enforcement and Removal Operations' *Performance-Based National Detention Standards 2011* ("PBNDS 2011");[2] (2) ICE Policy Memorandum 11065.1, "Review of the Use of Segregation for [Persons in ICE Detention]," (Sep. 4, 2013); and (3) Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794 and its implementing regulations that are binding on the Department of Homeland Security ("DHS"), found at 6 C.F.R. § 15.30(b)(1)(i).

This complaint focuses on the experiences of eight clients, all of whom are currently or were recently detained in the Aurora facility.[3] The first section provides extensive evidence of prior mistreatment, abuse, and death reported at the Aurora facility, demonstrating Aurora's deadly and cruel history. The complaint follows by highlighting the ways in which the complainants' health and safety have been jeopardized and the facility has failed to protect complainants fearful of or who suffered violence. These threads provide background information that contextualize the Aurora facility's practice of overusing and misusing solitary confinement as a tool to control behavior instead of providing a safe environment and appropriate medical and mental health care. Finally, the complaint discusses DHS' obligations under Section 504 and provides examples of incidents where disability discrimination took place.

ICE has a duty to keep people safe while it imprisons them. Each complainant experienced a breach of that duty, leading to egregious harm. Systemic reform is needed to prevent further abuse and harm.[4] We urge your offices to recommend the immediate and permanent termination of the contract that allows for the operation of the Aurora facility and the release of all individuals detained in the Aurora facility. At a minimum, we ask your offices to promptly investigate the specific incidents reported in this complaint and the use of solitary confinement at the Aurora facility; assess whether the facility is complying with ICE policies; and recommend systemic policy reforms on the use of segregation as well as corrective actions for Aurora facility staff.

To ensure that violations described in this complaint do not occur in immigration detention more broadly, we call on ICE to halt the use of solitary confinement in all facilities incarcerating people in its custody across the country. As the practice is being reduced, we ask

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[2] U.S. Immig. and Customs Enforcement, 2011 ICE Performance-Based National Detention Standards, revised 2016, https://www.ice.gov/detain/detention-management/2011 [hereinafter "2011 ICE PBNDS"]; *See* U.S. Dep't of Homeland Sec., Immigration and Customs Enforcement, Office of Detention Oversight Compliance Inspection, Compliance Inspection 2023-004-068, Denver Contract Detention Facility 12 (Mar. 2023), https://www.ice.gov/doclib/foia/odo-compliance-inspections/denverCDF_DenverCO_Mar14-16_2023.pdf (detailing that the 2011 ICE PBNDS is binding on the Aurora facility).

[3] Pseudonyms have been used to protect the identities of the complainants.

[4] AIC, NIPNLG, and RMIAN each advocate for an end to the use of immigration detention in the U.S. immigration system and believe that is the only means to ensure people are treated humanely, have meaningful access to health and human services, and will allow for a process that is more fundamentally fair given people will have greater access to counsel and evidence necessary to litigate their immigration matters and be free from the harmful and coercive environment of incarceration while defending themselves in court. Until that goal is achieved, our organizations strive to reduce harm by improving the conditions of confinement for people incarcerated in ICE custody and provide a spotlight to the experiences of persons negatively impacted by the current system.

that you recommend system-wide changes in the use of solitary confinement, including explicitly forbidding the overuse and misuse of solitary confinement, and implement stricter measures of accountability for facilities that violate their affirmative obligations under Section 504.

I. THE AURORA FACILITY'S DEADLY AND ABUSIVE HISTORY

The Aurora facility has a lengthy history of human rights violations[5] and DHS has been on notice of a systemic practice of medical neglect[6] and inadequate care for people held in the Aurora facility.[7] Since 2012, someone has died every five years while detained in the Aurora facility. Each death was avoidable and stemmed from the poor medical care provided by the contract medical provider, GEO.

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[5] *See* Am. Immig. Council, Rocky Mountain Immig. Advocacy Network, Immig. Justice Idaho, Mariposa Legal, "Violations of ICE COVID-19 Guidance, PBNDS 2011, and Rehabilitation Act of 1973 at the Denver Contract Detention Facility," Feb. 11, 2022, https://www.americanimmigrationcouncil.org/sites/default/files/research/complaint_against_ice_medical_neglect_people_sick_covid_19_colorado_facility_complaint1.pdf; Am. Immig. Council, Am. Immig. Lawyers Assoc., "Failure to provide adequate medical and mental health care to individuals detained in the Denver Contract Detention Facility," June 4, 2018, https://www.americanimmigrationcouncil.org/advocacy/immigrants-inadequate-medical-care-aurora [hereinafter "AIC June 2018 Complaint"]; Am. Immig. Council, Am. Immig. Lawyers Assoc., "Supplement—Failure to provide adequate medical and mental health care to individuals detained in the Denver Contract Detention Facility," June 11, 2019, https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_supplement_failure_to_provide_adequate_medical_and_mental_health_care.pdf [hereinafter "AIC June 2019 Supplement"]; U.S. Dept. of Homeland Sec., Office of Inspector Gen., OIG-19-47 "Concerns about ICE [ ] Treatment and Care [for People it Detains] at Four Detention Facilities" (June 3, 2019), https://www.oig.dhs.gov/sites/default/files/assets/2019-06/OIG-19-47-Jun19.pdf.

[6] Most recently, the Office of Detention Oversight found 11 deficiencies of medical standards at the Aurora facility, including a repeat deficiency in performing medical, dental, and mental health screenings within 12 hours of a person's detention within the facility. *See* U.S. Dep't of Homeland Sec., Immigration and Customs Enforcement, Office of Detention Oversight Compliance Inspection, Compliance Inspection 2023-004-068, Denver Contract Detention Facility 12 (Mar. 2023), https://www.ice.gov/doclib/foia/odo-compliance-inspections/denverCDF_DenverCO_Mar14-16_2023.pdf.

[7] ACLU of Colorado, "Cashing in on Cruelty: Stories of death, abuse, and neglect at the GEO immigration detention facility in Aurora" (2019), https://www.aclu-co.org/sites/default/files/ACLU_CO_Cashing_In_On_Cruelty_09-17-19.pdf (reporting on substandard medical and mental health care at the Aurora Detention Facility); Am. Immig. Lawyers Assoc., "Complaint Filed with DHS Oversight Bodies Calls for Improvement to Medical and Mental Health Care of Immigrants in Aurora Detention Center," June 4, 2018, https://www.aila.org/advo-media/press-releases/2018/complaint-filed-with-dhs-oversight-bodies-calls ("The complaint illustrates the government's failure to comply with official policies on mandated care; grossly substandard medical and mental health care; limited transparency and public accountability regarding many other aspects of [] care; and facility staff and ICE's deliberate indifference to a [person's] serious medical needs.").

An ICE contractor review of Evalin-Ali Mandza's 2012 death at Aurora found that the fact that "medical staff were unfamiliar with the institution's Chest Pain Protocol [and that] appropriate cardiac medication was not administered, and the time it took to transport the patient to a higher-level care facility, all may have been contributing factors to the death of the patient."[8] ICE Office of Professional Responsibility's review of Kamyar Samimi's 2017 death at the detention center found that medical staff did not fully comply with multiple standards, including short-staffing of medical professionals, the facility's failure to provide an on-call doctor with whom nurses could consult, and failing to seek emergency care on his behalf.[9] Mr. Samimi was held in solitary confinement in the medical unit for the last 16 days of his life.[10]

On June 4, 2018, AIC and the American Immigration Lawyers Association filed a complaint with ICE, ICE Health Services Corps, the Office for Civil Rights and Civil Liberties ("CRCL"), and the DHS Office of the Inspector General ("OIG") regarding "failure to provide adequate medical and mental health care" to individuals detained at the Aurora facility, with seven case examples.[11] On June 11, 2019, the organizations filed a supplement to the complaint highlighting the experiences of five additional individuals.[12]

Most recently, on October 13, 2022, Melvin Calero Mendoza passed away in ICE custody after sustaining an injury while being detained at the Aurora facility.[13] While ICE refused to release a complete accounting of his death, all signs point to Aurora's failure to adequately care for him after his injury, with fatal results. Contemporary experiences of people in detention at the Aurora facility confirm that little has changed at the facility regarding access to healthcare services and it remains clear that the facility falls severely short of meeting the ICE detention standards.

Rather than affirmatively striving to provide adequate medical and mental health care, the Aurora facility instead places people at risk. Decisions about housing assignments, understaffing, and the staff culture of disregard for safety creates a hostile and inhospitable environment for the people detained within the Aurora facility. Besides the already well-documented failure to provide care to individuals detained at the facility, this complaint illustrates the facility's systemic failure to provide a safe environment for individuals detained and misuse and overuse of solitary confinement, resulting in an untenable situation where people are afraid to voice concerns and are left without any recourse to ensure their safety.

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[8] U.S. Dep't of Homeland Sec., Death Investigation for Evalin-Ali Mandza 16 (October 16, 2012), https://www.documentcloud.org/documents/2695514-MandzaEmilialin-Ali.html.
[9] Kieran Nicholson, *Medical care for [detained person] who died in ICE custody in Colorado fell short of federal standards, report says*, THE DENVER POST, May 20, 2019, https://www.denverpost.com/2019/05/20/aurora-ice-detainee-died-medical-care.
[10] *Id.*
[11] AIC June 2018 Complaint, *supra* note 5.
[12] AIC June 2019 Supplement, *supra* note 5.
[13] *See* Matt Bloom, *Aurora ICE death autopsy released, raises questions about medical care in federal detention centers*, CPR NEWS, Feb. 15, 2023, https://www.cpr.org/2023/02/15/aurora-ice-inmate-deaths/ ("Medical experts, along with family members, say the report shows that Calero-Mendoza's death was potentially preventable and follows a pattern of deaths at ICE facilities.").

II. VIOLATIONS OF PERFORMANCE-BASED NATIONAL DETENTION STANDARDS 2011

The evidence included in this complaint document violations of the 2011 ICE PBNDS, which is the set of detention standards ICE applies to the Aurora facility.

The Aurora Facility Fails to Provide a Safe & Controlled Environment

From the moment a person is detained within the Aurora facility, their safety and wellbeing are controlled by ICE and GEO staff members. The 2011 ICE PBNDS provides guidance for how to create a safe environment, including for survivors of assault or violence, but that relatively low baseline regularly remains unmet at the Aurora facility.

The 2011 ICE PBNDS requires that detained persons with special vulnerabilities be "identified and consideration … be given to providing appropriate accommodation."[14] Throughout the period of detention, the facility "shall" review a detained person's custody classification "at regular intervals, as well as when required by changes in the [person in detention's] behavior or circumstances, and upon discovery of additional, relevant information."[15] Adults in ICE custody "shall be assigned to the least restrictive housing unit consistent with facility safety and security."[16]

The detention standards further state that "[t]he facility administrator shall ensure that adequate provisions are made for staff and [detained persons'] safety."[17] To that end, "the facility administrator shall develop and document comprehensive [ ] supervision guidelines [for people detained in the facility], as well as a comprehensive staffing analysis and staffing plan, to determine and meet the facility's [ ] supervision needs."[18] The standards also require that "essential security posts will be staffed with qualified personnel."[19] "This detention standard protects…[detained persons] from harm by ensuring that facility security is maintained and events which pose risk of harm are prevented."[20] "[E]ach facility," applying the standards "shall ensure that it maintains sufficient supervision of [people in its custody], including through appropriate staffing levels and, where applicable, video monitoring, to protect [detained people] against sexual abuse[,] assault, other forms of violence or harassment, and to prevent significant self-harm and suicide. Security staffing shall be sufficient to maintain facility security and prevent or minimize events that pose a risk of harm to persons and property."[21]

When making decisions about risk classification of people detained in the Aurora facility, detention center staff are required to give "special consideration … to any factor that would raise the risk of vulnerability, victimization or assault."[22] Detained persons who may be at especially high risk of harm include "persons with disabilities … suffering from a serious

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[14] 2011 ICE PBNDS at 61.
[15] *Id.*
[16] *Id.*
[17] *Id*. at 21.
[18] *Id*. at 81.
[19] *Id.*
[20] 2011 ICE PBNDS at 81.
[21] *Id*. at 82.
[22] *Id*. at 62.

medical or mental illness, and victims of torture, trafficking, abuse, or other crimes of violence."[23]

When it comes to providing a safe environment for survivors of assault or violence, the 2011 ICE PBNDS is clear: "The facility will use a coordinated, multidisciplinary team approach to effectively respond to all incidents of sexual abuse or assault and address any safety, medical, or mental health needs."[24] The standards assert that "[s]taff shall be alert to potential risks or signs of sexual abuse or assault, and take appropriate action to mitigate any identified risks or protect a [detained person] as necessary."[25] The PBNDS counsels detention center staff to listen to survivors of abuse, and states that "[i]f it is documented, suspected, or reported that a [detained person] has been physically or sexually abused or assaulted, the [person's] perception of his or her own safety and well-being shall be among the factors considered in reclassification."[26] Staff have a responsibility to "immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or assault, retaliation against individuals who reported an incident, or any staff neglect or violation of responsibilities which may have contributed to an incident or retaliation."[27]

The experiences of people detained at the Aurora facility show that ICE is not adhering to the standards related to safety. Staff routinely fail to provide detained persons with a safe and controlled environment, and sometimes go as far as to place people it detains at risk. For example:

> Lauren
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> Lauren, a woman recently detained at the Aurora facility, explains that when women in her dorm reported disagreements amongst themselves to GEO staff members, or when staff otherwise became aware of these conflicts, staff members sometimes worsen those conflicts and create new dangerous situations by sharing details of complaints expressed by some women with others who are the subject of the complaint. Lauren describes that a detained woman in her dorm reported not feeling safe to her lawyer and was overheard by GEO staff, who "yelled at her in front of everyone about how she had gone running to call her lawyer." "Now everyone knows she reported the problem—and if she's trying to keep herself safe, [GEO staff] just ruined that for her."

GEO's failure to ensure that its staff act professionally and in a manner that supports the safety of detained persons at the Aurora facility has led people to stop reporting safety concerns to staff.

> Lauren reports that **"most of the time we just don't tell the guards about the problems, including about safety, because we know they will do something like [GEO staff] did, and we will be even less safe than we were before."**

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[23] *Id.*

[24] *Id.* at 127.

[25] 2011 ICE PBNDS at 127.

[26] *Id*. at 65–66.

[27] *Id*. at 127–28.

Other accounts demonstrate that the facility takes no meaningful action to provide a safe environment. Conversations with persons detained at the Aurora facility show that staff routinely discount the safety concerns of people in ICE custody until an incident occurs, and then separates individuals who are demonstrating dysregulated behavior for a short period of time and fail to address the safety or mental health needs of those involved. For example:

> <u>Emilia</u>
> Medical records from the Aurora facility confirm that Emilia has diagnoses of Post-Traumatic Stress Disorder and Depressive Disorder. She has a history of sexual assault, rape, abuse, violence, and trafficking for sex and labor. Yet despite her obvious vulnerability, staff at the Aurora facility placed Emilia in a dorm where she feared for her safety. The experience of being detained in a space where she felt completely disempowered brought back memories of when Emilia was sexually assaulted and raped in the past and contributed to Emilia's worsening mental health. **Medical records show that Emilia felt unsafe in her dorm, but staff members took no action to meaningfully protect her**. Rather, Aurora staff members only provided a temporary solution and did not act to ensure all involved were safe and had access to appropriate psychological care. "It's like living with your own predator," says Emilia, "it's a nightmare, a torture."

Aurora facility staff also completely discount the safety of survivors of assault or violence. For example:

> <u>Bianca</u>
> Bianca feared for her life and safety in her dorm at the Aurora facility because of threats she received from another woman. When she reported this to a staff person at the detention facility, the response was laughter. The response was that **staff "'can't do anything until something [bad] happens.'" Staff members told Bianca and other women in her dorm to fight each other, but as she points out "that doesn't make things better."** Instead, Bianca and seven other women requested to transfer dorms for their own safety. Later, Bianca learned from a GEO staff member that the woman, who likely needed access to mental health treatment, had threatened to harm herself and staff members. Rather than immediately provide mental health treatment to the woman, staff members became concerned for themselves and exhibited complete disregard for the safety of the women in the dorm. When a staff person explained to Bianca why they would not work in the dorm with the woman, they stated, "'I have a family and I am not risking my life.'" Yet, those incarcerated in the dorm had no agency to separate themselves. After vigorous advocacy from her attorney, Bianca moved to a different dorm. Yet, she was still not incubated from further harassment and harm and staff members took no action to offer her protection. Instead, a nurse told her to fight back harder. **"When there is a fight, the staff puts you right back together with the person who caused the problem. . . [An] officer said, 'you know how GEO policy is, they just put you back in the same dorm.'"**

Emilia

Emilia, who also experienced threats of violence, reports that **staff at the Aurora detention facility take a "wait and see" approach after a detained person harasses or threatens violence against another.**

The experiences of Complainants highlight the cavernous gap between the protections afforded by ICE guidance and the way in which people are being treated in practice within the Aurora facility. Staff members gaslight people incarcerated by ICE, making them feel as though their legitimate concerns for their wellbeing and safety are unimportant because of their status as persons in immigration custody. As described in more detail below, instead of affirmatively protecting the noncitizens it incarcerates, the Aurora facility uses solitary confinement as a tool to control behavior that would unlikely occur if safety were truly the primary focus.

The Aurora Facility Consistently Misuses Solitary Confinement

ICE regularly places people in its custody in solitary confinement, despite engaging in civil detention, which cannot be punitive in nature.[28] Yet, the practice has extraordinarily damaging effects. "More than a third (33%) of people held in solitary confinement become psychotic and/or suicidal within the first 15 days, and people who have been subjected to solitary confinement are 78% more likely to commit suicide within a year of being released from prison."[29] Complainants urge ICE to end the practice of solitary confinement in all of its facilities. At a minimum, it must ensure that facilities adhere to the basic protections afforded by ICE policy guidance.

According to the 2011 ICE PBNDS, persons in ICE custody "shall be placed in disciplinary segregation only after a finding by a disciplinary hearing panel that the [person] is guilty of a prohibited act or rule violation classified at a 'greatest,' 'high' or 'high-moderate' level."[30] Disciplinary segregation "shall only be ordered when alternative dispositions may inadequately regulate the [detained person's] behavior."[31] People detained by ICE who have "serious mental illness may not be automatically placed in [a special management unit] on the basis of such mental illness" and "[e]very effort shall be made to place [detained persons] with serious mental illness in a setting in or outside the facility in which appropriate treatment can be provided, rather than an SMU [Special Management Unit], if separation from the general population is

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[28] *See, e.g.*, *Bell v. Wolfish*, 441 U.S. 520, 538 (1979) (providing a framework for determining whether confinement constitutes punishment by first inquiring whether the intent to punish exists and if not, whether there was a reasonable government purpose for the restraint as well as if it was excessive).

[29] *Written Submission of Robert F. Kennedy Human Rights to the International Independent Expert Mechanism to Advance Racial Justice and Equality in the context of Law Enforcement* (Feb. 24, 2023), https://rfkhumanrights.org/written-submission-of-rfk-human-rights-to-the-international-independent-expert-mechanism-to-advance-racial-justice-and-equality-in-the-context-of-law-enforcement (citing Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 Crime and Delinquency 124 (2003); Lauren Brinkley-Rubinsten, Josie Sivaraman & David L. Rosen, Association of Restrictive Housing During Incarceration with Mortality After Release, JAMA Network Open (2019)).

[30] 2011 ICE PBNDS at 171.

[31] *Id.*

necessary."[32] When detention center staff choose to place a detained person in solitary confinement, they are required to perform "visual monitoring at irregular intervals at least every 15 minutes."[33]

The ICE Directive on the Use of Segregation says that "[p]lacement in segregation should occur only when necessary and in compliance with applicable detention standards."[34] The directive generally requires that ICE "shall take additional steps to ensure appropriate review and oversight of decisions to retain [persons in detention] in segregated housing for over 14 days."[35] For cases of individuals "for whom heightened concerns exist based on known special vulnerabilities and other factors related to the [person's] health or the risk of victimization," however, ICE must undertake appropriate review and oversight "for any length of time" when someone is held in solitary confinement.[36]

Despite the standards in place, the Aurora facility engages in overuse of solitary confinement, isolating people before a disciplinary hearing has taken place, and weaponizes the practice to punish and control people detained in its custody.[37] Additionally, Aurora facility staff members do not properly engage in an assessment of whether individuals qualify as "vulnerable" pursuant to the 2011 ICE PBNDS before placing them in punitive segregation. For example:

> Daniel
> Staff at the Aurora facility placed Daniel in solitary confinement after they accused him of being involved in a fight. Daniel has a chronic disease and had just returned from a doctor's visit outside of the detention facility when he learned he could not re-enter his dorm because the doors were locked. Instead, Daniel went to eat. **"The guards approached me and asked me if I belonged in the dorm. I said yes, I belonged in that dorm, and although I told them I was just eating and showed them my plate, they said everyone was going to solitary confinement."** Daniel feels that the investigation process was a sham. Aurora staff asked him if he had a witness that would clear him of involvement in the fight, and he said that he did, but was never asked to produce the witness because there was not a proper hearing to clear him of the accusation. "I ha[d] no faith that they would free me from solitary confinement if they found out I was not part of the fight or knew anything about it." "[M]y other dorm mate … provided a witness that stated that my dorm mate did not participate [in the fight] and he still went to solitary confinement." Aurora staff kept Daniel in solitary confinement for 10 days and threatened to send him back to solitary confinement if he does not follow the rules. Recently, a staff member threatened to send him to solitary confinement if he did not

[32] *Id.* at 172.
[33] *Id.* at 102.
[34] U.S. Dept. of Homeland Sec., U.S. Immigration and Customs Enforcement, 11065.1: Review of the Use of Segregation for [Persons Detained by ICE], (Sept. 4, 2013), https://www.ice.gov/doclib/detention-reform/pdf/segregation_directive.pdf.
[35] *Id.*
[36] *Id.*
[37] Order, *Menocal v. GEO Group, Inc.*, No. 1:14-cv-02887-JLK-MEH, ECF 380 at 40–41, (Oct. 18, 2022) ("GEO went beyond its contract with ICE in requiring [detained people] to clean up all common areas and after other [people in detention] under the threat of segregation.").

move to the top bunk in his dorm. "I usually sleep in the lower bunk bed because I don't have the strength to climb [to] the top" he explains. Fearing reassignment to solitary confinement, Daniel exerted himself to get to the top bunk but then found that he could not get down without help. He remained on the top bunk for a day, until dorm mates helped him come down.

Felix
On his first day at the Aurora facility, Aurora staff placed Felix in solitary confinement for eating too slowly. A staff member took his food tray away, and when he protested, told him he was being "noncompliant" and put him in solitary confinement for 3 days. Aurora facility staff forced him into solitary confinement about 10 more times during his detention there before ICE transferred him to another facility where he is receiving better care for his deteriorating mental health. **"If I spoke too loudly, solitary. If I climbed on top of a table to get a guard's attention, solitary. If I had suicidal thoughts, solitary. When the guards would tease me about being deported back to my home country and make airplane sounds at me and gesture like a plane was taking me away, I would become upset and then get solitary for being upset."**

Lauren
Lauren was placed in solitary confinement at the Aurora facility after a woman in her dorm falsely accused her of spitting on her bed. "I was trying to explain that I didn't want to do anything to her. But the officers said that it looked like I was being threatening, so they put me in the SHU [Special Housing Unit] while they 'investigated.'" She was not asked to participate in any investigatory proceeding and was instead told by Aurora staff that they had been found "not guilty." She was freed from solitary confinement after 6 days. She reports that those days were scary because she began to hallucinate. Lauren has severe anxiety, depression, and Post-Traumatic Stress Disorder related to past harm she endured. Aurora facility staff members threatened to put her back in solitary confinement due to arguments in her dorm that she is not involved in. **"The threat of being placed back in the SHU has made my anxiety and other mental health problems even worse," she says, "[i]t felt like they were using the threat of being placed in the SHU in order to control us. It wasn't to make anyone any safer."** After these threats, Lauren cut her arm with a razor "to get some control" and because it "felt better." A medical provider told her to not cut herself again, or else she would be sent back to solitary confinement, this time for medical segregation. "[I]t scared me. I wasn't feeling suicidal at all," she said. "I was feeling overwhelmed. But the idea of being placed back there, even if it was supposedly for my well-being, made me feel even worse."

Mateo
Mateo was attacked by another detained person in his dorm and fought back to defend himself. Staff immediately placed him in solitary confinement and removed him only for a short time to conduct a sham proceeding where he was found guilty of engaging in the fight. Mateo asked the GEO staff involved in the proceeding to check the video cameras to confirm that he had not caused the fight, but he does not know if they did. He was detained in solitary confinement for 15 days. **"ICE and GEO didn't do**

anything to protect me," he said, "[t]here were cameras recording the incident but no one … ever talked with me about what happened."

Odette

Odette, who has a known psychological disability, recalls being placed in solitary confinement many times while she was detained at the Aurora facility. "Once, they said I pushed someone, when I tried to get someone to move back from me because she was standing too close." Another time, she was sent to solitary confinement after she screamed in frustration when staff searched her possessions at midnight to look for a crochet hook. Of the disciplinary proceeding, Odette explains that she "was moved first, then served with a piece of paper that had a checklist of violations, the signature of a lieutenant, and the number of days I had to be in solitary." "I did not get copies of the evidence against me. A few times I did talk to someone before moving, which was maybe a hearing," she added, but it was unclear. Odette feels that the amount of time that these investigations took to conclude and how long she spent in solitary would sometimes be arbitrary. **"I feel like they only reviewed my status when they felt like I had been in solitary for too long, like months."**

Conditions in segregation confinement at the Aurora facility are degrading and frequently lead detained persons to decompensate mentally or physically. For example:

Daniel

Daniel explains that Aurora staff did not permit him to do anything outside of the solitary cell except to shower once a day. He was not permitted contact with the outside world and was told by staff that the phone did not reach his cell. **It was not until Daniel started hearing voices that a psychologist wrote a note to staff telling them to make a phone available**—he was moved to another cell where the phone could reach. The room was "very dirty, black with dirt and grime," he recalls. "The table was also very dirty, and stained, with milk and other food remains." At no point did staff members advocate for Daniel's release from solitary confinement.

Felix

"In the hole, one sits all day and night, trying to stay warm, with … no contact to the outside world, and no one else to talk to" said Felix of his experience in solitary confinement at the Aurora facility. **"You cannot talk to your family. You cannot make your legal calls. All you can do is sit there mostly naked, in a thick green jacket that is too stiff to bend, shackled on your writes and ankles, trying to stay warm, huddled into the corner of the small room thinking about everything in your life that has brought you to that moment."** Staff at the Aurora facility took his prison uniform away from him when he was sent to solitary confinement—he describes how, when he refused to strip off his clothes, "[t]he guards would hold me still and cut my clothes from my body, sometimes cutting my skin as I tried to resist them." Felix, who attempted suicide in another detention facility before arriving at the Aurora facility attempted suicide again at the Aurora facility by jumping from a second-story landing to the ground below. He hatched a plan to jump from a "great height" while he was detained in

solitary confinement. He landed on his neck, causing vertebrae fractures and severe swelling to his head and neck, requiring emergency hospitalization.

Lauren
Lauren started seeing shadows and hearing voices again while she was held in solitary confinement at the Aurora facility. **"I hadn't seen shadows or heard voices in a long time, but those symptoms started coming back when I was in the SHU. I was alone and hallucinating and scared."** Unfortunately, these symptoms did not stop when she was freed from solitary confinement. Lauren reports that her time in solitary confinement was made even more unbearable because a sewer problem caused sewage water to come up from the toilet in her cell. The smell was unbearable, but her complaints went unheeded.

Odette
Staff at the Aurora facility sometimes turned off the air conditioning unit in the solitary confinement wing where Odette was detained because it became cold in the non-cell areas. "I had high blood pressure and asthma, so the lack of cool air would make it hard for me to breathe."

III. VIOLATIONS OF SECTION 504 OF THE REHABILITATION ACT

ICE recognizes its obligations to ensure persons with disabilities are afforded appropriate care and accommodations or modifications under Section 504 of the Rehabilitation Act. Yet, in practice the Aurora facility systemically fails to adhere to its responsibilities.

Persons with disabilities are often punished for having a disability, in contravention of what is required under Section 504. In particular, the use of solitary confinement often exacerbates the symptoms of disabilities, causing health to worsen. "[I]ncarcerated people with mental illness are disproportionately assigned to extended solitary confinement, which is widely documented to cause physical and mental decompensation, and even lead to suicide."[38] Complainants' experiences illuminate a pattern within the Aurora facility of placing persons with disabilities at risk of self-harm in solitary confinement. "Death by suicide is the starkest example of how a lack of disability accommodations can curtail the legal rights of individuals with disabilities."[39]

The 2011 ICE PBNDS states that "[individuals in detention] shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis and treatment" and "shall be able to request health services on a daily basis and shall receive timely follow up."[40] The standards require that medical personnel be "appropriately trained and qualified" and that medical services be provided by a "sufficient number" of staff members.[41]

[38] Margo Schlanger, Elizabeth Jordan, Roxana Moussavian, *Ending the Discriminatory Pretrial Incarceration of People with Disabilities: Liability Under the Americans with Disabilities Act and the Rehabilitation Act*, 17 Harv. Law & Pol. Rev. 1, 245 (2022).
[39] *Id.*
[40] 2011 ICE PBNDS at 257.
[41] *Id*. at 259.

A person held in detention "who is determined to require health care beyond facility resources shall be transferred in a timely manner to an appropriate facility."[42]

Section 504 supplements what is required pursuant to ICE policy and prohibits discrimination on the basis of disability in programs, services, or activities conducted by U.S. federal agencies, including DHS.[43] Under Section 504, "[n]o qualified individual with a disability in the United States, shall, by reason of his or her disability, be excluded from the participation in, be denied benefits of, or otherwise be subjected to discrimination under any program or activity conducted by the Department."[44] Section 504 forbids not only facial discrimination against individuals with disabilities, but also requires that executive agencies and departments, such as DHS, alter policies and practices to prevent discrimination on the basis of disability. Covered entities have an affirmative obligation under Section 504 to ensure that their benefits, programs, and services are accessible to persons with disabilities.[45] Reasonable accommodations necessary to prevent disability discrimination are required unless modifications would create a "fundamental alteration" of the relevant program, service, activity, or would impose an undue hardship.[46] ICE adopted binding regulations to ensure that Section 504 is implemented within the agency.[47]

Section 504 defines disability as an "impairment that substantially limits one or more of the major life activities." This definition includes chronic illness, as well as physical, intellectual,

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[42] *Id.* at 258.
[43] Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §§ 794 *et seq*.; 6 C.F.R. § 15.30(b)(1)(i).
[44] 29 U.S.C. § 794(a); 6 C.F.R. § 15.30(a).
[45] U.S. Dep't of Homeland Sec., Office for Civil Rights & Civil Liberties, Component Self-Evaluation and Planning Reference Guide 17–18 (Jun. 6, 2016), https://www.dhs.gov/sites/default/files/publications/ disability-guide-component-self-Emilialuation.pdf; *see also Vinson v. Thomas*, 288 F.3d 1145, 1154 (9th Cir. 2002) (holding that once a government agency is alerted to the need for a reasonable accommodation, there is "a mandatory obligation to engage in an informal process 'to clarify what the individual needs and identify the appropriate accommodation") (quoting *Barnett v. U.S. Air, Inc.*, 228 F.3d 1105, 1112 (9th Cir. 2000)); *Pierce v. DC*, 128 F. Supp. 3d 250, 272 (D.D.C. 2015) (holding that "prison officials have an affirmative duty to assess the potential accommodation needs of inmates with known disabilities…and to provide the accommodations that are necessary…without regard to whether or not the disabled individual has made a specific request for accommodation.).
[46] 28 C.F.R. § 35.150(a)(3).
[47] The Secretary of Homeland Security, through DHS Delegation Number 19003, delegated responsibility for coordinating the enforcement of the Department's regulations issued pursuant to the requirements of Section 504 to the Officer for Civil Rights and Civil Liberties. 6 C.F.R. Part 15, *et seq.* For each complaint, the regulations require the Department to issue findings of fact, conclusions of law, a description of a remedy for each violation found, and a notice of the right to appeal to the Officer for Civil Rights and Civil Liberties. *See* 6 C.F.R. § 15.70(g)(1)(i)– (iii); *see also* U.S. Department of Homeland Security (DHS) Directive 065-01: Nondiscrimination for Individuals with Disabilities in DHS Conducted Programs and Activities (Non-Employment) (September 25, 2013) (establishing policy and implementation mechanisms for ensuring nondiscrimination for individuals with disabilities served by DHS-conducted programs and activities under Section 504).

developmental, psychiatric, visual, and auditory disabilities.[48] Evidence of a medical diagnosis is not required and proof from an individual's personal experience demonstrating that the impairment is substantial is sufficient to qualify for Section 504 protections.[49] Once an entity is on notice of a person's disability, it must affirmatively engage in an inquiry as to whether a reasonable accommodation is required to ensure the individual has equal access as persons without a disability to agency programs, services, and activities.[50] Failure to do so amounts to disability discrimination.[51]

In the context of immigration detention, there are multiple mechanisms through which ICE may receive notice when people it detains exhibit, complain of, or are diagnosed with disabilities. As a custodian, ICE is responsible for providing medical care to the people it detains[52] and has broad access to medical records that indicate whether patients have a diagnosis or exhibit symptoms that implicates Section 504.[53]

Despite binding law and regulations, the Aurora facility regularly violates its Section 504 obligations. For example:

> Daniel
>
> Daniel has a chronic disease that limits one or more major life activities and is protected under Section 504. He expresses that when he feels pain or severe weakness and alerts staff at the Aurora facility, medical staff typically only put him under observation but do little else and then return him to his dorm. As mentioned above, due to his weakness related to his chronic illness, he struggles with accessing the top bunkbed in the Aurora facility.

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[48] Margo Schlanger, Elizabeth Jordan, Roxana Moussavian, *Ending the Discriminatory Pretrial Incarceration of People with Disabilities: Liability Under the Americans with Disabilities Act and the Rehabilitation Act*, 17 Harv. Law & Pol. Rev. 1, 237–48 (2022).

[49] *Robertson v. Las Animas County Sheriff's Dept.*, 500 F.3d 1185, 1194 (10th Cir. 2007) (applying an analogous analysis for how to determine whether an individual has a qualifying disability protected by the American with Disabilities Act).

[50] *See Updike v. Multnomah Cnty.*, 870 F.3d 939, 949 (9th Cir. 2017) ("[Section] 504 include[s] an affirmative obligation for public entities to make benefits, services, and programs accessible to people with disabilities.").

[51] *See* Margo Schlanger, Elizabeth Jordan, Roxana Moussavian, *Ending the Discriminatory Pretrial Incarceration of People with Disabilities: Liability Under the Americans with Disabilities Act and the Rehabilitation Act*, 17 Harv. Law & Pol. Rev. 1, 257 (2022) (explaining that under Section 504, "liability attaches for disability discrimination based not on discriminatory intent but on failure, intentional or not, to provide individuals with disabilities an opportunity equal to that afforded nondisabled people to participate in or benefit from government programs, where—as the next section explains, equality could be accomplished by a reasonable modification to the rules or practices governing the service, program, or activity.").

[52] 2011 ICE PBNDS at 258 (requiring that each person processed into the facility "receive a comprehensive medical, dental and mental health intake screening as soon as possible, but no later than 12 hours after arrival at each detention facility.").

[53] *See, e.g.*, *Matter of M-A-M-*, 25 I&N Dec. 474, 480 (BIA 2011) (recognizing DHS is often "in possession of relevant evidence" that implicates indicia of incompetence, including medical records it may access as the individual's custodian).

Daniel describes a specific incident where the facility failed to accommodate his disability, stating "[t]he lieutenant came and told me that I had to sleep in the top bunk bed or else I would go to solitary confinement. The lieutenant told me to get a medical reason for not being able to sleep in the top bunk bed. I told him the reason was in the medical records, and he told me he would not review anything to prove the medical reason. **I was forced to sleep in the top bunk bed, and I could not get down until my dorm roommates got me down.** I missed most of the meals on Sunday. On Tuesday, I [requested] another medical report that stated that I could not sleep in the top bunk bed."

When describing his experience of living with a chronic disease while in ICE detention, he reflects, **"I fear that when I am finally released from this detention facility, months from now, I will find that my medical condition had progressed to a deadly level because it was never addressed at a stage where it could be effectively treated."**

<u>Felix</u>

Felix feels that medical staff at the Aurora facility were not interested in helping him and others detained at the facility. The psychologist he saw at the Aurora facility, he says, mocked him, discounted the things that he told him, and generally did not listen to him. Felix was previously detained by ICE but was released when his mental health deteriorated to a dangerous degree. Felix attempted suicide while incarcerated. Nevertheless, ICE re-detained Felix, who quickly decompensated once stripped of his liberty. Despite possessing Felix's medical records that indicate he has a history of suicidality when placed in solitary confinement, on his first day in the Aurora facility, he was punished for eating too slowly by being placed in solitary confinement. That was just the first of many times Felix was placed in segregation, or as he describes it, "el hoyo" (the hole). **In total, he recounts being placed in either punitive or medical solitary confinement about 10 times.**

Felix attempted suicide for the second time while he was detained at the Aurora facility by jumping from a second-story landing. "The fall did not kill me, but it caused vertebrae in my neck to fracture, muscles within my neck and head to swell, and made it necessary for me to be taken out from the detention center to the hospital for several days for treatment. Even when I was in the hospital from my suicide attempt, ICE would not tell my attorneys where I was being kept or allow them to speak to me."

After several days at the hospital, when Felix returned to the Aurora facility, staff placed him back in solitary confinement for 15 days. As he recalls it, "I laid on my back with no pillow to support my neck, in agony, with only some ibuprofen to try and numb the pain." **"They told me solitary kept me safe and helped me, but it was only ever a punishment. No one gets better in solitary … I have tried to kill myself three times already because of this endless nightmare and the consistent torture of solitary confinement."**

Lauren

Lauren saw the same psychiatrist as Felix and reports that the medical provider is not helpful. "When I go to see him to process some of what is going on, he often starts talking about the bible. He has asked me, 'what would Jesus do?' He has also tried to show me videos about Jesus during therapy." Despite having significant symptoms related to her severe anxiety, depression, and Post-Traumatic Stress Disorder diagnoses, Lauren reported that the psychiatrist's behavior deterred her from seeking care. She resents being compared to Jesus and finds no therapeutic value in her conversations with the doctor.

Additionally, Lauren, who has diabetes, encountered medical negligence on at least one occasion. She nearly missed a nurse at the Aurora facility giving her the wrong injection. The nurse prepared a needle with the incorrect medication in the attached vial. "The only reason I didn't get the wrong medication was because I happened to notice the name of the medication on the vial." Lauren filed a complaint the next day, but her concerns were dismissed by the nurse and facility staff who told her that it was her fault for not adequately presenting her identification, which she insists is not true. Lauren found this incident upsetting and sought counsel from the psychologist. He responded by telling her that, "I needed to be merciful because everybody is human and makes mistakes. I was angry about his reaction and walked out of his office."

Staff members placed Lauren in solitary confinement after she and another woman got into a verbal argument. Prior to being taken to solitary, "I asked to see the psychiatrist, and there was no psychiatrist to evaluate me before they took me to the SHU, so they did not take me. That was on a Tuesday. [The doctor] came back on Friday and I saw him, and I guess he said it was ok for them to put me in the SHU, even though I have anxiety, depression, and PTSD. I spent 6 days in the SHU." **About 5 days after being placed in solitary confinement, Lauren reported to a psychiatrist that she was hallucinating and seeing shadows, but the Aurora facility made no change in her custody status**, though such a modification would be reasonable. Lauren was only released after GEO staff members decided she did nothing wrong, and they found her "not guilty." "My time in the SHU was scary. I hadn't seen shadows or heard voices in a long time, but those symptoms started coming back when I was in the SHU. I was alone and hallucinating and scared. Unfortunately, these symptoms did not stop when I was finally let out of the SHU."

Lauren's placement in solitary confinement continued to haunt her even after she was returned to the general population. **"The threat of being placed back in the SHU has made my anxiety and other mental health problems even worse."**

Betsy

Betsy has diagnoses of recurrent depression with psychotic features as well as an intellectual developmental disorder, among other diagnoses, and has a long history of suicidal ideation. While detained in the Aurora facility, she was assessed for suicidal ideation on at least 15 occasions, many of which resulted in her being placed on suicide watch, which means being alone in medical segregation. Betsy decompensated

significantly while detained and attempted suicide three separate times. **Despite multiple independent psychological evaluations reporting that the primary stressor causing Betsy's self-harm and suicidality was her detention and separation from her family, ICE refused to release her from its custody as a reasonable accommodation.**

Betsy reports that her mental health was at its lowest when she was isolated from others and while in ICE custody she strongly preferred being with her friends. However, while she was housed with the general population at the Aurora facility a staff member provided her with a razor less than a month after a serious suicide attempt. A RMIAN social worker reports that "while Betsy was in the shower in her housing dorm, she asked for a razor and was given one. She used it to cut her wrist, resulting in multiple lacerations and a large amount of bleeding. She was taken to a hospital for emergency care and returned to the detention center several hours later." ICE should not detain someone in Betsy's situation due to the threats it posed to her life. But if incarcerated, the Aurora facility must be able to accommodate both her wish to be supported by community as well as assure she does not have easy access to materials that can clearly be utilized to engage in self-harm.

<u>Odette</u>

When Odette was held in medical segregation, staff put her in a "suicide suit" for several hours. Odette felt uncomfortable being naked, and a guard told her "not to worry because she had already watched [her] on camera while [she] was taking a shower." This made Odette feel uncomfortable and scared. To make matters worse, the Velcro agitated her skin and exacerbated her eczema. Though Odette complained, staff members made no modifications to make her more comfortable. When describing her experience in solitary confinement, Odette says **"I am just glad I survived."**

IV. RECOMMENDATIONS

In light of the pervasive issues at the Aurora facility reported previously and detailed in this letter, we urge your offices to:

(1) Recommend the immediate and permanent termination of the contract that allows for the operation of the Aurora facility and release all individuals detained therein.

Until that happens, we request that you:

(2) Investigate the specific incidents reported here; make recommendations for appropriate corrective actions for staff involved in misconduct; recommend the immediate release of all complainants who ICE continues to detain; and issue Z-holds for all complainants not otherwise protected from deportation as well as for anyone directly impacted by the Aurora facility's abusive policies who could provide additional information during the course of a broader investigation.

(3) Recommend systemic policy reforms including the cessation of the use of punitive, administrative, and medical segregation (where practicable) for purported medical reasons and for people with disabilities.

(4) Provide robust training on Section 504 and ICE's affirmative obligation to provide reasonable accommodations or modifications to persons with qualifying disabilities detained in ICE custody.

(5) Ensure that there is oversight and enforcement of Section 504's requirements such that individuals in ICE custody have meaningful access to the protections it affords.

Respectfully submitted,

AMERICAN IMMIGRATION COUNCIL
NATIONAL IMMIGRATION PROJECT (NIPNLG)
ROCKY MOUNTAIN IMMIGRANT ADVOCACY NETWORK