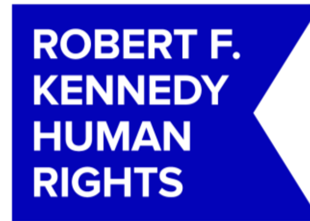

November 14, 2024

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Via Electronic Mail

Re: Sexual Abuse, Use of Force, Solitary Confinement, Medical Neglect, and Retaliation against Ana (A# XXX-XXX-XXX) at the Baker County Detention Center in Macclenny, Florida

Dear CRCL Officer Wadhia, Acting Ombudsman Gersten, Inspector General Cuffari, and Associate Director Fenton:

The American Civil Liberties Union of Florida ("ACLU FL") and Robert F. Kennedy Human Rights ("RFK Human Rights") submit this civil rights complaint on behalf of Ana[1] (A# XXX-XXX-XXX),[2] an individual who was detained in immigration custody at the Baker County Detention Center ("Baker") for two months from May through July 2023. Ana was released from

[1] Not her real name. She is proceeding under the pseudonym "Ana."
[2] Ana's A-number has been redacted.

Baker on bond after an Immigration Judge found that she was neither a danger to the community nor a flight risk.

As detailed below, Ana's experiences at Baker illustrate many of the most egregious patterns of abuse at the facility, including sexual abuse in the form of voyeurism, abuse of solitary confinement, the improper use of force and restraints, denial of mental health care, denial of access to counsel, failure to provide language access services, and incomplete and falsified records.

We respectfully request that the Office of Civil Rights and Civil Liberties ("CRCL") intervene at Baker by commencing an investigation into the incidents described below and auditing its records. We also respectfully request that CRCL urge ICE to suspend assigning detained immigrants to Baker during the pendency of this investigation.

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BACKGROUND ON BAKER

The Baker County Detention Center, located in Macclenny, Florida, is a county jail that operates in part as an immigration detention facility. The Baker County Sheriff's Office ("BCSO") jointly operates Baker along with the county's Baker County Corrections Management Corporation, which owns Baker and is ultimately responsible for the facility's lawful operation.

BCSO entered into an Intergovernmental Services Agreement ("IGSA") with Immigration and Customs Enforcement ("ICE") on August 3, 2009, to detain individuals in ICE custody. This IGSA contractually binds Baker to abide by the 2019 National Detention Standards ("NDS").[3]

Baker provides medical care to detained individuals through subcontractors. During all times relevant to this complaint, Baker contracted with Armor Correctional Health Services.[4]

Unfortunately, Baker has a documented history of engaging in unlawful and abusive treatment of people who are detained there by ICE.

- In **July 2022**, a multi-individual civil rights complaint documented the inhumane conditions at Baker, including physical assault, medical neglect, verbal abuse, racialized harassment and targeting, COVID-19 negligence, and retaliation.[5]
- In **July 2022**, the ACLU FL sent a letter to the ICE Field Office Director alerting them to conditions at Baker that were not only in violation of the law, but placed people in danger.[6] Specifically, the July 2022 letter documented that:

    1) Baker officers engaged in illegal retaliation against people who exercised their protected right to hunger strike and their protected right to make complaints about the conditions and treatment at Baker;

    2) Baker's living conditions were unsanitary and inhumane;

    3) Baker exhibited a pattern and practice of medical neglect and lack of translation services;

    4) Baker inhibited detained individuals' access to counsel, and

    5) Baker officers repeatedly engaged in physical abuse, intimidation, harassment and voyeurism.

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[3] ICE, National Detention Standards for Non-Dedicated Facilities (hereinafter "NDS"), Foreword (2019), https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf (establishing standards intended to "ensure that detainees are treated humanely; protected from harm; provided appropriate medical and mental health care; and receive the rights and protections to which they are entitled").

[4] For purposes of this complaint, we do not distinguish between personnel employed by Baker and Armor Correctional Health Services; we refer to all personnel who work at Baker as Baker personnel, including but not limited to staff, officers, and medical providers.

[5] Letter from Immigration Action Alliance et al. to Hon. Joseph V. Cuffari, DHS Inspector General, et al. (July 21, 2022), https://static1.squarespace.com/static/5a33042eb078691c386e7bce/t/62d95e2af761ff08f169367f/1658412594632/Public_Copy_Multi-Individual+CRCL+for+Baker+County+Sheriff%27s+Office+July+21%2C+2022_Redacted.pdf.

[6] Letter from Katie Blankenship, ACLU of Florida, to Garrett Ripa, ICE Field Office Director (July 26, 2022), https://www.aclufl.org/sites/default/files/field_documents/07.26.2022.ltr_to_ice_re_baker_conditions.kb_1.pdf.

- In **September 2022**, another multi-individual civil rights complaint documented the same unlawful, abusive, and inhumane treatment that was set forth in the July 2022 Complaint, and provided firsthand accounts from people who were detained at Baker.[7]
- In **September 2022**, women who were detained at Baker engaged in a letter writing campaign, sharing their firsthand experiences of their unacceptable treatment at Baker. For example, Bobbeth Morgan wrote that "[w]hile sitting on the toilet undressed, coming from the shower in my undergarments, I am being watched from staff from the staff tower" and Samantha Lindsay wrote that "[o]ther females and I must be sitting in our monthly blood for at least 4 days before anyone would provide us with sanitary napkins."[8]
- In **November 2022**, the ACLU FL filed Prison Rape Elimination Act (PREA) complaints on behalf of women detained at Baker, documenting how women detained at Baker had been subjected to unlawful and inhumane treatment, including voyeurism.[9]
- In **May 2023**, a civil rights complaint documented untreated mental health conditions and the unlawful and inhumane use of solitary confinement for people who are disabled. This complaint was substantiated by medical experts who reviewed individuals' medical files and noted alarming concerns in the lack of medical care and attention at Baker.[10]
- In **May 2023**, a woman who was detained at Baker filed a sexual assault and trafficking suit against Baker.[11] In **early 2024**, this Baker officer was convicted of sexual battery and sentenced to 25 years.[12]
- In **March 2024**, CRCL confirmed[13] that it had identified "immediate concerns regarding the health and well-being of persons detained at Baker" and that ICE needed to implement an action plan to address these urgent concerns.

ANA'S BACKGROUND AND EXPERIENCES AT BAKER

1. Ana's Background

Ana, a [redacted] national and native Spanish speaker, is a 33-year-old woman and mother who has survived domestic violence and human trafficking. Ana has been diagnosed with post-

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[7] Letter from Katie Blankenship, ACLU of Florida, to Hon. Joseph V. Cuffari, DHS Inspector General, et al. (Sept. 13, 2022), https://www.aclufl.org/sites/default/files/crcl_complaint_-_baker_county_detention_center_-_final.pdf.
[8] *See* Letter from Bobbeth Morgan to Baker County Detention Center (Sept. 3, 2022), https://www.ACLU FLfl.org/en/voices-baker-bobbeth; Letter from Samantha Lindsay to Baker County Detention Center (Sept. 8, 2022), https://www.ACLU FLfl.org/en/voices-baker-samantha; Letter from Hyacinth Bailey to Baker County Detention Center (Sept. 30, 2022), https://www.ACLU FLfl.org/en/voices-baker-hyacinth.
[9] Letter from Katie Blankenship, ACLU of Florida, to Officer of Inspector General et al. (Nov. 2, 2022), https://www.aclufl.org/en/prison-rape-elimination-act-prea-complaint-baker-county-detention-center.
[10] Letter from Katie Blankenship and Maite Garcia, ACLU of Florida, to Dr. Ada Rivera et al. (May 4, 2023), https://www.aclufl.org/en/letter-dhs-systemic-medical-neglect-baker-county-detention-center.
[11] *Doe v. Baker County et al.*, 3:23-cv-00609 (M.D. Fla. filed May 19, 2023).
[12] Allison Matthews, *Former Baker County Detention Deputy Sentenced to 25 Years Sexually Battering Inmate*, Action News Jax (May 5, 2024), https://www.actionnewsjax.com/news/local/baker-county/former-baker-county-detention-deputy-sentenced-25-years-sexually-battering-inmate/PZPOCG2BWVDC3GDJQX3F2RDVX4/ (last visited November 13, 2024).
[13] FOIA Response including Memorandum from CRCL to ACLU of Florida (Sept. 19, 2022) and Proposed Immediate Action Plan for Baker County Detention Center (Oct. 6, 2022), https://www.aclufl.org/en/crclfoiaresponsereceived2-13-24.

traumatic stress disorder ("PTSD"), clinical depression, and clinical anxiety, all of which have made it difficult for her to function in her adult life.

In 2019, Ana got married and had a baby. Ana describes her son as "the best thing that has happened to her."

In early 2022, Ana and her husband began contentious divorce and custody proceedings, and her husband got a temporary court order that limited her custody to supervised visitation. After violating this court order by taking her son to get ice cream, Ana was arrested. In August 2022, Ana was taken to [redacted] Correctional Center ("[redacted] Correctional").

On [redacted], 2023, Ana was released from [redacted] Correctional and taken into ICE custody. She was transported to Baker on [redacted], 2023.

2. Baker's Intake and Screening Failures

Ana is a native Spanish speaker and does not speak or understand English well. Despite this, her initial Baker medical screening inaccurately identifies English as her spoken language,[14] and throughout her time at Baker, officers routinely failed to interpret or translate materials when communicating with her. As described below, Baker's failure to communicate with Ana in a language she understands led to and exacerbated several severe issues during her time at Baker.

Baker also failed to conduct a proper assessment of her physical and mental health needs upon her arrival. For example, despite Ana's chronic hypothyroidism, PTSD, depression, and anxiety, the question about "immediate health needs or problems" on the screening form is marked "no."[15] Ana's electronic medical record similarly contains incorrect information in response to questions about whether she had ever received mental health treatment, had ever been hospitalized for mental health concerns, or had a history of being sexually abused or victimized.[16]

An additional health assessment from May 20, 2023,[17] similarly contains incorrect information regarding Ana's mental health history, current mental health, and past experience with abuse and violence, including whether Ana had ever been hospitalized in a psychiatric unit; had received outpatient counseling or treatment for emotional problems; had past psychiatric medications; had any current emotional problems; or had ever been a victim of sexual assault, physical abuse, or violence.[18]

3. Baker Officers Sent Ana to Solitary Confinement Due to an Avoidable Language Barrier

On **May 25, 2023**, an officer entered Ana's housing pod to announce that they were going outside for recreation and escorted the group into the hallway.[19] Ana was menstruating, so she asked the officer in English for "bathroom" and tried to explain in Spanish that she needed feminine products. According to the officer's incident report, he told Ana she could not return to her cell but explained a few alternatives for restroom use in English.[20] She did not understand the officer,

[14] *See* Combined Medical Records in Exhibit A (hereinafter "Medical Records") at A-8.
[15] Medical Records at A-5.
[16] Electronic Medical Record in Exhibit B (hereinafter "EMR") at B-6 (showing the responses as "no").
[17] EMR at B-17–21.
[18] EMR at B-20–21 (showing the responses as "no").
[19] Combined Incident Reports in Exhibit C (hereinafter "Incident Reports") at C-1–2; Detention File in Exhibit D (hereinafter "Detention File") at D-28–31.
[20] Incident Reports at C-1–3; Detention File at D-28–31.

and accordingly, could not respond. Contrary to the account in the officer's report, Ana did not try to return to her housing pod. The officer became irate, began speaking faster, still in English, and then proceeded to yell at Ana—all of which compounded her inability to understand him. Despite Ana's clear language limitations, the officer made no attempt to use an interpretation service during the encounter. Instead, as the officer documented in the incident report, he threatened to put Ana in solitary confinement if she did not respond to his orders.[21]

Additional officers arrived during the exchange, including at least one sergeant, none of whom spoke to Ana in Spanish or provided or used any translation service. Ana tried to tell the officers, including the sergeant, that her rights were being violated because she was being denied the right to use the bathroom and facing verbal abuse for seeking to exercise that right and that she wanted to speak with an immigration officer.[22] Her protest was not physical, and she did not act aggressively or threaten to harm the officers, herself, or other detained individuals. Nonetheless, the officers responded to Ana's pleas by handcuffing her, grasping her arms, and forcibly escorting her to the booking area for charges of "disobeying a verbal order," "conduct that disrupts," and "interfering with a staff member."[23]

4. Baker Personnel Cleared Ana for Solitary Confinement Despite Her Mental Health Diagnoses

Despite Ana's history of PTSD, anxiety, and depression,[24] Baker personnel cleared her for administrative segregation.[25] The electronic medical record incorrectly indicates that Ana had not been diagnosed with a "major mental illness such as . . . major depressive [disorder]," had no mental health needs requiring special accommodation, and had no mental health needs that contraindicated clearance for confinement.[26] A nurse medically cleared Ana for confinement and did not check the box stating: "Notify Mental Health for Confinement."[27]

The officers placed Ana in an isolation cell in the facility's booking area. People detained at Baker view the booking area as the "punishment area" because the conditions of these cells are particularly appalling. Ana's cell was filthy and dark and did not have a mattress.

5. Ana Had a Panic Attack While in Solitary Confinement, and Baker Subjected Her to the Restraint Chair as Punishment

Ana felt unwell after being put in the cell. Ana knocked on the door to request a nurse and the feminine products she never received. When an officer finally responded, he taunted her by holding up two fingers and repeating "two days," to tell Ana that she would stay in that isolation cell for two days.

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[21] Detention File at D-28.
[22] Incident Reports at C-1–3; Detention File at D-28–31.
[23] Response to Resistance Reports in Exhibit E (hereinafter "Response to Resistance Reports") at E-1.
[24] EMR at B-68.
[25] The NDS identify two kinds of solitary confinement: administrative segregation and disciplinary segregation. Administrative segregation is "non-punitive" and intended to be used only to ensure safety, protect property, or protect "the security or good order of the facility." NDS § 2.9(II)(A). On the other hand, disciplinary segregation can be used against "anyone whose behavior does not comply with facility rules and regulations." *Id.* § 2.9(II)(B). Both administrative segregation and disciplinary segregation are considered "special management units" and subject to particular requirements described in NDS, Section 2.9 and BCSO's SOG Special Management Units (each as defined below).
[26] EMR at B-25.
[27] EMR at B-26.

As discussed above, Ana had previously been trafficked, and she was suffering from anxiety, depression, and PTSD. Upon realizing that she would be trapped in the cell for two days, Ana had a panic attack. Ana began crying, could not breathe, and started vomiting. And, as she had still not been provided with feminine hygiene products, she was bleeding through her clothing. The officers did not assist her or call for medical attention; instead, they openly laughed at her. When the officers tired of her anguish, they covered the door's window. The officers ignored Ana's cries for help for several hours.

Ana took all actions in her power to alert the officers to her condition and to get help. She banged on the door and repeatedly called out that she needed a doctor. After several failed efforts to gain the officers' attention, Ana broke the cell's sprinkler[28] in a desperate plea for medical assistance.[29] The sprinkler sprayed dark, foul liquid all over Ana and the cell.

Two officers entered the cell,[30] and the officers took her by the arms down the hall. Ana did not resist and went with the officers willingly, believing she was finally receiving medical attention. Rather than taking her to receive care, the officers placed Ana in a different isolation cell.[31] The officers still did not provide Ana with feminine hygiene products or a towel to clean off the foul-smelling dark liquid that spewed out of the sprinkler.

Alone in the new cell, she removed her saturated blouse and tried to use the dry portion to clean her face and body. As she was doing so, the officers returned with a restraint chair, strapped her in[32] while she was dressed only in a bra and shorts, and rolled her into a nearby bathroom.

Distraught, exposed, and wet in the cold facility, Ana sobbed uncontrollably while she was confined in the restraint chair. No staff member made any effort to cover Ana. Officers leered at her through a window for the next hour.[33] During this time, a nurse checked her vitals[34] but ignored Ana's requests for medical treatment.

Baker's incident report does not indicate that the officers perceived Ana to be an ongoing threat to herself, others, or property[35] when they placed her in the restraint chair.[36] The incident report does not indicate that Ana resisted the officers or disobeyed their orders when they removed her from the cell with the broken sprinkler.[37] On the contrary, the incident report states that Ana was "placed into the restraint chair for her disruptive actions."[38]

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[28] Incident Reports at C-4–5; Detention File at D-32–35.

[29] Detention File at D-34 ("Detainee Ana stated, that she was only trying to get help because she was locked in the room and could not breath [*sic*]. . . . She stated she broke water line because she couldn't breath [*sic*]. No one would listen to her.").

[30] Incident Reports at C-4–5.

[31] Incident Reports at C-4–5

[32] Incident Reports at C-4–5.

[33] 15-Minute Checks, May 25, 2023 in Exhibit F (hereinafter "15-Minute Checks") at F-1.

[34] 15-Minute Checks at F-1.

[35] Ana's threat to property had ceased when she was moved to the other cell, prior to her placement in the restraint chair. *See* Incident Reports at C-5 ("We then escorted her to cell 317 until we got the water turned off in cell 300. At that time we placed Inmate Ana into the restraint chair . . . . Inmate Ana was then removed from the restraint chair an hour later . . . .").

[36] Incident Reports at C-5.

[37] Incident Reports at C-4–5.

[38] Incident Reports at C-5.

6. Baker Personnel Noted, But Disregarded, Ana's Mental Health Distress

The following day, on **May 26, 2023**, Baker officers documented that Ana began to refuse her meals and medication.[39] Ana also met with Baker's mental health care provider, Dustin Williams, for the first time.[40] Ana reported that she felt overwhelmed, had anxiety and PTSD, had taken the antipsychotic medication Seroquel, had received outpatient therapy at a trauma center, and had been a victim of trafficking and physical abuse.[41] Williams recorded that Ana was "very anxious," "extremely tearful and upset," and was experiencing hopelessness, decreased sleep, and decreased appetite.[42]

Despite these indications of serious mental health needs, Williams did not make any effort to treat Ana's mental health conditions. Nor did he accept her own description of her concerns. Instead, his notes reflect skepticism of Ana, describe her as "arrogant," and conclude that "she was exhibiting very manipulative behavior."[43] Williams recorded that he instructed Ana that she "could be referred for discussion of possible medication for anxiety but her behavior was more manipulative than anxious."[44] He also instructed the nursing staff to "encourage control of her behavior and following rules of facility to avoid further post use of force."[45]

7. Baker Extended Ana's Time in Solitary Confinement

On **May 27, 2023**, after Ana had spent two days in isolation, a disciplinary hearing officer determined that Ana's "offense" of misunderstanding the guard on May 25, 2023, was satisfied by time served.[46]

However, an additional disciplinary proceeding was convened regarding the sprinkler incident, which resulted in Ana being sentenced to an additional thirty days of solitary confinement for disciplinary segregation.[47] Ana was not permitted to attend this hearing. She instead listened in by telephone from a room in the medical clinic. Although an interpreter joined by phone to translate the proceeding into Spanish, Ana was not given an opportunity to defend herself or to explain the severe distress that led her to break the sprinkler. Despite her limited English proficiency, Ana was only provided with an English-language document informing her of the 30-day sentence.

When deciding to extend Ana's time in solitary confinement, Baker continued to ignore the serious mental health distress that this isolation was causing her. Despite how she was refusing meals and medication,[48] and despite how the previous day she had expressed serious mental health concerns and her previous diagnoses to a medical provider,[49] a nurse's written comment on the disciplinary report indicates that Ana "has no mental health issues noted."[50]

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[39] Incident Reports at C-6–8.
[40] EMR at B-64–68.
[41] EMR at B-64-68.
[42] EMR at B-66–67.
[43] EMR at B-68.
[44] EMR at B-68.
[45] EMR at B-68.
[46] Detention File at D-28–30.
[47] Detention File at D-32–36, D-51.
[48] Incident Reports at C-6–9.
[49] EMR at B-64–68.
[50] Detention File at D-35.

As was foreseeable, the extended time in solitary confinement significantly exacerbated Ana's mental health crisis. And to make matters worse, during this time, Baker officers subjected Ana to several additional egregious abuses, as detailed below, that caused her further distress and trauma.

8. Baker Repeatedly Denied Ana Access to Counsel and the Ability to Participate in Legal Proceedings

While at Baker, Ana was involved in a custody dispute with the father of her three-year old son. During her time in solitary confinement, Ana repeatedly asked to speak to her lawyer about the status of her custody case. The officers repeatedly refused Ana's requests to use the telephone to call her attorney.[51] On multiple occasions, Baker staff also refused to allow Ana to appear for videoconferences in connection with this custody matter.

After Ana refused several meals, an ICE agent visited her and told her he would allow her to make a call if she accepted food. In other words, Baker staff only permitted Ana to contact counsel after ICE intervention.

By repeatedly denying her the ability to contact her attorney or participate in custody proceedings, Baker guards further compounded her extreme emotional distress by causing her to fear that she would lose custody of her young son.

9. Ana's Physical and Mental Health Deteriorated in Solitary Confinement

Throughout this period, Ana felt depressed and lost. She often cried for hours, fearing that missing mandatory custody hearings during her sentence would cause her to lose her son. Not only did Baker staff fail to provide her access to counsel, but one of the nurses told a distraught Ana that her son would be better off without her.

Ana also stopped eating because, in response to these experiences, she lost her desire for food. In fact, Baker placed Ana on hunger strike status and admitted her to the medical unit at the beginning of her sentence because she was refusing her meals.[52] However, they failed to conduct the hunger strike protocol's mandated mental health assessment and treatment.

At this point, Baker personnel were fully aware of Ana's mental health history and deteriorating mental and physical condition. But instead of helping her, they taunted her. When Ana was able to eat, the officers who were delivering her food pretended to drop her food on the ground, for example, or pulled the tray back rather than leaving it in the slot to pass to her. The officers would look at each other and laugh. Time after time, Baker personnel sent the message to Ana that they were always watching but would not help.

On June 2, 2023, Ana again met with Dustin Williams, who continued to dismiss her reports of PTSD and anxiety and her requests for medication.[53] He described Ana as "very manipulative," "very angry and demanding," and "passive-aggressive."[54] He again deferred any serious consideration of treatment.[55] Ana was unable to see another medical provider about mental health

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[51] *See* Incident Reports at C-13, C-23.
[52] Incident Reports at C-9; EMR at B-27.
[53] EMR at B-170–71.
[54] EMR at B-170–71.
[55] EMR at B-171.

treatment for almost two weeks, even though Baker personnel were aware of her significant mental health needs and she remained in solitary confinement, and had refused meals.[56]

On or around June 14, 2023, Ana met with a nurse practitioner who prescribed a medication that treats depression, anxiety, and nerve pain.[57] However, that medication caused an adverse reaction and was discontinued on June 26, 2023.[58] Ana was not prescribed an alternative medication until almost a month later, on July 21, 2023.[59]

10. In Response to Her Mental Health Crisis, Male Officers Stripped Ana, Strapped Her to a Restraint Chair With Her Breast Exposed, and Laughed at Her

By **June 23, 2023**, Ana had been in solitary confinement for more than four weeks. Her physical and mental health had declined significantly.

That evening, Ana grew distraught and began to self-harm. Greatly distressed, she began banging her shoe and head on the door of her cell. At least four officers responded. None of the officers sought interpretation services to speak with Ana to address the concerns that had led her to self-harm. Instead, they aggressively placed Ana in a restraint chair. In the process, at least one officer grabbed Ana by the neck and jaw, leaving fingernail marks. The officers left Ana in the cell where, according to the officers, she wept openly.[60]

After some time, the officers returned and wheeled a visibly shaken Ana to a medical exam room to connect her with interpretation services for the first time since she began to self-harm. However, the interpretation services were unavailable. Sometime during the attempts to contact an interpreter, Ana expressed that her life "made no sense."[61]

Based on that comment, and without seeking mental health assistance for Ana, the officers placed her on suicide watch.[62] The officers wheeled her to another room where they released her from the restraint chair and allowed her to use the restroom.[63] Then, five officers—two women and three men—forcibly grabbed Ana, pinned her to a bed, and ripped off her clothes, including her bra and underwear.[64] No one explained to Ana what was happening. Ana—a survivor of trafficking and domestic violence—screamed that men should not be handling her or removing her clothes, but the male officers remained present, staring and laughing at her while her breasts were exposed. This experience left Ana feeling like she had been raped. The officers left Ana in a ripped anti-suicide smock.

A short time later, Ana began hitting her head against the plumbing fixture in her cell. Officers reentered and strapped her into the restraint chair. Once again, rather than taking steps to provide Ana with medical care during this mental health emergency, officers resorted to brute force.

[56] Incident Reports at C-14–21 (showing meal refusals from June 3–5, 2023).
[57] EMR at B-202–03.
[58] EMR at B-89 and B-91, B-101.
[59] EMR at B-108-09.
[60] Response to Resistance Report E-10; Incident Reports at 29–37.
[61] Incident Reports at C-29–37 (detailing the incident, the incident report recorded Ana saying "I don't wanna live anymore" however this inconsistent with Ana's recollection, as detailed herein there are numerous inconsistencies between the incident reports and Ana's memory of the recorded incidents).
[62] Incident Reports at C-29–37.
[63] Incident Reports at C-29–37.
[64] Incident Reports at C-29–37 (discussing that three men and two women were present and that they took off her bra and underwear).

Because the anti-suicide smock was torn, it hung down off her shoulder, exposing her bare breast. With her arms fastened to the chair, Ana was unable to adjust the smock and was physically constrained from taking any action to cover her body. While her breast was exposed, male officers walked by to ogle her and mock her through the window. Ana was left there for approximately three hours before being released from the restraint chair and left in an anti-suicide cell.[65]

In total, Ana remained in the restraint chair for approximately four hours.[66] During this time, Ana recalls the medical staff checking on her only twice. To the extent medical records[67] or incident reports[68] indicate that she was checked on more frequently or refused to be examined, those records may be incorrect or falsified.

After she was removed from the restraint chair, Ana had contusions and marks on her body. The records state that no photographs were taken, and they note that Ana caused those injuries herself.[69]

11. Baker Falsified Ana's Records, Falsely Writing That She Refused the Care That She Had Asked For

On **June 24, 2023**, Ana met with the mental health provider after her second traumatic experience in the restraint chair,[70] apparently at the direction of ICE officials on-site. Dustin Williams' notes from the appointment continue to reflect his dismissive and disdainful attitude toward Ana. For example, he describes her as "a little arrogant and entitled."[71] Nonetheless, the provider agreed to prescribe medication for anxiety.[72] The provider's records also acknowledge anxiety, depression, insomnia, loss of appetite, lack of interests, crying spells, impulse control, racing thoughts, and chronic pain as "target symptoms."[73] At the conclusion of the appointment, the provider downgraded Ana from suicide watch to mental health watch and indicated she would be reassessed by a mental health therapist in two days and a psychiatric provider in a few weeks.[74]

According to her electronic medical record, Ana completed a follow-up appointment on **June 27, 2023**,[75] but did not have another scheduled appointment to address her mental health until July 5, 2023.[76] Regardless, Ana's medical records indicate that the July 5 appointment was cancelled because she allegedly "refused" the visit.[77] The corresponding refusal of treatment form indicates that she "refused to sign" it and does not give a reason for her refusal.[78] Ana denies that she refused this appointment.

Medical appointments at Baker were easy to miss because Baker officials made little effort to ensure the people in its custody knew about them—Baker personnel announced appointments by yelling in the loud, crowded detention facility rather than retrieving people individually.

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[65] Incident Reports at C-29–37; Medical Records at A-40–41.
[66] Medical Records at A-40–41.
[67] Medical Records at A-40–41.
[68] Incident Reports at C-29–37.
[69] Incident Reports at C-29, C-33, C-36.
[70] EMR at B-74–88.
[71] EMR at B-74-75.
[72] EMR at B-75, 88.
[73] EMR at B-87.
[74] EMR at B-75.
[75] EMR at B-164–65.
[76] EMR at B-88.
[77] EMR at B-88.
[78] Medical Records at A-44.

Additionally, according to a former medical practitioner at Baker who recently came forward as a whistleblower to shed light on a variety of egregious civil rights violations that Baker routinely practices,[79] Baker's medical team had a practice of forging false medical refusals to avoid doing the work. It should be noted that Ana's records include a number of refusal of treatment forms, some or all of which may be inaccurate or falsified.[80]

Because of this cancelled appointment, Ana did not have another appointment to address her serious and ongoing mental health needs for over three weeks.[81] On **July 21, 2023**, Ana met with the mental health provider to treat her anxiety and depression.[82]

12. At a Staff Meeting, Baker Officers Played Video Footage of Ana Being Stripped and Restrained, With her Breast Exposed, as an Example of a Good Use of Force

The Baker whistleblower, who interacted with Ana in their position as a medical practitioner, attended an all-staff meeting a few days after the June 23, 2023 restraint chair incident. During this all-staff meeting, Baker officers played video footage of Ana exposed in the restraint chair with her naked breast exposed. They described this video as a "good example" of a use-of-force incident. The whistleblower reported that officers at the meeting again laughed at Ana's experience, despite her obvious mental distress.

13. Baker's Generally Horrific Conditions Further Exacerbated Her Distress

Ana experienced consistently unsanitary and inhumane conditions throughout her time at Baker, exacerbating the mistreatment and abuse described above.

As previously noted, Baker regularly failed to provide her with feminine hygiene products, as was the case during her initial encounter with solitary confinement, and again on July 18, 2023, when she was denied extra products to handle a heavy menstrual cycle and was told she needed to seek medical approval "to determine if you are truly in need to having a special allotment,"[83] among other times.

Baker staff also denied Ana adequate access to the shower. This was especially egregious during Ana's time in solitary confinement in the clinic, when officers would only permit her to shower late at night after she had broken down begging to be able to shower.

Throughout Ana's time at Baker, staff served her cold, inedible, and nutritionally deficient food, including spoiled meals that caused her to vomit for days.[84]

Baker housed Ana in filthy, cold cells (at least one of which lacked a mattress) and issued Ana dirty, ripped, and unhygienic clothing that left her freezing and caused skin reactions. When she asked for clean clothes, Baker denied her request and an officer yelled at her and wrote an incident report.[85]

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[79] *See* the Protected Whistleblower Disclosure of Provider Vera Goodwin at: https://whistleblower.org/wp-content/uploads/2024/11/Nov-2024-Whistleblower-Disclosure-of-Nurse-Practitioner-Vera-Goodwin-re-Baker.pdf

[80] *See* Medical Records at A-12, A-14, A-17–19, A-25–31, A-36, A-37 (some of which look identical except for the date (e.g., A-14, A-26, and A-30; A-19 and A-29) and some of which indicate "male" as Ana's gender (A-14, A-25, A-26, A-30, A-37)).

[81] EMR at B-89–91 (showing an appointment with the mental health provider on July 21, 2023).

[82] EMR at B-89, B-91.

[83] Detention File at D-64–65.

[84] *See* Detention File at D-22–23, D-42–43, D-61–62, D-66–67.

[85] *See* Incident Reports at C-41–42; Detention File at D-68–69.

14. Baker Obstructed Ana's Access to Her Records

Following her release from Baker, Ana sought her Baker detention file and medical records with assistance from the ACLU FL. ACLU FL first requested the detention file and medical records in October 2023. Despite requesting *all* documents related to Ana, Baker and ICE initially provided incomplete medical records. ACLU FL repeatedly followed up with Baker and ICE throughout November and December 2023 to obtain her complete medical records. While Baker eventually provided additional documents, those still appear to be incomplete and include inaccurate and potentially falsified information, such as the potentially forged medical refusals, as discussed above.

Baker similarly provided an incomplete detention file for Ana. After submitting the initial request in October 2023, ACLU FL again directly requested the detention file from the BCSO in November 2023. ACLU FL repeatedly followed up with the BCSO from November 2023 through February 2024, regarding missing documents and record abnormalities. As with the medical records, the detention file still appears to be incomplete and includes inaccurate and potentially manipulated information. For example, one of the incident reports was edited after ACLU FL requested it, months after Ana left the facility.

LEGAL VIOLATIONS

1. Baker Personnel's Sexual Abuse and Voyeurism of Ana Violated the NDS

The NDS "require[] that facilities that house detainees act affirmatively to prevent sexual abuse and assaults on detainees; provide prompt and effective intervention and treatment for victims of sexual abuse and assault; and control, discipline and prosecute the perpetrators of sexual abuse and assault."[86] Baker personnel violated NDS policies on sexual abuse prevention and intervention when they left Ana exposed on two occasions, leered at her for hours, and failed to intervene or report the abuse.

The NDS define acts of sexual abuse and assault to include voyeurism, which is "the inappropriate visual surveillance of a detainee for reasons unrelated to official duties."[87] The NDS provide a non-exhaustive list of types of conduct that, when done for reasons unrelated to official duties, qualify as voyeurism: "staring at a detainee who is using a toilet in his or her cell to perform bodily functions; requiring an inmate detainee to expose his or her buttocks, genitals, or breasts; or taking images of all or part of a detainee's naked body or of a detainee performing bodily functions."[88] Staff must intervene to protect a detainee if they have "a reasonable belief that a detainee is subject to a substantial risk of imminent sexual abuse and assault."[89] Similarly, staff are obligated to "take seriously all statements from detainees claiming to be victims of sexual abuse and assaults," "offer[] [the victim] immediate protection and separation from the assailant," and immediately report the incident consistent with internal policies and procedures.[90]

Baker personnel violated the prohibition on voyeurism and their obligations to report and intervene during the restraint chair incidents on May 25, 2023, and June 23, 2023, as described herein.

[86] NDS, Sexual Abuse and Assault Prevention and Intervention § 2.11(I).
[87] NDS, Sexual Abuse and Assault Prevention and Intervention § 2.11(II)(B)(2)(h).
[88] NDS, Sexual Abuse and Assault Prevention and Intervention § 2.11(II)(B)(2)(h).
[89] NDS, Sexual Abuse and Assault Prevention and Intervention § 2.11(II)(I).
[90] NDS, Sexual Abuse and Assault Prevention and Intervention § 2.11(II)(J).

This behavior constitutes voyeurism under the NDS, as the officers forced Ana to expose her breast, for hours. The officers sexualized Ana while she was in a compromised position, and in doing so violated her privacy and bodily autonomy. Clearly, such behavior was unrelated to the officers' official duties. In allowing this behavior to continue unabated, each officer and staff member involved breached his or her obligation to intervene on Ana's behalf. Additionally, officers and medical personnel failed to report the incident consistent with the NDS and the facility's internal reporting protocol. None of the incident reports reflect this prohibited conduct. At bottom, Baker personnel and the facility writ large breached their duty to "provide prompt and effective intervention and treatment for victims of sexual abuse and assault; and control, discipline and prosecute the perpetrators of sexual abuse and assault."[91]

2. Baker's Abusive Use of Solitary Confinement Violated the NDS

The NDS and the BCSO's SOGs permit separation of "certain detainees from the general population in Special Management Units" (or solitary confinement) through administrative segregation and disciplinary segregation to "protect[] detainees, staff, contractors, volunteers, and the community from harm."[92] As described below, Baker personnel violated the NDS and a BCSO SOG when they: (1) placed Ana in administrative segregation due to an avoidable language barrier; (2) cleared her for solitary confinement without considering her mental health; and (3) repeatedly failed to adequately respond to Ana's mental health crises during her time in disciplinary segregation.

(1) Baker violated the NDS when they placed Ana in administrative segregation due to an avoidable language barrier.

Administrative segregation "is a non-punitive status in which restricted conditions of confinement are required only to ensure the safety of detainees or others, the protection of property, or the security or good order of the facility."[93] Among other reasons, a detainee may be assigned to administrative segregation while "awaiting an investigation or hearing for a violation of facility rules."[94]

Here, Baker personnel placed Ana in administrative segregation on May 25, 2023, due to a peaceful misunderstanding with a guard that could have been avoided, had the officer provided language interpretation, as the NDS require. Throughout this "incident," Ana was not a threat to anyone or any property, nor was she disrupting the good order of the facility or breaking any rules. Rather, she was asking for a pad for her period, and the officer refused to speak to her in a language that she understood. This situation did not warrant the use of solitary confinement, and Baker's decision to place Ana in solitary confinement violated the NDS.[95]

(2) Baker violated the NDS when they cleared her for solitary confinement without considering her mental health.

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[91] NDS, Sexual Abuse and Assault Prevention and Intervention § 2.11(I).
[92] NDS, Special Management Units § 2.9(I).
[93] NDS, Special Management Units § 2.9(II)(A).
[94] NDS, Special Management Units § 2.9(II)(A)(1).
[95] NDS, Special Management Units § 2.9(II)(A)(1).

Initial booking - The NDS require a health care provider to evaluate an individual prior to segregation. "The assessment should include a review of whether the detainee has a suspected or diagnosed mental illness."[96]

Here, a Baker nurse cleared Ana for solitary confinement after she arrived at the booking area. However, records of the so-called assessment indicate that the nurse neither identified nor considered Ana's history of PTSD, anxiety, and depression—indeed, the electronic medical record for the "confinement clearance" assessment fails to reflect any mental health needs contraindicating confinement.[97] If the nurse had conducted a thorough evaluation, Baker personnel would have realized that placing Ana into solitary confinement was dangerous to her well-being.

Extension - According to the NDS, facility personnel may use disciplinary segregation punitively in limited circumstances. As with administrative segregation, the NDS require a health care provider to evaluate a detainee prior to disciplinary segregation. "The assessment should include a review of whether the detainee has a suspected or diagnosed mental illness."[98] The NDS also require the disciplinary process to "consider whether a detainee's . . . mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed."[99]

Here, Baker violated the NDS when they failed to adequately consider Ana's mental health before clearing her for 30 days of disciplinary segregation, as well as when they failed to consider how her mental illness contributed to her breaking the sprinkler in the first place. After she had been taken to solitary confinement for an avoidable misunderstanding, she had a panic attack and tried to call out for medical assistance. After being mocked and ignored for hours, she broke the sprinkler in a desperate attempt to get medical care. She would not have resorted to such measures if Baker had properly treated her mental health needs in the first place. Instead, they extended her time in isolation, still without proper mental health care, further exacerbating her mental health crisis.

(3) Baker violated the NDS when they repeatedly failed to adequately respond to Ana's mental health crises during her time in disciplinary segregation.

The NDS require a security supervisor or equivalent to interview detained persons placed in disciplinary segregation at least every seven days to confirm that the individual is being provided with basic necessities.[100] Mental health care is a basic necessity.

Here, the Disciplinary Segregation Review forms in Ana's Detention File are incomplete and insufficient to meet the NDS' requirements. The first form does not even purport to answer the questions regarding Ana's basic needs, and instead has a slash across all the corresponding checkboxes.[101] *None* of the forms include: (1) records showing that an interview was actually conducted; (2) a selection by the officer completing the form that either "I Recommend" or "I Do Not Recommend" removal from segregation; or (3) *any signature* on the line where the Supervisory Immigration Enforcement Agent completing the form was supposed to sign.[102] The signature of a sergeant, who is listed as the reviewing officer on each of the forms, is missing from

[96] NDS, Special Management Units § 2.9(II)(M).
[97] EMR at B-25–26.
[98] NDS, Special Management Units § 2.9(II)(M).
[99] NDS, Disciplinary System § 3.1(II)(A)(6).
[100] NDS, Special Management Units § 2.9(II)(B)(3).
[101] Detention File at D-37.
[102] Detention File at D-37–46.

all of them.[103] In the field where the Field Office Director or Representative is meant to review, every form checks the box "Concur with Recommendation"—despite there being no recommendation selected—and it is unclear who signed the form, as there is no printed name, and the signatures are inconsistent or missing entirely.[104]

Baker repeatedly violated the NDS in failing to ensure that Ana's basic mental health needs were met throughout her time in disciplinary segregation. As described above, the mental health provider repeatedly dismissed her requests for mental health care and failed to properly treat her mental health needs throughout her time in solitary confinement. Instead, Baker officers responded with unnecessary force, further exacerbating her mental health emergencies.

In addition to violating the NDS, Ana's placement in solitary confinement for 31 days was a form of torture under international law.[105]

3. Baker Violated the NDS and the U.S. Constitution Through Their Improper Use of Force and Restraint

Officers and medical personnel routinely flouted several NDS provisions while Ana was detained at Baker.

The NDS permit the use of force, defined as "the physical actions necessary to overcome resistance, to gain control, contain, or restrain a detainee," "only after all reasonable efforts to resolve a situation have failed."[106] The NDS state that "[s]taff shall use only that amount of force necessary to gain control of the detainee"[107] and prohibits "[u]sing force against a detainee offering no resistance."[108] Ana was not resisting officers leading up to the use of the restraint chair, so no force was necessary or justified.

Complementing this provision is another that requires staff to "attempt to gain the detainee's willing cooperation, in a language or manner that the detainee understands, before using force."[109] Ana was already willingly cooperating with the Baker officers, and they failed to speak with her in Spanish to address the situations.

The NDS specifically address the application of restraints, stating that "[i]mmediate use of restraints is warranted to prevent the detainee from harming self or others, or from causing serious property damage," and "[i]f, after the detainee is under control, the continued use of restraints appears necessary, facility administrator approval is required."[110] The NDS also create a hierarchy of restraint techniques, stating that "[w]henever possible, staff shall apply ambulatory restraints," but "[i]f the detainee's behavior makes use of more restrictive or secure restraints necessary, the facility administrator shall decide on the appropriate restraint method."[111] The progressive restraint

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[103] Detention File at D-37-46.
[104] Detention File at D-37-46.
[105] The United Nations Revised Standard Minimum Rules for the Treatment of Incarcerated People, known as the "Mandela Rules," identify the use of solitary confinement beyond 15 days as a form of cruel, inhuman, and degrading treatment that rises to the level of torture. *See* United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), adopted by the General Assembly on December 17, 2015.
[106] NDS, Use of Force and Restraints § 2.8(I).
[107] NDS, Use of Force and Restraints § 2.8(II)(A)(3).
[108] NDS, Use of Force and Restraints § 2.8(II)(C)(6).
[109] NDS, Use of Force and Restraints § 2.8(II)(A)(2).
[110] NDS, Use of Force and Restraints § 2.8(II)(A)(4).
[111] NDS, Use of Force and Restraints § 2.8(II)(E).

methods include four- or five-point restraints,[112] like a restraint chair. The decision to place Ana in the restraint chair, the more restrictive method, on May 25, 2023, contravened these requirements, as she was not a threat to anyone or an ongoing threat to any property.

Further, the NDS are clear that "[u]nder no circumstances shall force be used to punish a detainee."[113] Such practice is also barred by the U.S. Constitution; officers must have a legitimate penological purpose to use force against inmates in their custody.[114] The facts suggest that the use of restraints against Ana was punitive, which is a clear violation of the NDS.

4. Baker's Denial of Mental Health Care for Ana Violated the NDS and the U.S. Constitution

The NDS state that facilities must provide "medically necessary and appropriate medical, dental, and mental health care and pharmaceutical services at no cost to the detainee," "[c]omprehensive, routine and preventative health care, as medically indicated," "[e]mergency care," and "[t]imely responses to medical complaints."[115] Baker personnel failed Ana on all accounts.

Baker personnel denied Ana appropriate mental health care for her anxiety, depression, and PTSD, and caused her physical and mental condition to deteriorate during her time in detention. Specifically, Baker personnel: (1) failed to properly evaluate Ana upon arrival at the facility, including obtaining and reviewing her medical records; (2) simply initiated hunger strike protocols rather than also assessing and treating Ana's mental health crisis which led to her refusal of meals; and (3) failed to provide medically necessary and appropriate mental health care throughout her time at Baker, including in response to her obvious mental health emergencies. Instead, Baker's failure to provide Ana access to medical care was accompanied by actively antagonizing and harmful behavior.

Baker also exhibited deliberate indifference to Ana's serious medical needs in violation of the U.S. Constitution. "[W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being."[116] A facility is in violation of the Eighth Amendment's prohibition on cruel and unusual punishment when it is deliberately indifferent to a detained person's serious medical needs.[117] A facility is considered deliberately indifferent when a detained individual cannot access medical care or mental health care when needed, when isolation is employed punitively and constitutes solitary confinement, and when detained persons' mental health needs are ignored during or after isolation such that the individual is placed at risk of serious harm.[118] As explained in detail throughout this complaint, Baker's treatment of Ana involved each of these abuses.

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[112] NDS, Use of Force and Restraints § 2.8(II)(E).
[113] NDS, Use of Force and Restraints § 2.8(II)(A)(1).
[114] *See Sconiers v. Lockhart*, 946 F.3d 1256, 1266 (11th Cir. 2020).
[115] NDS, Medical Care § 4.3 (II)(A)(2)–(4), (6).
[116] *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 199–200 (1989).
[117] *Hughes v. Judd*, 108 F. Supp. 3d 1167, 1220, 1256–58 (M.D. Fla. 2015).
[118] In *Hughes v. Judd*, the court found that the facility was not deliberately indifferent to medical needs because the plaintiffs "had no problem accessing medical care or mental health care when needed" and "failed to produce evidence at trial that the Sheriff ha[d] a policy or custom of placing juveniles in isolation 'punitively' or without due process," because the facility ensured inmates placed in isolation were monitored, and because upon notification that an inmate was "hearing voices, staff immediately alerted mental health, and [plaintiff] promptly received several mental health evaluations."). 108 F. Supp. at 1256–58.

5. Baker's Denial of Ana's Access to Counsel and Participation in Legal Proceedings Violated the NDS

The NDS provide that "[a]ll detainees, *including those in disciplinary segregation*, shall be permitted to place calls to attorneys [and] other legal representatives . . . ."[119] BCSO's SOGs for Special Management Units similarly provide that while in disciplinary segregation, "inmate/detainees may have access to the telephones to call their attorney."[120]

Further, an amended ICE Directive issued in July 2022 that specifically addresses the rights of detainees involved in ongoing family court, child welfare, or guardianship proceedings provides that detainees must be given the ability to participate in family court proceedings or to consult with counsel.[121]

Baker personnel violated the NDS and other applicable standards when they denied Ana the ability to communicate with her attorneys regarding her ongoing custody matters involving her son and when they refused to allow her to remotely participate in the proceedings.

6. Baker's Actions Violated Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act ("Section 504") prohibits discrimination on the basis of disability in programs or activities conducted by executive agencies of the United States.[122] This provision imposes an affirmative obligation on public entities to reasonably modify their rules, policies, and practices, in order to make benefits, services and programs accessible to people with disabilities. Under Section 504, a federally funded agency illegally discriminates against individuals with disabilities when it fails to provide "meaningful access" to its benefits, programs, or services.

Individuals are entitled to accommodation under Section 504 if they have a disability—a "physical or mental impairment that substantially limits one or more major life activities." This includes individuals living with physical and mental health disabilities, like Ana.

Ana has been diagnosed with PTSD, clinical depression, and clinical anxiety, all of which have made it difficult for Ana to function in her adult life. As described above, Baker failed to appropriately identify these conditions and, far from providing her with accommodations to the Rehabilitation Act, engaged in conduct that was averse to and exacerbated her mental disabilities. As is detailed throughout this complaint, rather than providing her with mental health care, Baker kept Ana in solitary confinement, subjected her to chair restraints, and had male officers aggressively strip her without explaining what was happening to her and why.

7. Baker Repeatedly Failed to Communicate with Ana in Spanish, in Violation of the NDS

The NDS require immigration detention facilities to "identify detainees with limited English proficiency (LEP)," and the NDS establish an obligation to "provide meaningful access to LEP detainees [in] all aspects of detention, including but not limited to intake, disciplinary proceedings,

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[119] NDS, Special Management Units § 2.9(II)(W) (emphasis added).
[120] BCSO Corrections Bureau Guidelines CO 334, Special Management Units, § V(A)(1)(k).
[121] *See* ICE Directive 11064.3, *Interests of Noncitizen Parents and Legal Guardians of Minor Children or Incapacitated Adults* (July 14, 2022), §§ 4.3.3)e, 5.4.
[122] 29 U.S.C. § 794.

placement in segregation, sexual abuse and assault prevention and intervention, staff-detainee communication, mental health, and medical care."[123]

The NDS require detention facilities to provide a "language access and disability screening" at intake to "identify any necessary accommodations," which should inform the facility's approach to "ensure meaningful access to facility programs, services, and activities for detainees with limited English proficiency."[124] Baker's failure to properly assess Ana's limited English proficiency and make appropriate Spanish-language resources available to her at intake contributed to her anxiety and confusion upon her arrival and presaged subsequent failures to communicate with Ana in Spanish.

Baker subsequently failed to ensure that Baker personnel communicated with her in a language she could understand. As described above, Baker's failure to consistently make interpreters and Spanish-language resources available contributed to misunderstandings that caused Ana to be placed in solitary confinement for a minor infraction and denied her the ability to fully participate in the disciplinary proceedings against her.

The NDS provide that officers "shall attempt to gain the detainee's willing cooperation, in a language or manner that the detainee understands, before using force."[125] When it becomes necessary to use force in a coordinated fashion, officers must offer the detained individual a "last chance to cooperate before team action in a language or manner the detainee understands, outlining use-of-force procedures, engaging in confrontation avoidance, and issuing use-of-force orders."[126]

Baker repeatedly violated these standards when it failed to communicate with Ana in Spanish before using force. During the May 25, 2023 incident that led to Ana's initial placement in administrative segregation, a Baker officer repeatedly gave her instructions in English without using an interpreter or interpretation service. When Ana did not understand the officer's instructions, the officer berated her in English, handcuffed her, took her to the booking area pending a disciplinary hearing, and later strapped her in a restraint chair, without communicating with her in Spanish to explain what they were doing and why.

Similarly, during the June 23, 2023 incident, multiple officers responded to Ana's act of banging her shoe and head on the door of her cell after four weeks of solitary confinement by forcibly grabbing her from her cell, placing her in a restraint chair, pinning her to a bed and removing her clothes, and then placing her in the restraint chair again with a torn anti-suicide smock that exposed her bare breast. The officers' incident reports indicate that Baker personnel attempted to obtain interpreter services only after they initially placed Ana in the restraint chair, meaning that they used considerable force and subjected Ana to physical harm and humiliation without communicating with her in her native language about what was happening or giving her a chance to change her behavior before using force.

CONCLUDING RECOMMENDATIONS

We are confident that an investigation and audit will substantiate the claims outlined in this complaint and expose Baker's systemic abuse and mistreatment of individuals in their custody. At minimum, we ask that CRCL, OIDO, and OIG conduct a comprehensive investigation of the

[123] NDS, Foreword at ii.
[124] NDS, Admission and Release § 2.1(II)(A).
[125] NDS, Use of Force and Restraints § 2.8(II)(A)(2).
[126] NDS, Use of Force and Restraints § 2.8(II)(B)(2)(b).

abuses at Baker through unannounced inspections, interviews with detained individuals, and a thorough review of medical records, video surveillance footage, and any other evidence relevant to the complaints raised in this letter.

We urge the CRCL, OIDO, and OIG to fulfill their duty to preserve individual liberty, fairness, and equality under the law by taking all steps within their power to intervene at Baker, including but not limited to issuing findings and recommendations for the termination of use of Baker as an ICE detention facility.

We appreciate your prompt attention to these issues. Should you have any questions, please contact Amy Godshall at agodshall@aclufl.org.

Sincerely,

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