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Via Email and US Priority Mail

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Re: Complaint for Violations of Civil, Constitutional, and Disability Rights of Choung Woong Ahn, A# 042-028-791, at Mesa Verde ICE Processing Facility

I. Introduction

Disability Rights California (DRC), Centro Legal de la Raza (Centro Legal), and the California Collaborative for Immigrant Justice (CCIJ) submit this complaint in response to the death of Choung Woong Ahn, who died by suicide on May 17, 2020 when placed in an isolation cell in conditions akin

to solitary confinement¹ at the Mesa Verde ICE Processing Facility (Mesa Verde). Mesa Verde is operated by the GEO Group (GEO) under a contract with Immigration and Customs Enforcement (ICE).

DRC is the agency designated under federal law to investigate and litigate violations of the civil, constitutional, and disability rights of Californians with disabilities like Mr. Ahn.² Centro Legal is one of the largest providers of legal services to detained indigent immigrants in California, and represented Mr. Ahn in petitioning for release from ICE detention, speaking regularly with him and his family before his death.³ CCIJ leads the collection and analysis of data on the detained immigrant population in Northern and Central California, documenting detention conditions related to health, medical care, and solitary confinement during the COVID-19 pandemic, among other things.

Based on our investigation into Mr. Ahn's death conducted to date, we write to express grave concern that ICE and GEO repeatedly violated federal disability law, the U.S. Constitution, and binding detention standards throughout Mr. Ahn's time at Mesa Verde and ultimately causing his death. Among other things, the evidence shows that ICE and GEO repeatedly failed to provide Mr. Ahn with adequate and timely medical care and mental

¹ Authorities deploy "solitary confinement" "for a variety of reasons, only some of which are officially acknowledged," and use "many different names and acronyms" to describe the practice. Craig Haney, et al., *Consensus Statement from the Santa Cruz Summit on Solitary Confinement and Health*, 115 Northwestern L. Rev 335, 335 (2020) (hereinafter, the Medical Consensus Statement). At baseline, however, experts define solitary confinement as "in-cell confinement for upwards of twenty-two hours a day" with "depriv[ation] of meaningful social contact for lengths of time" including even "very brief periods." *Id.* at 335-337 (explaining that solitary confinement also frequently deprives detained people of access to "other aspects of everyday prison life that are essential to health and rehabilitation," such as "positive environmental stimulation, meaningful recreation, programming, treatment, [and] contact visits," among other things). ICE and GEO, in court filings and public statements, have used various terms to describe the isolation environments in which Mr. Ahn died at Mesa Verde, (e.g., medical isolation, administrative segregation, and restrictive housing, among others). However, the Medical Consensus Statement's definition set out above fits most squarely with the conditions in which Mr. Ahn died: extended in-cell confinement and deprivation of social contact. This complaint uses the term "solitary confinement."

² DRC does not represent Mr. Ahn's estate in any potential litigation related to his death.

³ Centro Legal represented him in release advocacy, but not removal proceedings.

health treatment, leading to his mental and physical deterioration; failed to adequately screen him, assess his risk of self-harm, and implement appropriate suicide-prevention protocols; segregated him on the basis of his disabilities and denied him reasonable accommodations, in violation of federal disability law; unlawfully placed him in segregation despite assessing his mental illness as “severe” and concluding that he showed a “high risk of suicide”; and while in segregation, failed to properly monitor him or provide adequate mental health care to prevent his death. These findings warrant immediate investigation by the Office of Civil Rights and Civil Liberties (CRCL) and the Office of the Inspector General (OIG).

To prevent needless additional suffering and death, we request that CRCL and OIG:

- (1) conduct an independent and comprehensive investigation into the circumstances at Mesa Verde that resulted in Mr. Ahn’s death, including an evaluation of medical and mental health care provided to him, the tracking and accommodation of his disabilities, and his placement in solitary confinement;
- (2) conduct an independent and comprehensive investigation into the use of segregation (administrative, medical, and disciplinary) at Mesa Verde. The investigation should evaluate facility practices regarding the purpose and duration of segregation, as well as practices relating to medical and mental health assessments, particularly during the COVID-19 pandemic;
- (3) publish the results of your investigation so that Congress and the state of California can take appropriate action to hold ICE and GEO accountable for the violations of law that led to Mr. Ahn’s death, address ongoing harms arising from the improper use of solitary confinement in California facilities, and prevent future deaths like Mr. Ahn’s.

Further underscoring the need for an independent investigation by OIG and CRCL, ICE initially reported false and misleading information to Congress and the public about the events leading up to Mr. Ahn’s death. As a growing number of federal courts have now found in the context of the COVID-19 pandemic, ICE and GEO cannot be trusted to protect the health

and safety of people in detention, and here, too, they have no incentive to meaningfully investigate themselves.⁴ Indeed, new evidence has emerged showing that Mr. Ahn's case illustrates a much deeper systemwide problem, demanding immediate action by OIG and CRCL.⁵

⁴ In litigation challenging the constitutionality of conditions at Mesa Verde during the COVID-19 pandemic, for example, a federal court recently expressed regret for having trusted ICE's promises to self-correct, finding that "from the start of the public health crisis until now, the conduct of the key ICE and GEO officials in charge of operations at Mesa Verde has been appalling." See *Zepeda Rivas v. Jennings*, Order Granting Motion for Second Preliminary Injunction, No. 20-cv-02731-VC (N.D. Cal. Dec. 3, 2020) (Dkt. 867) at 2-3 (hereinafter, *Zepeda Rivas* Second Preliminary Injunction). The court detailed how officials in ICE ERO's San Francisco Field Office repeatedly showed deliberate indifference to the lives of detained people at Mesa Verde, noting that ICE officials even gave "false testimony several times in these court proceedings on matters of importance" and otherwise "obstructed the proceedings" in their testimony. *Id.* at 2. Describing Respondents' management of Mesa Verde as "abominable," the court concluded that the defendant ICE and GEO officials "cannot be trusted to conduct themselves responsibly as it relates to the safety of the detainees." *Id.* at 3, 6; see also *Hernandez-Roman v. Wolf*, Adelanto Population Reduction Order, No. 5:20-cv-00768-TJH-PVCT (C.D. Cal. Oct. 15, 2020) (Dkt. 686) at 2-3 (noting that ICE "provided the Court with a blaring example of its dishonesty," which prompted the "court to re-assess the information the Government has provided it in this case, as well as the arguments the Government has made," and further expressing regret for having "given the Government and its counsel the benefit of the doubt" as to their self-reporting); *Fraihat v. ICE*, Order Granting Motion to Enforce, No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Oct. 7, 2020) (Dkt. 240) at 8-13, 18 (finding that ICE has "substantially failed to comply" with court orders to ensure minimum constitutional conditions for detainees, and decrying ICE's "pattern of noncompliance or exceedingly slow compliance" requiring increased court supervision); *Zepeda Rivas v. Jennings*, No. 20-cv-02731-VC, 2020 WL 3055449 at *4 (N.D. Cal. June 9, 2020) (hereinafter, *Zepeda Rivas* First Preliminary Injunction) (ordering ICE to close intake at Mesa Verde and commenting that ICE's conduct "since the pandemic began ha[s] shown beyond doubt that ICE cannot currently be trusted to prevent constitutional violations at [Mesa Verde] without judicial intervention.").

⁵ In January 2021, a California Department of Justice report characterized improper use of solitary confinement and restrictive housing as a "systemic" issue in California's immigrant detention centers. See Attorney General Xavier Becerra, *The California Department of Justice's Review of Immigration Detention in California* (Jan. 2021), <https://oag.ca.gov/sites/all/files/agweb/pdfs/publications/immigration-detention-2021.pdf>. The report cataloged cases, across multiple detention centers, of detained people housed in restrictive settings despite suffering from a mental health condition, and despite evidence that isolation worsened their symptoms. See *id.* at 24-28.

In preparing this complaint, DRC and Centro Legal reviewed Mr. Ahn's clinical and detention records from Mesa Verde, medical records from Mercy Hospital, 911 records, police reports from the Bakersfield Police Department, and other legal documents and filings.⁶ Additionally, Centro Legal interviewed over sixteen witnesses at Mesa Verde who interacted with Mr. Ahn in the days and weeks leading up to his death, as well as Mr. Ahn's brother, Young Ahn, who spoke with him on the day of his death. In addition, CCIJ and Centro Legal collected and analyzed data on conditions at Mesa Verde, especially regarding medical and mental health treatment and the use of segregation during the COVID-19 pandemic, based on interviews conducted with over 130 detainees since February 21, 2020, the date of Mr. Ahn's detention at Mesa Verde. This evidence forms the basis of this complaint.

II. Factual background

Mr. Ahn was a 74-year-old South Korean immigrant who was detained at Mesa Verde from February 21, 2020 until his death there on May 17, 2020. Mr. Ahn first came to the United States in 1988, and was admitted as a lawful permanent resident in San Francisco, California. On February 21, 2020, the state of California allowed ICE Enforcement and Removal Operations (ERO) to take custody of Mr. Ahn upon his release from Solano State Prison in Vacaville, California.

Mr. Ahn was a qualified person with a disability under Section 504 of the Rehabilitation Act⁷ and under the applicable regulations promulgated by the Department of Homeland Security (DHS) governing non-discriminatory treatment of people with disabilities.⁸ Mr. Ahn had a history of suicide

⁶ DRC did not review or disclose any of the information obtained using our federal and state access authority for this complaint.

⁷ See Rehabilitation Act of 1973, § 504, Pub. L. No. 93-112, 87 Stat. 355; 29 U.S.C. § 705(20).

⁸ 6 C.F.R. § 15.1 ("The purpose of this part is to effectuate section 504 of the Rehabilitation Act of 1973 ('Section 504'), as amended by section 119 of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, which prohibits discrimination on the basis of disability in programs or activities conducted by Executive agencies. The provisions established by this part shall be effective for all components of the Department, including all Department components

attempts, a diagnosis of unspecified depressive disorder, and numerous physical disabilities including hypertension, type 2 diabetes, and severe-heart related issues. These conditions interfered with his ability to function on a day-to-day basis.

Upon his arrival at Mesa Verde in February 2020, Mr. Ahn reportedly denied having a history of suicidal ideations or mental illness, a common response where someone fears being placed in suicide-watch isolation.⁹ However, staff did not conduct an adequate review of Mr. Ahn's previous incarceration records. Over the following three months, medical staff at Mesa Verde began to document more information regarding Mr. Ahn's history of suicide attempts in detention, his feelings of depression, and his previous mental health treatment. His mental and physical health together started to decline.

1. As Mr. Ahn's physical and mental state deteriorated, ICE and GEO documented his history of severe mental illness and prior suicide attempts in custody, but ignored mounting evidence suggesting ongoing suicidal ideation.

On March 12, 2020, Mr. Ahn reported experiencing shortness of breath and chest pain, and was admitted to the emergency department of Mercy Hospital in Bakersfield, California, where he received emergency surgery to remove a mass on his lung. Mr. Ahn understood his diagnosis at the time to be lung cancer. Hospital records obtained after his death show that he was supposed to return shortly for follow up care and to confirm the biopsy results. But ICE delayed authorizing and scheduling the appointment for months. Ultimately, Mr. Ahn died by suicide before he received follow-up care for the mass on his lung.

Aware that his medical conditions rendered him vulnerable to severe illness or death if he were to contract COVID-19, Mr. Ahn feared for his life. He

that are transferred to the Department, except to the extent that a Department component already has existing section 504 regulations.”).

⁹ See, e.g., U.S. House of Representatives, Committee on Homeland Security, *ICE Detention Facilities: Failing to Meet Basic Standards of Care* (Sept. 21, 2020), <https://homeland.house.gov/imo/media/doc/Homeland%20ICE%20facility%20staff%20report.pdf> (finding that many detainees were “reluctant to raise mental health issues” for fear of being placed in segregation, where mental health care is “lacking”).

stated, "I get the coronavirus, I could die. And there are lots of people here. So I am scared." On April 10, he joined a hunger strike occurring in his dormitory, and began refusing meals to protest the conditions at Mesa Verde.

In April 2020 during a mental health appointment, Mr. Ahn reported to a psychologist that he had feelings of sadness and low energy, as well as trouble sleeping. The psychologist concluded that Mr. Ahn had an unspecified depressive disorder and referred him to a psychiatrist. Later that same month, Mr. Ahn informed the medical staff that he had attempted suicide at least three different times in custody in 2014, 2015, and 2019.

On April 30, 2020 during one of his "talk therapy" sessions, Mr. Ahn reported that his depression was "6-7/10 (10 being the worst)." He expressed feelings of anxiety and not "want[ing] to live in this life ." When asked, Mr. Ahn denied suicidal ideations, but noted that he was awaiting a "decision regarding his deportation," and "when he is to the point of deportation" he might have thoughts "of wanting to die."

As the pandemic intensified and his physical and mental health deteriorated, Mr. Ahn submitted at least four requests for release through his lawyers, all of which were denied (including one by voicemail). On the day before his next hospitalization, witnesses in his dormitory noted that he cried and seemed abnormally quiet upon learning that his latest release request had been denied, commenting that he would never get out of detention. Multiple witnesses expressed that Mr. Ahn's mental and physical state was well known among GEO employees and detainees alike.

On May 12, 2020, Mr. Ahn was admitted to Mercy Hospital in Bakersfield due to chest pain. Throughout his detention at Mesa Verde, Mr. Ahn made several medical requests due to persistent pain in his feet, his shoulder, and his chest. He also complained that his diabetes and high blood pressure medication were not refilled in a timely manner. On the day Mr. Ahn was hospitalized, he was struggling to breathe, complaining of chest pain, and had liquid coming out of his nose. According to witness statements, detainees nearby asked the guards to help, while one guard radioed for an hour, but no one showed up. Witnesses in the dormitory also reported that when Mr. Ahn requested medical care, he frequently received attention several days later or not at all. One witness recounted that in his

experience, GEO employees did not take medical complaints seriously until they saw someone seriously ill or near death.

2. ICE and GEO quarantined Mr. Ahn in solitary confinement, despite his disabilities and history of suicide attempts.

Upon his return to Mesa Verde on May 14, 2020, Mr. Ahn was placed in an isolation unit, ostensibly for purposes of medical quarantine, even though he tested negative for COVID-19. At the time, public health experts warned that ICE’s “practice . . . of locking people in conditions . . . equivalent to punitive solitary confinement. . . as a form of ‘quarantine’ or ‘medical isolation’” in response to the COVID-19 pandemic, as it subjected detained people to “significant risk of grave harm (including harm that may be permanent, even fatal).”¹⁰ Citing “widely accepted” scientific consensus, experts explained that “ICE detainees with pre-existing mental illness or emotional impairment are especially at risk”; when “placed in conditions that are the equivalent of solitary confinement” they are “especially likely to suffer an exacerbation of their psychiatric disability,” rendering them “even more medically and psychologically vulnerable.”¹¹

Experts have concluded that solitary confinement is by design an “inappropriate, ill-conceived, and counter-productive” tool for quarantine.¹² Among other things, detainees held in solitary often lack access to adequate medical care and hygiene supplies “even more acute[ly]” than in the general population, surfaces may be unsanitary, and without the use of negative pressure rooms, the virus can still easily spread through airborne transmission.¹³ As such, this practice “very likely exacerbate[s] rather than limit[s] or alleviate[s] the spread of COVID-19” in ICE facilities.¹⁴ Though Mr. Ahn died before he could report conditions in his cell in detail, medical professionals have specifically highlighted his case as illustrating how “preemptive lockdowns” in a “solitary confinement” setting, “marked by

¹⁰ Declaration of Craig W. Haney, PhD., *Fraihat v. ICE*, No. 5:19-cv-01546-JGB-SHK (C.D. Cal. June 24, 2020) (Dkt. 172-8) ¶¶ 5, 32 (hereinafter, Haney Dec.); see also, e.g., *id.* ¶ 33 (“the scientific literature on the harmfulness of solitary confinement is now widely accepted and the research findings are consistent and alarming.”).

¹¹ *Id.* ¶ 5(D).

¹² *Id.* ¶ 31.

¹³ *Id.* ¶ 18.

¹⁴ *Id.* ¶ 31.

“extreme isolation and stark conditions,” pose “grave dangers to [detained persons’] mental and physical health” and threaten “needless suffering and loss of life.”¹⁵

Notably, at the time ICE and GEO purported to “quarantine” Mr. Ahn in isolation, they were regularly accepting incoming transfers from California prisons with confirmed outbreaks of COVID-19, *directly into the dormitories* at Mesa Verde, without universally quarantining or regularly testing them.¹⁶ They continued doing so for months after Mr. Ahn’s death, until a federal court ordered them to stop, finding that their inadequate testing and quarantine protocols likely violated the Fifth Amendment rights of all detainees.¹⁷

After being placed in solitary, Mr. Ahn informed the psychologist that he had feelings of depression. Nevertheless, staff held him there. The records show no consideration of any alternative housing placement.¹⁸

Mr. Ahn’s brother, Young Ahn, informed DRC that he spoke to his brother at least once a day while he was in detention. Young stated that his brother had not expressed suicidal ideation to him before he entered solitary confinement, and believed that the extreme isolation had a detrimental impact on his brother’s mental state.

¹⁵ *Id.* ¶ 46.

¹⁶ See, e.g., Joint Statement by the detained people at Mesa Verde (Aug. 6, 2020), <https://www.centrolegal.org/wp-content/uploads/2020/08/MV-COVID-19-Outbreak-Statement.pdf> (Mesa Verde detainees reporting that as of early August 2020, “new people continued to arrive in our dorms, straight from prisons with massive COVID-19 outbreaks, without being quarantined or even tested for the virus”); *Zepeda Rivas* First Preliminary Injunction (finding that ICE did not regularly quarantine or test detainees transferred from COVID-19-infected prisons upon intake at Mesa Verde, but rather brought them directly into dormitories); *Zepeda Rivas v. Jennings*, No. 20-CV-02731-VC, 2020 WL 4554646, at *1 (N.D. Cal. Aug. 6, 2020) (finally ordering ICE to stop incoming transfers to Mesa Verde).

¹⁷ *Zepeda Rivas* First Preliminary Injunction at *3 (further finding that ICE made “at least one misrepresentation” to the court about this “matter of great importance.”).

¹⁸ Haney Dec., *supra* note 10, ¶ 13(E) (“The goals of quarantining or medically isolating an individual can be met without placing them in dangerous conditions equivalent to solitary confinement.”).

3. After placing him in a setting known to exacerbate pre-existing mental illness, ICE and GEO failed to intervene to prevent his death.

On May 16, 2020, the day before Mr. Ahn died by suicide, a clinical psychologist supported Young Ahn's assertion and reported that Mr. Ahn appeared to be at "high suicidal risk if deported." On May 17, 2020, the morning of his death, an attorney for Mr. Ahn emailed ICE, requesting that they return him to his dormitory because isolation was proving detrimental to his mental health. That same day, a different medical provider indicated that Mr. Ahn's mental illness was "severe" and again stated that Mr. Ahn was at "high risk of suicide if deported." In fact, Mr. Ahn faced the possibility of being ordered deported in as little as two days, at his next scheduled hearing on May 19, 2020. He remained unrepresented in his removal proceedings, and had not prepared or filed any applications for relief to remain in the United States.

On the evening of Sunday, May 17, 2020, Mr. Ahn was left unobserved in his medical isolation room for at least a period of 18 minutes, according to police and autopsy reports. During this period, he died by hanging himself with a bedsheet. A witness familiar with the medical isolation area in which Mr. Ahn died reported that he frequently saw guards performing rote, perfunctory checks, often passing by the segregation unit without knocking on the door or looking through the window of the cell, but simply scanning a key fob at various points. This statement echoes reports by detainees at other facilities, and supports a public health expert's assessment that "superficial and pro forma" checks and "monitoring by security staff" at the Adelanto facility were one of many "lockdown practices" that exposed detainees to significant risks of harm there.¹⁹

¹⁹ See Haney Dec., *supra* note 10, ¶ 26; Declaration of Ruben Dario Mencias Soto, *Fraihat v. ICE*, No. 5:19-cv-01546-JGB-SHK (C.D. Cal. June 24, 2020) (Dkt. 187) ¶ 13 (detainee at Adelanto recounting that after potential COVID-19 exposure he was locked down 23 hours a day with insufficient medical care and monitoring by mental health staff, and describing checks as follows: "The rest of the day, the security staff comes by every 15 minutes. They have a little electronic tube that they hit on the door but I have observed that the do not look inside the cell to make sure we are okay. I am very worried that . . . I will die without them noticing.").

In a Congressionally-mandated Detainee Death Report released following Mr. Ahn's death, ICE initially published false and misleading information, describing Mr. Ahn's mental status at the time of death as "essentially normal."²⁰ After Mr. Ahn's attorneys notified ICE that the report contained false and misleading information, ICE deleted the phrase and published a new report.²¹

III. ICE and GEO discriminated against Mr. Ahn by segregating him on the basis of his disabilities and by denying him reasonable accommodations, violating federal disability law.

1. Segregation on the basis of disability.

Section 504 of the Rehabilitation Act prohibits disability discrimination in any program or activity conducted by an executive agency or entity that receives federal funding, which includes GEO.²² DHS has adopted and implemented Section 504's prohibitions as binding regulations to combat disability discrimination.²³ Section 504 and ICE's own standards state that any individual with a disability must enjoy an "equal opportunity to participate in, access, and enjoy the benefits of the facility's programs, services, and activities" in the least restrictive and most integrated setting possible.²⁴ Additionally, Section 504, as well as Supreme Court precedent, provide that placing an individual with a disability in a restrictive environment on the basis of that disability constitutes prohibited discrimination.²⁵ In this case, Mr. Ahn was placed in medical segregation because of his disabilities even though ICE well knows that segregation

²⁰ See Rebecca Plevin, 'This death was preventable': Family asks state to probe 74-year-old's suicide in ICE detention, Desert Sun (Aug. 7, 2020) <https://www.desertsun.com/story/news/politics/immigration/2020/08/07/family-asks-newsom-probe-choung-woohn-ahn-suicide-ice-mesa-verde/5504694002/> (linking to two versions of reports).

²¹ See *id.*

²² See 29 U.S.C. § 794.

²³ See generally 6 C.F.R. § 15.

²⁴ See 6 C.F.R. § 15.30; 2011 Performance-Based National Detention Standards (PBNDS) 4.8 at 345.

²⁵ See *Olmstead v. L.C.*, 527 U.S. 581 (1999).

settings can exacerbate existing mental illnesses, contribute to overall mental deterioration, and even lead to suicide.²⁶

First, placement in solitary-like conditions was unnecessarily restrictive. Generally, “psychologically vulnerable detainees should be excluded from all forms of severe social isolation, where they are “particularly likely to decompensate, suffer worsening depression, and much more frequently engage in self-harming and suicidal behavior in response to social isolation.”²⁷ Thus, although CDC quarantine guidelines developed for the general population recommend that individuals with confirmed or supposed cases of COVID-19 self-isolate at home, public health experts explain that these guidelines apply differently in the detention context. Specifically, to best prevent the spread of COVID-19 in detention, “ICE must avoid the use of lockdown procedures with detainees who suffer pre-existing mental health conditions unless they are *absolutely necessary*.”²⁸ “Only those persons who have confirmed or suspected cases of COVID-19” should even be considered for medical isolation.²⁹ And even a suspected

²⁶ See, e.g., Civil Rights Education and Enforcement Center, et. al., *Complaint for violations of civil, constitutional, and disability rights of Anderson Avisai Gutierrez* (March 13, 2020), https://www.splcenter.org/sites/default/files/2020-03-13_anderson_avisai_gutierrez_crcl_504_complaint_.pdf (describing cases of detainees who died by suicide following improper placement in segregation); Memorandum from DHS CRCL to ICE regarding Adelanto Correctional Facility Complaints (April 25, 2018), [https://www.pogo.org/document/2019/09/dhs-office-for-civil-rights-and-civil-liberties-review-of-adelanto-sent-to-ice-in-april-2018/#document/p47/a520498%20\(finding%20%22Detainees%20with%20serious%20mental%20health](https://www.pogo.org/document/2019/09/dhs-office-for-civil-rights-and-civil-liberties-review-of-adelanto-sent-to-ice-in-april-2018/#document/p47/a520498%20(finding%20%22Detainees%20with%20serious%20mental%20health) at 5 (“Detainees with serious mental disorders should only be housed in administrative segregation as a last resort, as that environment is not conducive to improving mental health status”); Memorandum from Ellen Gallagher, Senior Policy Advisor, DHS CRC. to Deputy Secretary Mayorkas, DHS (July 23, 2014) at 3 (stating that placing individuals in ICE custody who suffer from serious mental health conditions into segregated settings is non-therapeutic and “imposes improper punitive conditions, and subjects vulnerable detainees to physical and mental deterioration”); JD Strong et al., *The body in isolation: The physical health impacts of incarceration in solitary confinement*, PLOS ONE, Oct. 9, 2020, <https://doi.org/10.1371/journal.pone.0238510>. (explaining that “solitary confinement is associated not just with mental, but also with physical health problems” and “analyz[ing] a range of physical exacerbated by both restrictive conditions and policies.”).

²⁷ Haney Dec., *supra* note 10, ¶ 34.

²⁸ *Id.* ¶ 43.

²⁹ See Haney Dec., *supra* note 10, ¶ 34 (emphasis added).

diagnosis of COVID-19 may weigh towards release for medical care in the community rather than placement in solitary confinement, since solitary confinement likely “will increase the risk in the facility from COVID-19.”³⁰

Here, ICE and GEO knew that Mr. Ahn had neither a confirmed nor suspected case of COVID-19, and that placing him in isolation would exacerbate his disabilities. Mr. Ahn received a negative COVID-19 test result after discharge from the hospital; yet, ICE and the GEO Group still placed him in segregation without adequately considering any alternative housing option, let alone release.³¹ Mr. Ahn verbally expressed to staff that he had feelings of anxiety, loneliness, and depression, and one of his lawyers emailed ICE on the morning of his death requesting placement in the dormitory. But he did not receive enhanced treatment or screening, periodic assessment of his mental health status, or evaluation by medical staff for disability-related accommodations. ICE and GEO continued to segregate Mr. Ahn due to his disabilities.

ICE and GEO failed to provide Mr. Ahn with equal access to participate in the same programs, services, and activities as the general population. Because staff were aware of Mr. Ahn’s disabilities and negative COVID-19 test result, a reasonable modification that allowed Mr. Ahn to engage in the same activities as the general population, while maintaining the recommended social distancing, should have been considered and implemented.

³⁰ *Id.* ¶ 31. This is because solitary confinement, when operated without a negative pressure system, does not effectively stop transmission of the virus, and because detainees will likely under-report symptoms for fear of being placed in solitary. See Declaration of Lauren Brinkley-Rubinstein, *Arriaga v. Decker*, No. 20-cv-003600 (S.D.N.Y. May 29, 2020) (Dkt. 33-4) ¶ 23; see also Community Honors Memory of Choung Woong Ahn, <https://www.centrolegal.org/community-honors-memory-of-choung-woong-ahn/> (May 21, 2020) (Mr. Ahn’s dormmate reporting, “given what happened, now others do not want to go to Medical because they are scared.”).

³¹ Mr. Ahn had previously requested release on humanitarian parole, which ICE denied by voicemail with no written or reasoned analysis.

2. Failure to ensure adequate screening to identify, track, and provide reasonable accommodations for people with disabilities.

ICE and GEO routinely fail to adequately identify, track, and provide accommodations for detained individuals with disabilities as required by Section 504.³² Inadequate screening procedures result in the failure to identify individuals with disabilities, track their needs, and provide necessary accommodations for their disabilities. In this case, ICE and GEO failed to engage in an adequate individualized assessment to determine Mr. Ahn's disabilities and what accommodations were needed for his care.

According to ICE's own standards, "upon change of custody to ICE/ERO from federal, state or local custody, ICE/ERO staff or designee shall inquire into any known prior suicidal behaviors or actions, and, if behaviors or actions are identified, shall ensure detainee safety pending evaluation by a medical provider. The patient's 'medical summary report' shall be transferred to ICE."³³ Then, "At the time of screening staff should assess relevant available documentation as to whether the detainee has been a suicide risk in the past, including during any prior period of detention or incarceration."³⁴

The records show no inquiry by ICE and GEO into past suicidal behaviors at Solano State Prison, no adequate medical history review, and no adequate individualized determination of Mr. Ahn's needs upon intake to Mesa Verde, violating Section 504 and ICE's Performance Based National Standards 2011 (PBNDS 2011). For example, a mental health "receiving screening" dated February 21, 2020 failed to note any prior hospitalizations, prior mental health treatment, past suicide attempts, past prescription of medication, or past signs of depression or anxiety—and included no referral for mental health care. Given Mr. Ahn's history of suicide attempts in Solano State Prison, including as recently as 2019, staff should have carefully reviewed previous incarceration records when screening him at Mesa Verde. But Mr. Ahn's detention file does not show what, if any, records Mesa Verde staff reviewed, or what information they

³² See 6 C.F.R. § 15.30

³³ PBNDS 2011 4.6(G)(1).

³⁴ PBNDS 2011 4.6(V)(B)(2).

relied on, to support their determination that Mr. Ahn had no disabilities and no history of mental illness, and did not require any treatment. In sum, the screening process did not reflect any reasoned individualized assessment of whether Mr. Ahn had any disabilities that required accommodation.

ICE and GEO's failure to adequately screen for and timely identify Mr. Ahn's mental illness led to his placement in housing that was dangerous and detrimental to his health. As such, ICE and GEO failed to provide Mr. Ahn with reasonable accommodations for his disabilities that would have allowed him to access adequate medical care and appropriate housing, violating federal disability law.

IV. ICE and GEO violated Mr. Ahn's Fifth Amendment substantive due process rights.

The Fifth Amendment to the U.S. Constitution prohibits the government actors and their contractors from subjecting civil detainees to conditions that are in any way punitive, i.e. conditions that impose harm excessive to the government's interest, or that reflect "deliberate indifference" by government officials to the detainee's life and safety.³⁵ The Fifth Amendment also requires the government to ensure the "reasonable health and safety" of people detained civilly.³⁶ Courts have recognized that solitary confinement in ICE detention facilities can exacerbate pre-existing mental illnesses, and that improper placement in solitary confinement may reflect deliberate indifference.³⁷

³⁵ See e.g., *Jones v. Blanas*, 393 F.3d 918, 932 (9th Cir. 2004) (punitive conditions); *Unknown Parties v. Johnson*, No. CV-15-00250-TUC-DCB, 2016 WL 8188563, at *5 (D. Ariz. Nov. 18, 2016), *aff'd sub nom. Doe v. Kelly*, 878 F.3d 710 (9th Cir. 2017) (condition punitive "if it imposes some harm to the detainee that significantly exceeds or is independent of the inherent discomforts of confinement and is not reasonably related to a legitimate governmental objective or is excessive in relation to the legitimate governmental objective.")

³⁶ See, e.g., *Hernandez Roman v. Wolf*, No. 20-55436, 2020 WL 5683233, at *4 (9th Cir. Sept. 23, 2020) (reasonable health and safety) (citing *DeShaney v. Winnebago County Dep't of Soc. Servs.*, 489 U.S. 189, 199-200 (1989)).

³⁷ See *Disability Rts. Mont. Inc. v. Batista*, 930 F.3d 1090, 1098 (9th Cir. 2019) (holding that plaintiffs sufficiently pled factual allegations of deliberate indifference by describing that defendants: denied inmates adequate mental health treatment; had a pattern of placing mentally ill inmates in solitary confinement without significant mental health care; and their improper responses increased the risk of suicide); see also

For Mr. Ahn, solitary confinement was punitive—indeed, a death sentence. ICE and GEO exposed Mr. Ahn to a high risk of harm by intentionally placing him in conditions of extreme isolation and deprivation, despite knowing that it would exacerbate his pre-existing mental illnesses—while also failing to provide him adequate mental health treatment or properly monitor him. As referenced above, the day before Mr. Ahn died by suicide, a clinical psychologist at Mesa Verde warned that Mr. Ahn was experiencing sadness, trouble sleeping, low energy, and appeared to be at “high suicidal risk if deported.” Experts have described the psychological torture that Mr. Ahn was likely suffering in solitary confinement.³⁸ Though he was on the verge of an urgent mental health crisis, ICE and GEO did not attempt to improve or alleviate Mr. Ahn’s situation. Hours before Mr. Ahn’s death, another psychologist reported that Mr. Ahn’s mental illness was “severe” and echoed that he was at “high suicide risk if deported.” In response, ICE and GEO took no steps to intervene, and also failed to adequately monitor him. He took his life later that day. In the circumstances, ICE and GEO placed Mr. Ahn at a high risk of harm.

ICE had no legitimate interest in segregating Mr. Ahn. He tested negative for COVID-19, and in any event, as explained above, solitary confinement does not effectively prevent the spread of COVID-19 in detention. Moreover, at the same time they placed Mr. Ahn in solitary confinement, ICE and GEO were accepting incoming transfers to Mesa Verde from state prisons with confirmed outbreaks of COVID-19 without universally quarantining or testing new intakes.³⁹ Overall, ICE and GEO exposed Mr. Ahn to an excessive risk of harm, amounting to punishment in violation of the Fifth Amendment.

Braggs v. Dunn, 257 F. Supp. 3d 1171, 1192 (M.D. Ala. 2017); *Finley v. Huss*, 723 Fed. Appx. 294, 298 (6th Cir. 2016).

³⁸ See Medical Consensus Statement at 214 (arguing that “psychological and physical consequences” of solitary confinement “raise serious questions about its . . . status as a form of torture”); Haney Dec. ¶ 10 (describing ICE detention centers as “extremely stressful environments for the persons confined in them,” and “psychologically and medically harmful in their own right”); Section VII *infra* (describing recent case of detained person at Mesa Verde held in solitary confinement in intake cell in conditions the UN defines as torture).

³⁹ See *supra* note 16.

ICE and GEO also showed deliberate indifference to Mr. Ahn's life by quarantining him in solitary confinement, in violation of the Fifth Amendment. By placing him in isolation with environmental hazards and in conditions of extreme social isolation, and then also not observing him as required under their own standards (as detailed below), ICE and GEO left him "in a situation that [is] more dangerous than the one in which [they] found him," affirmatively placing him in danger, and amounting to punishment in violation of the Fifth Amendment.⁴⁰ For these same reasons, ICE and GEO failed to provide conditions of "reasonable health and safety."

V. ICE and GEO repeatedly violated their own detention standards, leading to Mr. Ahn's death.

Both ICE and GEO are obligated to follow PBNDS 2011. These national standards are necessary to guide and shape facility practices to ensure the safety and well-being of all detainees. Here, Mr. Ahn's medical and detention records suggest that ICE and GEO repeatedly violated the PBNDS by failing to provide timely and adequate mental health treatment; failing to provide timely and adequate medical care; failing to follow proper screening protocols; failing to adequately assess risk of self-harm; failing to abide by medical housing standards; and failing to implement suicide prevention standards.

1. Failure to provide timely and adequate mental health treatment.

At a basic level, the PBNDS 2011 require access to a continuum of adequate health care services, from screening and prevention through treatment, as well as timely transport to a higher-level care facility when needed.

Here, Mr. Ahn did not receive *any* adequate mental health evaluations or treatment until more than two months after his arrival at Mesa Verde, and he died by suicide 24 days later. Six days into Mr. Ahn's "talk therapy"

⁴⁰ *Hernandez v. City of San Jose*, 897 F.3d 1125, 1133 (9th Cir. 2018); see also Complaint, *Estate of Escobar Mejia v. Archambeault, et. al.*, No. 20-CV-2454 (S. D. Cal Dec. 16, 2020) (alleging negligence, deliberate indifference to health and safety, and wrongful death because ICE held Mr. Escobar Mejia, the first to die of COVID-19 in ICE custody, in conditions that they "knew would expose him to a deadly disease.").

treatment, he reported to staff that he had feelings of depression, anxiety, and not “want[ing] to live in this life.” Once ICE became aware of his depression and history of suicide attempts, it was critically necessary to provide Mr. Ahn with treatment beyond the scope of ordinary care. Yet, ICE did not modify Mr. Ahn’s treatment in the slightest. It was wholly insufficient to rely on basic talk therapy to ensure Mr. Ahn’s well-being. In sum, the documents show significant failures to provide proper treatment and escalate to higher levels of care, violating the PBNDS. Especially in light of the “longstanding pattern of frequent and severe deficiencies” in mental health care in ICE detention, CRCL and OIG should immediately investigate the inadequate mental health care leading to Mr. Ahn’s death.⁴¹

2. Failure to provide timely and adequate medical care.

Under PBNDS 2011 4.3 (II)(4), “detainees shall be able to request health services on a daily basis and shall receive timely follow up.” While at Mesa Verde, Mr. Ahn’s medical treatment was either (1) significantly delayed or

⁴¹ See, e.g., American Immigration Council, *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/sites/default/files/general_litigation/complaint_demands_investigation_into_inadequate_medical_and_mental_health_care_condition_in_immigration_detention_center.pdf; Human Rights First, *Prisons and Punishment: Immigration Detention in California* (Jan. 2019), https://www.humanrightsfirst.org/sites/default/files/Prisons_and_Punishment.pdf; Human Rights Watch, et al., *Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention* (2018), <https://www.hrw.org/report/2018/06/20/code-red/fatal-consequences-dangerously-substandard-medical-careimmigration#>; American Civil Liberties Union, et al., *Fatal Neglect: How ICE Ignores Deaths in Detention* (Feb. 2016), https://www.aclu.org/sites/default/files/field_document/fatal_neglect_acludwnnjjc.pdf; Southern Poverty Law Center, *Shadow Prisons: Immigrant Detention in the South*, (Nov. 2016), <https://www.splcenter.org/20161121/shadow-prisons-immigrant-detention-south>; Disability Rights California, *There Is No Safety Here: The Dangers for People with Mental Illness and Other Disabilities in Immigration Detention at Geo Group’s Adelanto ICE Processing Center* (Mar. 2019), https://www.disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTION_MARCH2019.pdf; Disability Rights California, *Otay Mesa Detention Center: Inhumane Conditions and the Harsh Reality of ICE’s Civil Detention System* (Nov. 2020), <https://www.disabilityrightsca.org/system/files/file-attachments/OM-Report-Final.pdf>.

(2) categorically nonexistent. Mr. Ahn made multiple patient health requests for a variety of medical concerns, including swollen feet & shoulder pain; however, Mr. Ahn only received one documented follow-up with a medical provider. As noted above, witnesses corroborated that Mr. Ahn did not receive timely follow-ups to his medical requests.

In addition, following his March 2020 hospitalization to remove a mass on his lung, hospital records indicated that he needed to return for follow up care and to receive biopsy results. Mr. Ahn understood that he had been diagnosed with lung cancer. Yet ICE's records suggest that over month later, ICE had still not authorized a follow up visit. Two months after his hospitalization, records indicated that the "earliest appointment is June 1." By this point, it was too late—Mr. Ahn was already dead.

Additionally, while at Mesa Verde, Mr. Ahn established a critically important medication regimen for his diabetes, chest pain, and high blood pressure. However, he was forced to remind staff to fill his prescriptions on time, which again directly violated ICE's Performance-Based Detention Standards.⁴²

3. Failure to adequately recognize risk of self-harm.

The PBNDS provide that a detained person "may be identified as being at risk for significant self-harm/suicide at any time while in ICE custody. Staff must therefore remain vigilant in recognizing and appropriately reporting when a risk is identified."⁴³ Yet, staff did not remain vigilant in identifying Mr. Ahn's deteriorating mental condition. Far from it—Mr. Ahn repeatedly expressed feelings of depression, anxiety, and low energy, and possible suicidal ideation should he approach the "the point of" deportation. Although staff twice documented a "high risk of suicidality if deported," the records reveal no analysis of what the phrase "if deported" meant, including how imminent Mr. Ahn perceived his deportation to be. Thus, the records reveal no way that staff could have accurately assessed Mr. Ahn's risk of self-harm.

⁴² PBNDS 2011 4.3 (II)(20).

⁴³ PBNDS 2011 4.6 (V)(B)(3).

In addition, “where a detainee has a serious . . . mental health condition . . . staff shall complete a Medical/Psychiatric Alert form . . . and file the form in the detainee’s medical record.”⁴⁴ The PBNDS lists “suicidal behavior or tendencies” as a condition “meriting the completion” of such an alert. Mr. Ahn’s medical records do not contain psychiatric alerts. Moreover, the medical records do not show any escalation of these concerns to higher-level staff, or document any clinical deliberation as to whether Mr. Ahn should or should not have been placed in solitary confinement or on suicide watch, in light of his risk of self-harm. These were clear warning signs by themselves, but Mesa Verde staff should have been especially concerned and vigilant given Mr. Ahn’s known mental health history, including three prior suicide attempts in detention settings.

Shortly after Mr. Ahn’s death, on the evening of May 17, 2020, a GEO Group employee stated to a police officer responding to the scene that Mr. Ahn had not been on suicide watch, though the employee was aware that Mr. Ahn had spoken with a psychiatrist the day before and was “possibly depressed.” Far from “possibly depressed,” as noted above, a medical provider earlier that actually described Mr. Ahn’s mental illness as “severe,” and found him to be a “high risk” of suicide. In these circumstances, ICE and GEO failed to be “vigilant” and take “appropriate” steps to recognize the real risk of harm facing Mr. Ahn. To the extent he was not on suicide watch as the GEO employee suggested, he should have been.

4. Violation of medical housing standards.

“Prior to placing a mentally ill detainee in medical housing, a determination shall be made by a medical or mental health professional that placement in medical housing is medically necessary.”⁴⁵ Mr. Ahn’s medical and detention records show no individualized assessment by a clinician that placement in medical isolation upon return from the hospital was necessary.

5. Violation of Suicide Prevention Standards.

Given that ICE and GEO were aware of his history of self harm in detention, Mr. Ahn should have been under constant 1:1 observation.

⁴⁴ PBNDS 2011 4.3(M).

⁴⁵ PBNDS § 4.3(F)(3)(a).

According to ICE's Suicide Standards, "Suicidal detainees will be monitored by assigned security officers who maintain constant one-to-one visual observation, 24 hours a day, until the detainee is released from suicide watch. The assigned security officer makes a notation every 15 minutes on the behavioral observation checklist."⁴⁶ However, Mr. Ahn did not receive 24-hour supervision. In fact, during the period in which he died, Mr. Ahn was left alone for approximately 18 minutes, according to autopsy reports. That is a strikingly inappropriate amount of time for an individual described as a "high suicide risk," and clearly violates ICE's own detention standards.

VI. ICE initially reported false and misleading information about Mr. Ahn's death, underscoring the need for independent investigation, oversight and account.

As detailed above, Mesa Verde staff knew of Mr. Ahn's mental illness and history of suicide attempts, even describing him as a "high suicidal risk" on the day before his death. Nevertheless, in a Congressionally-mandated Detainee Death Report released following Mr. Ahn's death, ICE described his mental status at the time as "essentially normal."⁴⁷ After Mr. Ahn's attorneys notified ICE that the report contained false and misleading information, ICE deleted the phrase and published a new report.⁴⁸ Indeed, ever since Congress required in 2018 that ICE publicly release reports on in-custody deaths, ICE has a history of releasing incomplete, inaccurate death reports that lack a meaningful review of what led to the deaths.⁴⁹ As multiple federal courts have now recognized in the context of the COVID-19 pandemic, ICE cannot be trusted to meaningfully investigate itself.⁵⁰ And

⁴⁶ ICE/DRO Detention Standard, *Suicide Prevention and Intervention*, Housing and Monitoring – Constant Observation (F), IMMIGRATION AND CUSTOMS ENFORCEMENT, Dec. 2, 2008, available at: https://www.ice.gov/doclib/dro/detention-standards/pdf/suicide_prevention_and_intervention.pdf.

⁴⁷ Plevin, *This death was preventable*, *supra* note 20.

⁴⁸ See *id.*

⁴⁹ See, e.g., ICE Releases Sham Immigrant Death Reports As It Dodges Accountability And Flouts Congressional Requirements (Dec. 19, 2018), <https://immigrantjustice.org/press-releases/ice-releases-sham-immigrant-death-reports-it-dodges-accountability-and-flouts>.

⁵⁰ See note 3 *supra* (citing cases); see also Letter from U.S. House of Representatives Committee on Oversight and Reform to DHS CRCL (Dec. 23, 2019), <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2019-12-23.JR%20to%20DHS%20CRCL%20re%20ICE.pdf> (requesting information from CRCL

“because there is limited transparency and public accountability regarding many aspects of detainee care” at Mesa Verde, an independent and comprehensive investigation is necessary.⁵¹

VII. Mr. Ahn’s death illustrates a larger pattern: ICE disproportionately misuses solitary confinement against detainees with disabilities and other vulnerable groups, especially during the COVID-19 pandemic.

Further demonstrating the need for an independent investigation, reports by detainees at Mesa Verde, together with recent litigation, media reports, congressional findings, and the newest and most expansive empirical study on the subject to date suggest that Mr. Ahn’s death reflects a much deeper systemwide problem: ICE and their contractors have routinely abused medical isolation, disproportionately harming the most vulnerable detainees—such as people with disabilities and Black migrants—especially during the COVID-19 pandemic.

Following Mr. Ahn’s death, his dorm mates at Mesa Verde staged additional hunger strikes to protest the “mortal danger” posed by conditions there, highlighting that a detainee was placed in “solitary confinement cell for hours without any medical care.”⁵² Nevertheless, ICE and GEO continued to improperly subject detainees with disabilities to solitary confinement at Mesa Verde, ostensibly for purposes of medical isolation. Alton Edmondson, a Black detainee who has asthma, kidney issues, and a neurodevelopmental disability, was held in isolation for three weeks, including seven days in a windowless intake cell with no bed for up to 23 hours per day, in blatant violation of detention standards, and in conditions that the United Nations defines as torture.⁵³ Despite his known disabilities,

regarding “gross negligence” in medical care in ICE facilities that led to a death by suicide, among other things, and expressing concern that “no action was taken by ICE . . . to remedy the inadequacies that led to these horrific incidents”).

⁵¹ American Immigration Council, *Failure to provide adequate medical and mental health care*, *supra* note 41, at 4.

⁵² Joint Statement by the detained people at Mesa Verde (Aug. 6, 2020), <https://www.centrolegal.org/wp-content/uploads/2020/08/MV-COVID-19-Outbreak-Statement.pdf>.

⁵³ See Farida Jhabvala Romero, *ICE Misusing Solitary Confinement for COVID-19 Quarantine, Detainees Say*, KQED (Oct. 6, 2020)

he was also deprived of food in compliance with his religious diet, access to medical care, reasonable access to his family and attorney, and access to other amenities available to the general population—even though he repeatedly tested negative for COVID-19, and could have been placed in the dorms. In addition, he had blood in his urine for four months and was told he required specialty care, but never was given an appointment. ICE and GEO repeatedly changed their justification for placing him in solitary, and never supplied an explanation supported by facts.

Meanwhile, federal courts are recognizing the need for oversight. A federal district court recently issued a nationwide Preliminary Injunction, finding that systemwide conditions in ICE detention during the COVID-19 pandemic likely violated Section 504 and the Fifth Amendment rights of detainees with disabilities.⁵⁴ Concerned that conditions in ICE detention continue to subject class members with disabilities to a “substantial risk of death,” the court ordered ICE to “mandate that medical isolation and quarantine remain distinct from solitary, segregated, or punitive housing.”⁵⁵

In addition, a recent report by the House Committee on Homeland Security found widespread misuse of segregation in ICE detention against detainees with disabilities.⁵⁶ The Committee decried widespread failures in mental health care and specifically noted that ICE officials and contract employees “diminished past suicide attempts.”⁵⁷ Noting the deaths of multiple detainees by suicide in segregation, the Committee particularly highlighted the case of an individual, who, like Mr. Ahn, “could have been

<https://www.kqed.org/news/11841120/ice-misusing-solitary-confinement-for-covid-19-quarantine-detainees-say>.

⁵⁴ See *Fraihat v. U.S. Imm. and Customs Enforcement* 445 F. Supp. 3d 709 (C.D. Cal. 2020).

⁵⁵ See *Fraihat v. U.S. Imm. and Customs Enforcement*, Order Granting Motion to Enforce, No. 5:19-cv-01546-JGB-SHK (C.D. Cal. Oct. 7, 2020) (Dkt. 240).

⁵⁶ See U.S. House of Representatives, Committee on Homeland Security, *ICE Detention Facilities: Failing to Meet Basic Standards of Care* (Sept. 21, 2020), <https://homeland.house.gov/imo/media/doc/Homeland%20ICE%20facility%20staff%20report.pdf> at 3, 17, 19-20 (finding widespread misuse of segregation in ICE detention, and noting that “40 percent of those placed in segregation suffer from some form of mental illness.”).

⁵⁷ *Id.* at 17.

saved,” but instead of “being treated with . . . medication” was “remanded to segregation.”⁵⁸

Another congressional report reviewed recent internal audits of Mesa Verde “reveal[ing] a host of concerns regarding medical treatment that have gotten worse over the past three years.”⁵⁹ Turning to detainee deaths in solitary confinement in ICE detention generally, the report found “alarming similarities” between cases, including many of those present in Mr. Ahn’s case— detainees “were placed in solitary confinement despite having serious mental illnesses,” did not “receive recommended mental healthcare,” and then “officers failed to properly monitor their cells.”⁶⁰ The OIG has also recently found that staff at a different facility failed to properly monitor detainees in solitary confinement.⁶¹

Finally, a recent empirical study provided the first “systematic, nationally representative analysis” of the use of solitary confinement placements in ICE detention.⁶² In solitary confinement throughout ICE detention, the study found, “cases involving individuals with mental illnesses are overrepresented, more likely to occur without infraction, and to last longer, compared to cases involving individuals without mental illnesses.”⁶³ In addition, migrants from Black-majority countries are overrepresented by a

⁵⁸ *Id.* Mr. Ahn is the ninth person to die by suicide in immigration detention since ICE began publicly reporting in-custody deaths in fiscal year 2018. See ICE Detainee Death Reporting, <https://www.ice.gov/detainee-death-reporting> (accessed Feb. 25, 2021).

⁵⁹ U.S. House of Representatives, Committee on Oversight and Reform and Subcommittee on Civil Rights and Civil Liberties, *The Trump Administration’s Mistreatment of Detained Immigrants: Deaths and Deficient Medical Care by Staff* (Sept. 24, 2020), <https://oversight.house.gov/sites/democrats.oversight.house.gov/files/2020-09-24.%20Staff%20Report%20on%20ICE%20Contractors.pdf> at 24.

⁶⁰ *Id.*

⁶¹ Department of Homeland Security, Office of Inspector General, *Capping Report: Observations of Unannounced Inspections of ICE Facilities in 2019* (July 7, 2020), www.oig.dhs.gov/sites/default/files/assets/2020-07/OIG-20-45-Jul20.pdf.

⁶² See Konrad Franco, Caitlin Patler & Keramet Reiter, *Punishing Status and the Punishment Status Quo: Solitary Confinement in U.S. Immigration Prisons, 2013-2017* (April 27, 2020), <https://osf.io/preprints/socarxiv/zdy7f/> (forthcoming in *Punishment and Society*) (pre-print) (cited with permission of author)

⁶³ *Id.* at 13-17.

factor of 6.8 in solitary confinement when compared to the overall detained population, “suggesting the possibility of racialized differential treatment.”⁶⁴

VIII. An independent, comprehensive investigation into violations of the civil, constitutional, and disability rights of Mr. Ahn is necessary to hold ICE and GEO accountable for breaking the law, and to prevent additional needless suffering and death.

As described herein, Mr. Ahn was subjected to inadequate treatment and discriminatory conditions while confined at Mesa Verde. Specifically, the absence of appropriate treatment and the negligent use of administrative segregation violated federal law under Section 504, Mr. Ahn’s constitutional rights, and DHS policy. The evidence demonstrates that Mr. Ahn’s disabilities were unconstitutionally minimized, ignored, and dismissed. The conditions at Mesa Verde, combined with ICE and GEO’s gross misconduct, tragically led to Mr. Ahn’s suicide. Yet, Mr. Ahn’s experience was far from anomalous. His case illustrates a troubling pattern of failed oversight by ICE and its contractors in detention facilities across the state of California. Without swift and meaningful action by CRCL and the OIG, more individuals with disabilities will face serious and irreparable harm under DHS’s supervision.

For these reasons, DRC, Centro Legal, and CCIJ request that CRCL and OIG:

- (1) conduct an independent and comprehensive investigation into the circumstances at Mesa Verde that resulted in Mr. Ahn’s death, including an evaluation of medical and mental health care provided to him, the tracking and accommodation of his disabilities, and his placement in solitary confinement;

⁶⁴ *Id.* at 13 (finding that while migrants from Black-majority countries collectively represent only 3.64 percent of the population in ICE detention, 24.74 percent of solitary confinement cases involve individuals from those countries); *see also* Jhabvala Romero, *ICE Misusing Solitary Confinement*, *supra* note 16 (quoting study author Dr. Caitlin Patler as stating, “There might be some really problematic racialized practices happening within detention facilities where a situation involving a Black detained person results in solitary confinement much more frequently than we would expect based on their portion of the detained population.”).

- (2) conduct an independent and comprehensive investigation into the use of segregation (administrative, medical, and disciplinary) at Mesa Verde. The investigation should evaluate facility practices regarding the purpose and duration of segregation, as well as practices relating to medical and mental health assessments, particularly during the COVID-19 pandemic;
- (3) publish the results of your investigation so that Congress and the state of California can take appropriate action to hold ICE and GEO accountable for the violations of law that led to Mr. Ahn's death, address ongoing harms arising from the improper use of solitary confinement in California facilities, and prevent future deaths like Mr. Ahn's.

Sincerely,



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