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via Email

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Re: CONTINUED MEDICAL FAILURES AND WEAPONIZATION OF CARE AT MESA VERDE AND GOLDEN STATE ICE DETENTION FACILITIES

For years, physicians and detained people have condemned the abject medical care at two ICE detention centers in California's Central Valley–Mesa Verde ICE Detention Center ("Mesa Verde") and Golden State Annex Detention Facility ("Golden State").[1] This October, six Congressmembers "reiterate[d their] call for DHS to end contracts with GEO for Mesa Verde and Golden State" in light of confirmed "disturbing and ongoing reports" of deplorable conditions.[2] And two weeks ago, the California Department of Justice wrote to DHS Secretary Mayorkas and ICE Director Lechleitner, describing inspections that further corroborated that people detained at the facilities "face significant challenges in receiving adequate, quality care" due to "problematic practices."[3]

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[1] *See, e.g.*, Letter from Physicians for Human Rights, University of Colorado School of Medicine, University of Southern California Keck School of Medicine to Counselor to DHS Secretary Mayorkas, San Francisco ICE Field Office Director, Mesa Verde Facility Administrator, Golden State Facility Administrator, et al. (March 29, 2023), https://drive.google.com/file/d/1zzCyj2nvziCZ-ck04kiLKzs0IKejNRTt/view; James Anderson, *California ICE Detainee's Hunger Strike is Part of a Long Fight for Freedom*, Progressive International (Sept. 13, 2023), https://progressive.international/wire/2023-09-13-california-ice-detainees-hunger-strike-is-part-of-a-long-fight-for-freedom/en; Mesa Verde and Golden State Annex Resistance, History, https://sites.google.com/ccijustice.org/mv-gsa-resistance/about/history?authuser=0 (last accessed Dec. 13, 2024).

[2] Letter from Members of Congress of the United States to Alejandro Mayorkas, Sec'y, U.S. Dep't of Homeland Security, and Patrick J. Lechleitner, Acting Dir., U.S. Immigration and Customs Enforcement (Oct, 8, 2024), https://lofgren.house.gov/sites/evo-subsites/lofgren.house.gov/files/evo-media-document/10.8.24%20-%20Letter%20-%20Dangerous%20Conditions%20at%20GEO%20Detention%20Centers.pdf.

[3] Letter from California Attorney General Rob Bonta to Alejandro Mayorkas, Sec'y, U.S. Dep't of Homeland Security, and Patrick J. Lechleitner, Acting Dir., U.S. Immigration and Customs Enforcement (Dec. 3, 2024), https://drive.google.com/file/d/1B5LRuT-bS7DjB5sRGUGR6jvnBlCsj6yJ/view?usp=sharing.

Instead of addressing these failures, ICE and GEO have systematically utilized their excess of taxpayer dollars[4] to suppress any effort to publicize their "problematic practices." They have weaponized medical care[5] and employed physical[6] and sexual[7] violence to quell protests and avoid accountability.

Despite these threats, 21 people detained at Mesa Verde and Golden State came forward to undersigned authors throughout the past year to disclose their own accounts of the outrageously substandard care that persists at the facilities.[8] As one Complainant shared:

> I'm at the mercy of people that don't care if I live or die. They don't know my name. I'm an annoyance to them. I'm a mosquito to them. The people that are supposed to help me are the ones that ignore me.

I. BINDING STANDARDS OF CARE

ICE's contract authorizing GEO Group to operate Mesa Verde and Golden State requires the latter to "ensure that [detained people] receive no lower level of onsite medical care and services . . . based on community standards of care."[9] In addition to comporting with "community standards of care," medical services must also comply with the 2011 Performance Based National Detention Standards ("PBNDS"), the National Commission on Correctional Health Care standards, and the American Correctional Association standards.[10]

The PBNDS requires facilities to provide a "continuity of care" for chronic conditions, acute needs, and mental health, including making available twenty-four hour medical and mental health services.[11] If medical services cannot be provided on-site, they must instead be provided "with minimal wait times for community providers."[12] ICE's approval is required for *every* instance a detained person needs off-site care, except in emergency situations.[13]

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[4] *See* Jenny Huh, At McFarland ICE detention facility, tax dollars may have been misused, KGET (May 6, 2024), https://www.kget.com/news/local-news/at-mcfarland-detention-facility-tax-dollars-may-have-been-misused/.

[5] Complaint to OCRCL et al. by Parada Calderon, et al., *Weaponization of Medical Care to Suppress First Amendment Activities* (Sept. 24, 2024), https://www.ccijustice.org/es/2024-09-24-mv-gsa-medical-crcl.

[6] *See* Complaint to OCRCL et al. by Anonymous Complainants, *Excessive Use of Force, Retaliatory Dragnet Searches, and Other Abuses Against People Detained At Golden State Annex ICE Detention Facility on and after April 15* (Aug. 15, 2024), https://www.ccijustice.org/post/civil-rights-complaint-gsa-a4-raid; Complaint to OCRCL et al. by Adan Castillo Merino et al., *Retaliation Against Individuals in Immigration Detention at Mesa Verde Detention Facility and Golden State Annex* (Sept. 13, 2022), https://www.aclunc.org/sites/default/files/Mesa%20Verde%20-%20Golden%20State%20CRCL%20Complaint_09.22.pdf; Complaint to OCRCL et al. by Joe Mejia Rosas, et al., *First Amendment Retaliation Against Individuals in Immigration Detention* (Aug. 26, 2021), https://www.ccijustice.org/laf-08-26-22.

[7] Complaint to OCRCL et al. by Mr. B, et al., *Sexual Abuse, Gender-Based Harassment and Violations of Transgender Care Standards at the Golden State Annex Immigration Detention Facility* (Aug. 27, 2024), https://cdn.craft.cloud/5cd1c590-65ba-4ad2-a52c-b55e67f8f04b/assets/media/Programs/Immigrant-Rights/CRCL-Complaint-FINAL-9.3.2024_Redacted.pdf; Complaint to OCRCL et al. by Anonymous Complainants, *Sexually Abusive Pat-Downs Against Individuals in Immigration Detention at Mesa Verde Detention Facility* (Jan. 17, 2023), https://www.aclunc.org/sites/default/files/2023.01.17_Sexually_Abusive_Pat-Downs_Complaint_REDACTED.pdf.

[8] Out of fear of retaliation, these individuals identities' are anonymized in this Complaint. Undersigned authors will provide your offices with names, signed privacy waivers, and medical records releases upon request.

[9] *See* Reply by United States to Mot. to Dismiss, *Ahn v. GEO Group, Inc.*, No. 1:22cv-00586-CDB, at 64-1 p.2 (N.D. Cal. July 21, 2023).

[10] *Id.*

[11] *See* Performance-Based National Detention Standards ("PBNDS") 2011, Revised 2016 § 4.3.

[12] *Supra,* Footnote 10.

[13] *Id.* The contract also provides that ICE, and not GEO Group, pays the costs for all off-site care. *Id.*

During a four-month period this year, community organizations (including those of the undersigned authors) documented at least 80 violations of the PBNDS relating to medical care at Mesa Verde and Golden State–a number believed to be a gross undercount of the actual number of violations, due to access issues.[14]

II. STAFFING AND CONTINUED WEAPONIZATION OF MEDICAL CARE

ICE requires that GEO staff Mesa Verde and Golden State with at least one physician, one psychiatrist, one pharmacist, one dentist, and nine nurses.[15] However, the facilities appear to suffer the same shortages of medical workers seen nationwide and most acutely in rural settings,[16] an issue exacerbated by the difficulties of staffing correctional facilities generally.[17] As the below examples and bodies of independent research demonstrate, "'understaffing' is an untreatable symptom of mass incarceration–not a recruitment problem."[18]

Limits on Access to Care. Alarmingly, the facilities have implemented various measures to avoid providing needed medical care to detained people. At Golden State, staff frequently schedule medical appointments between 4:00am-6:00am when most individuals are asleep and with no advanced warning. A nurse informed a Complainant that the unit was receiving 30 sick calls per day,[19] and that because they could not handle the requests, they were calling individuals for appointments during the early hours in order to increase the odds that detained people would refuse their appointments. Staff even scheduled one Complainant's appointment on a federal holiday when no medical staff were working, and then subsequently closed his medical "request" despite not actually addressing it. Medical staff have also informed detained people that they can only submit one request for medical care per day, and that staff can address only one medical need per visit to the medical unit, even though requests for medical care take several days to be addressed.

One detained person at Golden State reported that the physician is *only* available on Monday, Tuesday, and Wednesday. One of many natural consequences of this limited window is that people are forced to wait up to five days to obtain new or refilled prescriptions.

Medical Mix-Ups. Earlier this year, undersigned author CCIJ alerted ICE and GEO to instances of people receiving incorrect ID cards, seeing incorrect information in their files, being called to medical appointments meant for others, and in at least one instance, receiving vaccines intended for someone else.[20] Despite our notification, these problems appear to persist: one Complainant reported being called into the medical unit to have his blood drawn for laboratory

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[14] S*tandards Violations Ticker, Mesa Verde and Golden State Annex Resistance*, https://sites.google.com/ccijustice.org/mv-gsa-resistance/standards-violations-ticker?authuser=0 (last accessed Dec. 13, 2024).

[15] *Supra,* Footnote 10.

[16] O'Connell-Domenech, Alejandra, *The U.S. is suffering a healthcare worker shortage. Experts fear it will only get worse*, The Hill (Sept. 28, 2023), https://thehill.com/changing-america/well-being/prevention-cures/4225960-the-us-is-suffering-a-healthcare-worker-shortage-experts-fear-it-will-only-get-worse/. *See also* Footnote 3 ("Health care staffing vacancies were common across many facilities and pose a challenge to solving many of the problems identified . . .").

[17] *See* Nam-Sonenstein, Brian, et al, *Why jails and prisons can't recruit their way out of the understaffing crisis*, Prison Policy Initiative (Dec. 9, 2024), https://www.prisonpolicy.org/blog/2024/12/09/understaffing/.

[18] Footnote 18.

[19] The population at Golden State Annex Detention Facility is currently around 450.

[20] Letter from ACLU Foundation of Southern California, et al. to ICE ERO San Francisco Field Office Director, et al. (March 11, 2024), https://www.ccijustice.org/advocacy-gsa-population-increase.

testing on three separate occasions. Staff refused to believe that he already had his blood drawn, and insisted on redrawing it each time.

Weaponization. At the same time, staff are abusing their positions to weaponize medical care against those they are paid handsomely to serve. Earlier this year your offices received a complaint documenting disturbing instances in which detention staff at both Golden State and Mesa Verde utilized medical isolation, medical transfers, and the denial of care in order to prevent people from speaking out about horrendous conditions of their confinement.[21]

Undersigned authors have since confirmed that medical care is also being weaponized to deprive detained people of their right to counsel. One Complainant at Golden State overheard Officer [redacted] telling Officer [redacted]

> [T]he director said that everyone who is a criminal here, we should give them warnings so that nobody takes their cases. We're already in agreement with medical providers so that they do not affirm what people are complaining about.

As your offices know, the nationwide class settlement in *Franco-Gonzalez v. Holder* requires that detained people who are found to be mentally incompetent by an immigration judge must be provided with counsel at government expense.[22] The settlement requires ICE to file with the immigration court mental health records from the detention centers, which immigration judges then use to determine competency. Considering the disconcerting examples described immediately below of mental health staff routinely recording accusations of malingering in medical records,[23] Officer [redacted] was likely referring to an "agreement" with the mental health providers to "not affirm" detained people's mental health symptoms, so that they would be deprived of access to counsel under the *Franco-Gonzalez* protections.

III. MENTAL HEALTH CARE

ICE's contract requires that GEO provide those detained at Mesa Verde and Golden State with "group counseling, individual talk therapy, peer-support groups, and psychiatric services to meet the needs of the population."[24] But instead of services adequate to meet their needs, Complainants revealed to undersigned authors that the care provided at the facilities only worsens their mental health symptoms. Moreover, their experiences strongly suggest that ICE and GEO are weaponizing mental health care at the facilities in order to deny access to counsel.

Golden State. At Golden State, individuals who require mental health support are referred to Dr. [redacted] the facility's psychiatrist. Over the past year and a half, undersigned authors CCIJ reviewed the medical records for 16 people who had been identified as potential *Franco* class members[25] and who experienced psychiatric services at Golden State. Of the 16 sets of records reviewed, 15 included recorded accusations by Dr. [redacted] that the detained person was narcissistic, malingering, drug-seeking, and/or otherwise feigning symptoms and past trauma.

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[21] Footnote 5.

[22] The class settlement in *Franco-Gonzalez v. Holder* provides that the government must provide, at their expense, counsel to represent mentally incompetent people. *See* No. CV 10-02211 DMG (DTBx), 2013 WL 3674492 (C.D. Cal. Apr. 23, 2013).

[23] *See infra*, Section III.

[24] Footnote 10.

[25] *See supra*, Section III & Footnote 23..

In one case, medical records reflect that Dr. [redacted] alleged that a Complainant was narcissistic and expressed skepticism as to his history of torture. Additionally, the noted behavioral observations varied widely, at times alleging that the person was fine and lying about their mental health needs, and at other times documenting mental health symptoms. Despite these claims, Dr. [redacted] diagnosed the person with depression and post-traumatic stress disorder ("PTSD"), and prescribed medication.

In a second case, Dr. [redacted] also diagnosed a Complainant with narcissistic personality disorder and labeled him as drug-seeking. After this individual received a new evaluation upon transfer to Mesa Verde, the psychiatrist there diagnosed him with adjustment disorders with mixed anxiety and depressed mood, raising competency concerns relevant for his Immigration Court removal proceedings.

In a third case, Dr. [redacted] mocked a Complainant enduring solitary confinement who suffers from auditory hallucinations ("AH") and visual hallucinations ("VH"). During their brief consultation regarding the voices, Dr. [redacted] taunted: "No one loves you. Tell the voices to care about you." When he alerted the psychiatrist that he would tell a lawyer about this misconduct, Dr. [redacted] simply shrugged it off. After the Complainant filed a grievance, ICE responded that they did not understand their complaint because it was in Spanish. Dr. [redacted] also included notes in the person's medical record alleging that his high depression and anxiety ratings were inconsistent with his presentation, adding also that the person "presented with typical gang-attitude." Other recorded accusations by Dr. [redacted] included that this person "continually reports AH & VH without any supportive evidence," and he diagnosed the individual with narcissism. Despite these allegations, Dr. [redacted] also diagnosed him with major depressive disorder, a history of hallucinations, adjustment disorder and unspecified psychosis, and prescribed medications.

The same Complainant also endured inadequate medical care after a dispensing nurse forgot to provide his Trazodone medication on time, which is used to manage and treat depression.[26] When she returned later that evening, he alerted her that the pill she dispensed was a different medication he was taking, but she insisted that it was Trazodone. As a result, he endured a sleepless night. Under PBNDS, "[a]ll prescribed medications and medically necessary treatments shall be provided to detainees on schedule and without interruption, absent exigent circumstances."[27]

In a fourth case, Dr. [redacted] noted in a medical record that the Complainant was more concerned about convincing him to write a letter for the judge than discussing his mental health, adding that he externalizes emotions on everything other than himself. Throughout the record, Dr. [redacted] repeatedly states that this individual never accessed mental health support during his time in prison, which he opines to be more challenging than detention, so he concludes that the individual "does not demonstrate Franco need." However, this individual had been taking mental health medication for two decades prior, and had also alerted medical staff at intake about his mental health needs and medications. Despite the allegations and misinformation Dr. [redacted] recorded in the medical records, he diagnosed this individual with persistent depressive disorder and provided medication.

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[26] Shin, Justin J., et al., *Trazadone*, Nat'l Library of Medicine (Feb. 29, 2024), https://www.ncbi.nlm.nih.gov/books/NBK470560/.
[27] PBNDS § 4.3(V)(U)(4).

The overall gap in equitable mental health assessments and services, plus the use of discriminatory language by medical staff, has serious implications for judicial competency inquiries. The Department of Homeland Security routinely files mental health records in Immigration Court, and undersigned authors are aware of several instances where Dr. [redacted] recorded accusations of malingering and narcissism influenced the Immigration Court's view on the credibility of an individual's health needs, history of violence, and/or competency. The biased and accusatory records also influence forensic competency evaluations performed by outside evaluators during some *Franco* inquiries. Moreover, the pervasive abuse of power, disdain for mental health needs, and deprivation of privacy has induced severe stress, paranoia, and anxiety among those seeking mental health support, which exacerbates distrust with medical support staff.

Mesa Verde. Meanwhile, because the vast majority of people detained at Mesa Verde were originally detained in Golden State, any interactions with Dr. [redacted] risk influencing transferred individuals' trust and ability to access services at Mesa Verde.

Mesa Verde itself has a documented history of failing to provide adequate mental health care as well. In May 2020, Choung Woong Ahn died by suicide while housed in solitary confinement there.[28] Although Mr. Ahn had disclosed suicidal ideation while at Mesa Verde and records documented prior suicide attempts, providers failed to place him on suicide watch or to provide other needed mental health treatment, resulting in his untimely death.[29]

Earlier this year your offices received a complaint from an individual in solitary confinement at Mesa Verde who requested an emergency mental health appointment during a time of acute mental distress.[30] At the end of his appointment with the psychiatrist, a nurse walked in and asked, "is he still talking shit?" Triggered, the person threw a can of Ensure at the wall and was soon after physically assaulted and threatened with death by over a dozen officers.[31]

IV. ACUTE AND CHRONIC NEEDS

Under the PBNDS, facilities "shall directly or contractually provide its detainee population with…2. Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services; 3. Comprehensive, routine and preventive health care, as medically indicated; 4. Emergency care; 5. Specialty health care; 6. Timely responses to medical complaints."[32] Moreover, the PBNDS also states that "when a detainee requires close medical supervision, including chronic and convalescent care, a written treatment plan, including access to health care and other care and supervision personnel, shall be developed and approved by the appropriate qualified licensed health care provider, in consultation with the patient, with periodic review."[33] Despite these requirements, multiple Complainants provided alarming details of

[28] Plevin, Rebecca, *'This death was preventable': Family asks state to probe 74-year-old's suicide in ICE detention*, Palm Springs 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/.

[29] *See* U.S. Dep't of Homeland Security, *Detainee Death Review Report: Choung Woung [sic] Ahn* (April 9, 2021), https://www.documentcloud.org/documents/24656097-part-1-selected-death-review-reports-and-related-documents-of-ice-detainees/#document/p471.

[30] Footnote 6.

[31] *Id.*

[32] PBNDS §§ 4.3(V)(A)(2-6).

[33] *Id.* at §§ 4.3(V)W).

inadequate medical care, including delays in approving medical procedures ranging from months to a few years.

Golden State. One Complainant at Golden State endured and consistently reported severe gastrointestinal pain with rectal bleeding since August of 2023 before medical staff ordered a colonoscopy. He did not receive ICE approval to obtain the colonoscopy over six months after reporting symptoms.[34] Additionally, medical staff never disclosed the results, nor scheduled follow ups.

A second Complainant was scheduled to undergo knee surgery in prison before being transferred to Golden State. Upon arrival in December of 2021, he requested that medical staff obtain his medical records from the prison to schedule the surgery. Although medical staff approved physical therapy, he did not receive the knee surgery until September of 2024, almost three years later. During this three-year period, the person endured chronic pain which limited his mobility. Moreover, while the person's surgeon recommended orthopedic therapy post-surgery, staff at Golden State have failed to coordinate these services as often as recommended.

The same Complainant also had an external eye appointment in August of 2024 where he was recommended to undergo eye surgery. When he submitted a medical request to follow up on the status of this appointment with GEO medical staff, they inexplicably responded with a message that because his medical consult was scheduled on a federal holiday and there was no medical staff present that day, they closed his request for medical care. Once he was able to engage with medical staff, they responded that ICE had long delays in approving surgery. The only alternative, according to Health Services Administrator ("HSA") [redacted] was to transfer him to a detention facility out of state as it "may" speed up the approval. Your office received a complaint earlier this year documenting HSA [redacted] pattern and expressly-stated intent of transferring detained people to detention facilities out of state for nonmedical reasons.[35] This person ultimately declined transfer given that relocation would prevent visits from his family or access to the legal services he was being provided. As of December 2024–four months later–his necessary eye surgery is still pending approval.

A third Complainant at Golden State was seen by medical staff for a spider bite on his left rib in August of 2024. He was prescribed antibiotics, which caused a rash-like reaction that spread throughout his body. During the next two months, this person sought emergency medical attention for the spreading rash by placing numerous sick calls, yet medical staff only provided Ibuprofen and acne ointment, claiming that the rash was induced by stress and without running any skin exams. Frustrated by the lack of adequate medical attention, this person followed up with HSA [redacted] multiple times, who responded that ICE had long delays for approval to see a dermatologist. Ultimately, this person engaged in a peaceful sit-in to request effective medical care from ICE officers and requested that they take photo and video documentation of the rash to help speed up the approval process. The person finally saw a dermatologist in October, two months after the initial medical consultation. The dermatologist requested that GEO medical staff conduct further blood work, which they have yet to complete.

A fourth Complainant suffered abuse during an arrest by a Border Patrol officer who pulled his arm out of its socket and then later forced him to clean his own vomit after he was sick from the pain. When this individual arrived at Golden State in February of 2024, he was only

[34] Footnote 10.
[35] Footnote 5.

given 200mg of Ibuprofen for the pain and waited two months for X-rays. Medical staff also neglected to provide a follow up about the results of the X-rays. He also waited five months for physical therapy, which only consisted of six one-hour sessions. By September, seven months after the assault, medical staff finally ordered an MRI, which confirmed the injury. The person's experiences with institutional violence followed by medical neglect impacted his mental health, resulting in having to seek medication for anxiety and insomnia.

A fifth Complainant at Golden State suffered a fall while shackled in a van during transportation to an external medical appointment in March of 2023, after the officers who placed him in the van neglected to buckle his seatbelt.[36] After he fell, GEO drivers refused to lift him off of the floor of the van for 45 minutes until highway patrol and an ambulance opened the van door and took him to a nearby hospital. At the hospital, he was told that his left hand and knee were fractured. Upon arriving back to Golden State later that day, he requested a wheelchair but medical staff responded that he was "fine" and gave him crutches instead. Months later, he slipped and fell on a wet area without a "wet floor" sign while using these crutches. This incident prompted GEO medical staff to finally provide a wheelchair for what was initially said to be nine months. Yet, a GEO officer later took the wheelchair away. The officer threatened the Complainant, "give me the wheelchair or I'll drag you out of it" and then pulled it out from under him. Under the PBNDS, "[i]n no event shall clinical decisions be made by non-clinicians"[37] and "detainees will be provided medical prosthetic devices or other impairment aids, such as eyeglasses, hearing aids, or wheelchairs."[38]

This same Complainant also waited five months for knee therapy and only received two 10-minute sessions. He also waited eight months to receive surgery that inserted twelve screws from his hand to his elbow. The surgeon recommended cleaning the surgical site daily post-operation to promote healing, but medical staff refused to clean it for two weeks because they did not want to have to take off and reapply the bandage. This Complainant was also unable to access pain medication as the surgeon prescribed.

A sixth Complainant at Golden State was denied medical attention until he vomited, urinated blood, and fainted. Under PBNDS, "in an urgent situation, the housing unit officer shall notify medical personnel immediately."[39] On April 5, 2024 the person alerted his unit officer that he was experiencing severe abdominal pain and urinating blood. The GEO officer noted the matter, but did not notify medical personnel. The next day, he vomited blood in front of a GEO officer who without any basis stated that he did not believe it was blood, but rather merely the color of condiments he had eaten. Due to the housing unit officer's refusal to notify medical personnel of the person's illness, the person was forced to make a medical request using the unit's tablets. He saw GEO medical staff who gave him an injection and electrolytes, which provided no relief. This individual was rushed to the hospital only when, that same day, he vomited, urinated blood, and fainted. His dormmates filed a collective grievance on the negligence in delaying urgent medical attention and highlighted that the GEO officer mocked the matter. At the hospital, the doctor alerted the affected individual that his appendix had ruptured and infected his blood stream, so they had to perform immediate surgery. They kept him under

[36] Although a GEO officer claimed that video evidence existed showing that GEO staff caused the incident by neglecting to buckle him in, they refused to provide the footage to the injured person.
[37] PBNDS § 4.3(V)(B).
[38] *Id.* at § 4.3(V)(W).
[39] *Id.* at § 4.3(V)(S).

observation while disinfecting his system for six days without allowing him access to a phone call. His family remained unaware of the life-threatening incident and procedure until he returned to the facility on April 11th.

A seventh Complainant shared that he was advised by a doctor, prior to his detention, to have routine CT-Scans every year, due to the build up of fluid in his head. While he was on a medley of medications before his incarceration, he has been offered little to no effective medication during his detention at Golden State Annex and has been denied consultation with a specialist. The Complainant's lack of adequate care has resulted in the deterioration of his memory, intense headaches that prevent him from sleeping at night, and painful constipation due to lack of a necessary special diet.

Mesa Verde. One Complainant at Mesa Verde reported visiting an oculist in January of 2024 who recommended cataract surgery. Upon waiting for approval from ICE, he asked a representative from the Office of the Immigration Detention Ombudsman ("OIDO") if she could help speed up the approval process, but the representative responded that she could only confirm that the request was made, and she never subsequently followed up with the person. By July, during a short-term transfer to an out-of-state facility, the oculist there scheduled surgery that same week due to the size of his cataracts. However, the person was transferred back to Mesa Verde before the surgery date. Back at Mesa Verde, medical staff told the person that a new policy requiring approvals before speaking to the facility's doctor made it more difficult to follow up on his need for surgery. Additionally, medical staff alerted the person that his "request" for surgery was "deleted" upon transfer, so they would have to restart the approval process, further delaying the surgery. He has now been waiting another four months for approval from ICE.

The above Complainant was also told by medical staff that they would request an MRI to evaluate his chronic back pain. When he requested a back brace, the nurse said she would place an order that would arrive in three weeks. At follow up six weeks later, the medical staff responded that there were no requests for a back brace in his medical record.

A second Complainant reported that medical staff at Golden State refused to administer an injection for back pain that he was able to get in prison because "it is too expensive." After the person was transferred to Mesa Verde, medical staff there responded that "ICE does not have a contract with clinics that administer those injections." Under the PBNDS, facilities should have policies and procedures of "a method for promptly approving and obtaining medicines not on the formulary."[40] Additionally, "The facility administrator, in collaboration with the [Clinical Medical Authority] and HSA, negotiates and maintains arrangements with nearby medical facilities or health care providers to provide required health care not available within the facility."[41] This highlights another case in which the facility administrator has neglected to coordinate access for essential acute care, which has resulted in persistent back pain.

A third Complainant at Mesa Verde told providers about his history of chronic kidney failure. Yet, the medical staff prescribed Topiramate (Topamax) for his migraines. Studies show

[40] PBNDS § 4.3(V)(G)(2).
[41] PBNDS § 4.3(V)(B).

that this medication is known to increase the risk of developing kidney stones.[42] After taking Topiramate for about six months, the individual began experiencing intense pain near his kidneys and had to abruptly stop the medication.

As the above examples demonstrate, medical and other detention staff at Mesa Verde and Golden State have a widespread practice of delaying or refusing services associated with acute or chronic health needs, further endangering the health of detained people in these facilities. Without access to timely care and service referrals or approvals, detained people are forced to endure pain, until and beyond the point where some individuals require emergency hospitalization.

V. PREVENTATIVE CARE

Dental Care. Medical staff at Golden State Annex have also delayed or denied access all together to important dental care. One Complainant reported that the filling in his molar fell out when he was in ICE detention at Golden State Annex. When he requested a new filling, the dentist at the medical unit told him he needed to be detained for more than a year to get dental assistance. The only exception, she said, would be if his molar got infected and needed to be removed. However, under the PBNDS, routine dental treatment is authorized after six months of detention.[43]

COVID-19. In late July 2024, several individuals at Golden State Annex, including people detained in dorms A-4 and A-2, reported COVID symptoms such as coughing, body aches, and fever to medical staff, and as a result they requested testing. However, medical staff refused to test them, and instead informed the sick individuals that they were probably having allergies.

Because of ICE and GEO's failure to take preventative measures, such as by testing these individuals for COVID and containing the people who test positive, COVID spread through Golden State Annex. In August, detained people in dorm A-4 reported that over a dozen people had gotten sick. One individual, who had high blood pressure and took 7-8 pills daily, noticed he was fatigued, coughing, and had a sore throat. He advised medical staff via a medical request on his tablet, but did not hear back. The next day, he went to the medical unit and complained about having fever, back pain, muscle soreness throughout his body, and uncontrollable trembling. Medical personnel gave him cough drops and Tylenol. The day after, he was running a fever of over 105 degrees and had trouble staying conscious. Only after his dormmates demanded he be cared for did GEO personnel take him to the medical unit. By August 13, several people had been hospitalized.

In response to the outbreak, GEO moved people in dorm A-1 into dorms A-2 and A-3, so that A-1 could be used as a quarantine dorm for people previously held in A-4 who were exhibiting serious symptoms. The people who were moved included people who were experiencing symptoms but had not been tested. By August 27, several people in A-2 had also tested positive,[44] and many individuals in A-3 exhibited symptoms but were refused tests despite requesting them. Undersigned authors also received information that detention staff sent people

[42] Welch, Brian J. et al., *Biochemical and Stone-Risk Profiles With Topiramate Treatment*, American Journal of Kidney Diseases, Vol 48, No 4 (October), 2006: pp 555-563, https://www.ajkd.org/article/S0272-6386(06)01162-0/pdf.

[43] PBNDS § 4.3, (V)(R)(2).

[44] These individuals were only able to obtain tests after filing grievances.

who were hospitalized with COVID back into their dorms within six days of their hospitalization, less than the 10-20 days recommended by the CDC.[45]

Detained people have also reported that GEO staff refused to provide them masks despite repeated requests, and that GEO staff refuse to wear masks themselves. As a result, it is possible, and perhaps likely, that staff were responsible for the spread of COVID throughout the dorms at Golden State Annex in July-August 2024. In fact, a group of hunger strikers, who were quarantined at the time of this outbreak from other detained people but not from GEO staff, exhibited COVID symptoms and had to quit their hunger strike.

On August 30, 2024, undersigned author ACLU of Southern California sent a letter to Field Officer Director Polly Kaiser of ICE's San Francisco Field Office, attorneys at the U.S. Department of Justice, and [redacted] [redacted] Facility Administrator at Golden State Annex. In that letter, the ACLU laid out the facts described above, expressed its strong concern about ICE and GEO's response to the outbreak of COVID at GSA, and asked that remedial measures be taken. GEO and ICE did not respond to the letter.

Unfortunately, four months after this outbreak, GEO's lack of preventative care for COVID has not changed. In October and November 2024, detained individuals reported that many detained people still exhibited COVID symptoms. Nevertheless, GEO often refused to test, and GEO personnel rarely, if ever, wear masks. Moreover, COVID vaccines remain difficult to access. Detained people report that 10 people have to sign up for the vaccine before GEO will administer it. As a result, people often have to wait for more than 30 days after their request to receive the vaccine. Several detained people reported that they are still suffering the painful effects of long COVID, such as fatigue and muscle spasms. One detained individual who got COVID and eventually pneumonia in September 2024 reported that three months later, he still has not recovered his voice and has difficulty speaking.

GEO and ICE's failure to provide preventative care to the people in their custody violates their own standards, as well as detained people's civil rights.

Failing to test symptomatic individuals before moving them throughout the facility violates ICE and CDC guidance. In its Post Pandemic Emergency COVID Guidelines and Protocols (the "ICE Guidelines"), ICE mandates that all detained individuals who have a fever or report COVID symptoms "will be tested."[46] This is consistent with the CDC's post-emergency guidance for mitigating the spread of COVID in congregate settings, which instructs facilities to "test residents and staff who have been exposed or are symptomatic."[47]

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[45] *See* CDC, *Infection Control Guidance: Duration of Transmission-Based Precautions for Patients with SARS-CoV-2 Infection*, https://www.cdc.gov/covid/hcp/infection-control/ (last visited Dec. 13, 2024).

[46] U.S. Immigration and Customs Enforcement and Removal Operations, Post Pandemic Emergency COVID-19 Guidelines and Protocols Version 3.0 (August 2, 2024), https://www.ice.gov/doclib/coronavirus/eroCOVID19PostPandemicEmergencyGuidelinesProtocol_08022024.pdf%20at%209 (emphasis added).

[47] Centers for Disease Control and Prevention, *Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities*, May 11, 2023, https://archive.cdc.gov/#/details?q=https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-correctional-settings.html&start=0&rows=10&url=https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-correctional-settings.html (last visited Dec. 13, 2024) (emphasis added). Although the CDC has archived this guidance, it has not issued any new or contrary recommendations regarding testing practices in congregate settings. As recently as March 2024, ICE cited this CDC guidance in district and asserted that Golden State Annex follows its terms. *See* Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction and Motion to Dismiss, *Jimenez v. U.S. Imm. & Customs Enf't*, 1:23-cv-06353- RMI, ECF No. 50 at 6 (N.D. Cal. Mar. 11, 2024).

The importance of testing symptomatic individuals before moving them between dorms should be obvious to ICE and GEO. For the past four years, ICE and CDC guidance has not changed: facilities have been required to test symptomatic individuals in congregate settings.[48] Moreover, a similar failure to test symptomatic individuals before moving them between dorms caused a devastating COVID outbreak at Mesa Verde. In August 2020, GEO staff moved symptomatic individuals between dorms at Mesa Verde without first administering tests. Over the following weeks, over half of the individuals detained at Mesa Verde were infected with COVID.[49] At the time, ICE and GEO refused to test even symptomatic individuals because they knew that they did not have sufficient space to appropriately cohort and quarantine people based on their results—in other words, they were afraid of what they would learn.[50] In holding that ICE and GEO's conduct during the August 2020 outbreak likely violated the Constitution, a U.S. District Court in the Northern District of California noted that ICE and GEO's failure to test symptomatic individuals "flew in the face not only of the advice of the facility's medical stuff but also of the CDC guidelines for detention facilities in effect at the time," and that "ICE's own medical expert testified that mixing symptomatic and asymptomatic detainees together … was likely a 'mistake.'"[51] It is unacceptable that four years later, ICE and GEO continue to make the same "mistake" at Golden State.

GEO's refusal to make masks available to those detained and refusal to require masks among staff is also a violation. ICE Guidelines explicitly provide that "[m]asks should be made available to noncitizens in ICE custody and staff" and, in instances where an individual has been hospitalized due to COVID or when "[t]he occurrence of COVID-19 cases at the facility on a scale that significantly impacts the availability of the facility to conduct normal operations"—as was the case at Golden State Annex—the facility must "[r]equire all noncitizens in ICE custody, staff, visitors, and any other persons in the facility to wear a well-fitting mask while indoors."[52] Such circumstances have been met in this instance.

Finally, when a detained individual tests positive for COVID, Golden State must offer COVID antivirals, such as Paxlovid and Lagevrio, which should be available to individuals detained at Golden State per ICE's Formulary.[53] Golden State should also provide people with vaccines upon request.[54] However, to the knowledge of undersigned authors, Golden State has failed to adequately test individuals, failed to provide COVID antivirals to people who test positive, and failed to provide vaccines to people despite requests.

COVID continues to pose a severe threat for people in California, and even more so for people detained at detention facilities where the virus can spread more easily.[55] ICE's own

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[48] *See, e.g.*, U.S. Immigration and Customs Enforcement, *COVID-19 Pandemic Response Requirements version 10.0* (Nov. 1, 2022), https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf at 18.

[49] *See* Plaintiffs' Reply Memorandum in Support of Order to Show Cause Why Preliminary Injunction Should Not Be Entered, *Zepeda Rivas v. Jennings*, 3:20-cv-02731-VC, ECF No. 799 at 16 (N.D. Cal. Nov. 10, 2020).

[50] *Zepeda Rivas v. Jennings*, 504 F. Supp. 3d 1060, 1068—69 (N.D. Cal. 2020).

[51] *Id*. at 1069.

[52] ICE Guidelines at 9-10.

[53] *See* U.S. Dep't of Homeland Security, ICE Health Service Corps: FY 2024 Medication Formulary for non-IHSC Staffed Detention Facilities, https://www.ice.gov/doclib/about/offices/ihsc/pdf/medicationFormularyNonIHSC.pdf.

[54] U.S. Immigration and Customs Enforcement and Removal Operations, Post Pandemic Emergency COVID-19 Guidelines and Protocols Version 3.0 (August 2, 2024), https://www.ice.gov/doclib/coronavirus/eroCOVID19PostPandemicEmergencyGuidelinesProtocol_08022024.pdf at 14.

[55] Los Angeles Times Staff, *Tracking COVID-19 in California*, Los Angeles Times, https://www.latimes.com/projects/california-coronavirus-cases-tracking-outbreak/ (last updated Nov. 2, 2024)

standards acknowledge that COVID can still lead to severe health outcomes, including "severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock, and multi-organ failure," despite the availability of vaccines and the declared end of the pandemic. It is essential for ICE and GEO to take immediate action to prevent the further spread of COVID.

Failure to provide conditions adequate to ensure the basic safety of individuals in civil immigration detention violates the Constitution's Due Process Clause requirement of ensuring adequate medical treatment.[56] If ICE is unable to provide this necessary care or lacks sufficient space to separately quarantine individuals who have tested positive for COVID from those who have not, it should release people from custody until the population reaches a level at which it can comply with its own guidance and meet its constitutional obligations.

VI. SANITATION AND HYGIENE

In December 2022, the California Occupational Safety and Health Administration ("Cal/OSHA") investigated, cited, and fined GEO for numerous workplace violations at Golden State.[57] At least one of GEO's violations was found to be "willful," resulting in a fine of over $100,000. The fine marked the first time Cal/OSHA penalized a private detention operator for workplace violations.

Yet, the issues cited and fined two years ago persist. Cal DOJ's inspections of Mesa Verde and Golden State last year found concerns over "haphazard" facility sanitation practices.[58] Their letter to DHS and ICE also noted the "use of lower quality cleaning materials, which at Golden State reportedly did not remove mold from showers, and at Mesa Verde reportedly led to two cases of fungal infection."[59]

During a weeks-long period in August and September of this year, the medical unit at Golden State was plagued by a putrid, rotten smell. Medical staff informed a Complainant that they believed the smell to be from a decomposing carcass in the vents, but when the person asked what was being done about it, he received no response. The smell was so pungent that Dr. [redacted] [redacted] the facility's only doctor, refused to remain in the medical unit to evaluate whether the Complainant was cleared of shingles, a viral infection that can be spread from person to person. After proclaiming "I can't work in here" and storming out, Dr. [redacted] authorized the Complainant to be released back to his dormitory without even conducting an evaluation.

Detained people have also noted that medical staff do not handle biohazardous substances properly. One Complainant noted seeing a bag full of blood vials to be sent out for laboratory testing sitting on a desk, unrefrigerated, for at least four hours. The same person also reported seeing the same bag of used needles sitting on the floor of the unit each time he visited the unit over a three-day period. Another report stated that the water jug used by detained people to take pills in the medical unit was full of black mold. When the Complainant informed Officer [redacted] about the mold, she rushed out of the unit, slamming the door. The person then tried to inform a nurse in the unit about the issue, but the nurse stated that she was not actually supposed to be in the unit, and did not act to clean or change out the water jug.

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[56] *See e.g.*, Roman v. Wolf, 977 F.3d 935, 943 (9th Cir. 2020); *Youngberg v. Romeo*, 457 U.S. 307, 315-316 (1982).
[57] *See* U.S. Dept. of Labor, Occupational Safety and Health Admin., Inspection No. 1609228.015, Inspection Detail, https://www.osha.gov/ords/imis/establishment.inspection_detail?id=1609228.015 (last visited Aug. 12, 2024).
[58] Footnote 3.
[59] *Id.*

VII. LANGUAGE ACCESS

Lack of interpretation for monolingual Spanish-speakers. During undersigned authors' investigation for this Complaint, at least seven people, all monolingual Spanish-speakers, reported attending medical visits for both mental and physical health assessments that lacked interpretation or were primarily conducted in English. An eighth person reported that the after-visit summaries he received were only in English. Under the PBNDS, expected practices include "[s]taff or professional language services necessary for detainees with limited English proficiency (LEP) during any medical or mental health appointment, sick call, treatment, or consultation."[60]

The usage of interpretation for Spanish-speaking individuals varies significantly across both Golden State and Mesa Verde. One Complainant at Golden State shared, "About four times they spoke to me in English and I didn't understand more than half of what they were saying." Another Complainant at Mesa Verde reported, "There have been many times I've been alone in medical trying to understand what they're saying . . . They don't give me interpretation over the phone." Three additional monolingual Spanish-speaking Complainants report that they have almost never been provided with interpretation while seeking medical care. Other Complainants shared that interpretation was sometimes provided, but not always.

The consequences are obvious: lack of language assistance and interpretation in the medical unit has prevented detained individuals from expressing their medical needs, receiving adequate evaluation of pain and discomfort, and meaningfully participating in and advocating for their own wellbeing with medical staff. On one occasion, a monolingual Spanish speaker who was experiencing great levels of pain was not able to meaningfully express to medical staff his needs or understand his medical visit due to lack of interpretation.

Even in the instances that interpretation was used, its quality and effectiveness varied. One Complainant reported being provided a telephonic interpreter, but that it was incredibly difficult to hear and understand what the interpreter said. Moreover, the summaries and care instructions routinely provided after medical appointments are written only in English, with no Spanish translation. One Complainant did not understand what the cause of his symptoms were or the status of his health, and could not refer to his after-visit summaries for this information because they were never translated or interpreted back to him.

Another detained person who is bilingual in English and Spanish reported to undersigned authors being called by GEO officers to interpret between staff and detained people, multiple times a day and under various circumstances: during or after physical altercations, in which he is expected to both translate and deescalate, as well as during medical appointments, pill call, and consultations. During one such incident, a monolingual Spanish-speaking individual was attempting to communicate to a nurse that she was giving him the wrong medication in the morning. The nurse did not provide him with interpretation, and the bilingual speaker was required to intervene. While the person who sought to correct his medication requested that the bilingual speaker interpret for him–given the lack of alternatives available to him–this is a violation of the PBNDS standard that states, "Where appropriate staff interpretation is not available, facilities will make use of *professional* interpretation services. Detainees shall *not* be used for interpretation services during any medical or mental health service. Interpretation and translation services by other detainees shall only be provided in an emergency medical

[60] PBNDS § 4.3(V)(A)(8).

situation."[61] The bilingual speaker reported that he and other bilingual detained people are regularly called upon to interpret for medical personnel, raising significant concerns about staff's repeated violations of medical privacy.[62]

Lack of interpretation for speakers of other languages. For those who speak neither English nor Spanish, it is even more difficult to obtain the medical attention and assistance they require. The Complainant referenced above in Section IV, who experiences a build up of fluid in his head, has never been provided an interpreter in the language in which he is fluent. Instead, he is only ever offered an interpreter in a language he does not speak fluently, or he is expected to continue with his medical appointment in English, a language he knows very little of. The Complainant's lack of adequate care has resulted in the deterioration of his memory, intense headaches that prevent him from sleeping at night, and painful constipation due to lack of special diet. He shared, "[I]t's not possible to communicate my needs . . . . They do not care. They say it doesn't matter." Instances like these call into question whether facility medical staff are respecting the PBNDS[63] and medical ethical standard of informed consent when evaluating and administering treatment to monolingual non-English speakers, who report not being given adequate language to engage and communicate with said providers.

There is no meaningful difference between the medical interpretation services provided at Golden State and Mesa Verde. A non-English/non-Spanish monolingual speaker shared that the lack of adequate interpretation at Mesa Verde has made it difficult to understand his medical appointments, which have included mental health appointments, dental care, and physical checkups.

Non-English/Non-Spanish speakers reported being further barred from advocating for their own health and rights in detention, due to their inability to file grievances in their primary language. Undersigned authors have spoken to several detained people who confirmed that there is no way to make grievances on the facility issued tablets in languages such as Mandarin, for example, and that GEO staff regularly decline to help them write and submit grievances. This violates the PBNDS standard that requires "procedures are in place to provide [] assistance to detainees with impairments or disabilities, interpretation/translation services for detainees who [have limited English proficiency], and assistance for detainees with limited literacy."[64] Even Spanish speakers have encountered difficulty lodging complaints, as exemplified by ICE's claim, described above, that it could not understand a detained person's grievance about Dr. [redacted] because it was written in Spanish.[65] A Complainant illustrated the facilities' approach to caring for individuals in their custody, especially those with different language needs, "There's many people here that need help and don't speak English. They transfer them, ignore them, and that's not okay."

VIII. RECOMMENDATIONS

The systemic problems described in this complaint cannot be cured simply by more adequate staffing. As explained in a recent policy briefing:

[61] PBNDS § 4.3(V)(E). (emphasis added)
[62] *See, e.g.*, PBNDS § 4.3(V)(L) ("Medical and mental health interviews, screenings, appraisals, examinations, procedures, and administration of medication shall be conducted in settings that respect detainees' privacy.").
[63] PBNDS § 4.3(V)(D).
[64] § 6.2(C)(3)
[65] *See supra*, Section III.

> When there are fewer workers than necessary to operate facilities as planned, correctional authorities cut back on the things staff are needed to manage, and conditions get worse . . . As conditions deteriorate, fewer people want to work in these facilities. Decarceration should seem like the obvious way to break the cycle, but it's readily dismissed by corrections leaders whose livelihoods depend on mass incarceration.[66]

Indeed, the *only* way to ensure that the people detained at Mesa Verde and Golden State receive adequate medical and mental healthcare is to free them and end the contracts for both facilities. To that end, we recommend that your offices:

1. Urge ICE to end the contract authorizing GEO Group to operate Mesa Verde and Golden State. In the interim:
2. Recommend ICE stop detaining people at Mesa Verde and Golden State;
3. Recommend ICE free individuals who are unable to access *adequate* and *comprehensive* medical and mental health care, by competent medical providers, in languages that they understand;
4. Ensure compliance with community standards of medical care;
5. Ensure compliance with the PBNDS provisions regarding medical care, and recommend that the PBNDS is revised as indicated immediately below;
    a. Prohibit the penalization of First Amendment-protected activity, referred to as "[e]ngaging in or inciting a group demonstration" in the PBNDS.[67] Undersigned authors have requested this recommendation in prior complaints to your offices.[68]
    b. Prohibit the use of solitary confinement, referred to as "administrative segregation" in the PBNDS, "for medical reasons" and make clear that "medical isolation" does not warrant confinement in a solitary cell.[69] All forms of solitary confinement are torturous.[70]
    c. Explicitly require that routine dental treatment be required to people in ICE custody, regardless of length of detention.[71]
    d. Explicitly require that after-visit summaries from medical and mental health appointments be translated for non-English speakers.[72]

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[66] Footnote 18.
[67] *See* PBNDS § 2.2, Appendix 2.2.D(II)(213).
[68] *See* Footnotes 5, 6.
[69] *See* PBNDS §§ 2.12(V)(A)(1), 4.2(II)(4).
[70] *See* Andrew Sheeler, *'Solitary confinement truly is torture.' Bill to restrict it, vetoed by Newsom, is reintroduced*, The Sacramento Bee (Jan. 24, 2023), https://www.sacbee.com/news/politics-government/capitol-alert/article271642677.html?ac_cid=DM754670&ac_bid=1956508522; Tiana Herring, *The research is clear: Solitary confinement causes long-lasting damage*, Prison Policy Initiative (Dec. 8, 2020), https://www.prisonpolicy.org/blog/2020/12/08/solitary_symposium/; Press Release, United Nations Human Rights Office of the High Commissioner, United States: Prolonged solitary confinement amounts to psychological torture, says UN expert (Feb. 28, 2020), https://www.ohchr.org/en/press-releases/2020/02/united-states-prolonged-solitary-confinement-amounts-psychological-torture.
[71] *See* PBNDS § 4.3(V)(R)(2).
[72] *See id.* at § 4.3(V)(A)(8).

6. Ensure compliance with the provisions outlined in ICE's post-pandemic emergency guidelines, and recommend that it be revised to require detention staff to wear masks in both facilities; and
7. Urge ICE to direct GEO to meet the demands of people detained at Mesa Verde and Golden State for *consistent* access to *adequate* cleaning supplies, which detained people have been requesting at both facilities for the majority of this past year;
8. Ensure that ICE and GEO take additional remedial measures as necessary, including but not limited to remedial measures mandated by Section 504 of the Rehabilitation Act; and
9. Press ICE and GEO to provide to undersigned authors and Complainants video footage of all incidents involving physical injury described above, including but not limited to the video footage described in Footnote 36.

We thank you for your attention and eagerly await your response.

Sincerely,

Emily Almendarez
Ana Linares Montoya
Kathleen Kavanagh
Priya Arvind Patel
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