ROBERT F. KENNEDY HUMAN RIGHTS

December 10, 2024

VIA CERTIFIED MAIL AND E-MAIL
Office of the General Counsel
U.S. Department of Homeland Security
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U.S. Department of Health and Human Services
Office of the General Counsel
200 Independence Avenue SW
Room 713-F
Washington, DC 20201
HHS-FTCA-Claims@hhs.gov

Re: Notice of Claim for Damages under the Federal Tort Claims Act

CORTES DE LA VALLE, Daniel, A#[redacted]

Dear Sir or Madam:

Enclosed, please find an administrative claim under the Federal Tort Claims Act ("FTCA") against the United States government for the extreme suffering, severe pain and distress, and other harms inflicted upon Mr. Daniel Cortes De La Valle ("Mr. Cortes De La Valle" or "Daniel") as a result of severe medical neglect, physical abuse, sexual assault, verbal abuse, retaliation, and inhumane use of solitary confinement by Immigration and Customs Enforcement ("ICE") at the Central Louisiana ICE Processing Center in Jena, Louisiana ("CLIPC") and during the deportation process through Alexandria, Louisiana and Houston, Texas. The U.S. government is responsible for the actions of its employees, including those employed by ICE, under the FTCA.

Sarah Decker, Staff Attorney with Robert F. Kennedy Human Rights, represents Mr. Cortes De La Valle and serves this complaint on his behalf. Mr. Cortes De La Valle seeks an award of damages to compensate for the harms he sustained in connection with the medical negligence and

events related to inhumane use of solitary confinement and other forms of sexual, physical, and verbal abuse.

As described in detail in the enclosure, while detained under ICE's control, Mr. Cortes De La Valle was repeatedly denied adequate medical care by ICE, including medication and treatment for his seizure condition, resulting in the deterioration of his physical and mental health. As punishment for his self-advocacy and the multiple grievances and complaints he filed, ICE subjected Mr. Cortes De La Valle to retaliatory and inhumane solitary confinement, physical and verbal abuse, sexual assault, and threats of torture. This abuse caused Mr. Cortes De La Valle significant physical and psychological harm.

ICE, ICE employees, ICE contractors, and other individuals and entities acting on behalf of the U.S. government knew or should have known that their acts, omissions, and conduct constituted mistreatment, inadequate care, and gross medical negligence. Accordingly, ICE is responsible for the egregious treatment of Mr. Cortes De La Valle.

Sincerely,

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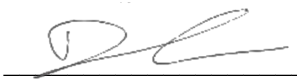
Claim Authorization Form

I, Daniel Cortes De La Valle, hereby authorize Sarah Decker and Robert F. Kennedy Human Rights to submit a claim under the Federal Tort Claims Act on behalf of myself to the U.S. Department of Homeland Security, including U.S. Immigration and Customs Enforcement, and any other government agency, seeking compensation for the unlawful actions of their employees or against me.

DATED: December 10, 2024



Daniel Cortes De La Valle

FTCA Standard Form 95 – Attachment
Claimant: CORTES DE LA VALLE, A#203-085-888

1. **Date and Day of Accident/Incident**

   December 12, 2022- December 5, 2023

2. **Time (A.M. or P.M.)**

   N/A, Multiple Incidents

3. **Basis of Claim**

Factual Basis of FTCA Claim

Daniel Cortes De La Valle ("Mr. Cortes De La Valle" or "Daniel"), a native and citizen of Colombia, first entered the United States in 1998 as an eight-year-old child. He settled in South Florida, where he lived in the United States for over 25 years and raised two United States Citizen children. In 2019, Daniel began to suffer from an undiagnosed seizure condition, resulting in several prior admissions to the emergency room and recurring seizures every three to four months. A prior electroencephalogram ("EEG"), a test that measures electrical activity in the brain, detected seizure activity and a neurologist prescribed Daniel medications to manage his seizures. Daniel's neurologist was in the process of determining a full diagnosis and medical treatment plan when Daniel was taken into criminal custody following an arrest in South Florida. Daniel was taken into custody by the Department of Homeland Security ("DHS"), Immigration and Customs Enforcement ("ICE") on December 13, 2022. He was detained continuously at the Central Louisiana ICE Processing Center ("CLIPC") in Jena, Louisiana, until on or about November 21, 2024. CLIPC is an immigration detention facility that is operated through a contract between ICE and private prison company, the GEO Group, Inc ("GEO"). Medical care at the facility is directly provided onsite by ICE's Health Service Corps ("IHSC").

During his one-year in immigration custody, ICE and its contractors at CLIPC repeatedly denied Daniel access to his seizure medications; delayed his access to a neurologist; failed to adequately respond to multiple medical emergencies; and subjected him to egregious medical neglect. Throughout his detention at CLIPC, Daniel was also repeatedly denied access to a lower bunk in the housing unit, despite his approved "special needs" designation due to his seizure condition. CLIPC's repeatedly forced Daniel to sleep on an upper bunk, placing him at high risk of suffering from a life-threatening fall and injury. This mistreatment resulted in the mismanagement and aggravation of Daniel's life-threatening seizure condition. During his detention at CLIPC, Daniel endured over 40 episodes of seizures or seizure-like activity, resulting in frequent hospitalizations. In response to Daniel filing multiple complaints and grievances reporting this medical neglect, ICE and their contractors pursued a campaign of egregious retaliation against Daniel, repeatedly issuing threats of physical torture, subjecting him to sexual assault and harassment, and placing him in punitive solitary confinement. ICE and its contractors created and maintained a hostile environment that placed Daniel's life at extreme risk and resulted in his physical and mental deterioration.

Fearing for his life in ICE custody, Daniel abandoned his legal claims for relief from removal in immigration court and requested voluntary departure, resulting in the permanent separation of Daniel from his United States citizen family, including his two young children. When ICE transported Daniel to Houston, Texas, to be processed for deportation, they subjected him to further abuse and medical neglect, including the denial of access to his seizure medications, resulting in multiple severe seizures and two additional hospitalizations. Daniel was deported to Columbia on December 5, 2023. In effectuating Daniel's removal from the United States, ICE failed to provide him with a 30-day supply of his seizure medications, resulting in him suffering multiple seizures in Colombia.

Abuse at the Central Louisiana ICE Processing Center in Jena, Louisiana

On December 13, 2022, Daniel was transferred from criminal custody to ICE custody at CLIPC. During this initial transfer, ICE denied Daniel access to his seizure medications, Keppra and Depakote, for a period of over 48 hours. On or about December 25, 2022, Daniel began having seizures in ICE custody at CLIPC, resulting in frequent emergency hospitalizations.

Between December 2022 and January 2023, Daniel filed multiple grievances with ICE, GEO Group, and the DHS Office of the Immigration Detention Ombudsman ("OIDO") related to the denial of consistent access to his seizure medications, denial of access to a neurologist, and other forms of medical neglect. On February 3, 2023, an ICE officer, upon information and belief, ICE Officer Allen spoke with Daniel about the grievances he had filed and threatened him, stating that if he continued to complain, he "could get deported." ICE then placed Daniel in a solitary confinement cell and eliminated his access to non-legal phone calls. On this date, while in the solitary confinement cell, Daniel had a seizure and was taken by ambulance to the Rapides Regional Medical Center in Alexandria, Louisiana. In the ambulance, Daniel was escorted by three GEO officers who harassed him and openly mocked his seizure disorder. One officer stated to a nurse at the hospital, "Hey, guess which ones are fake?" to which she replied, "Oh, I guess he is just a regular now."

When admitted at the Rapides Regional Medical Center, two GEO officers handcuffed and chained Daniel to the hospital bed by his wrists and ankles for a full 24 hours per day. The officers used short, metal handcuffs instead of the longer medical restraints available at the hospital. For five consecutive days, from February 3, 2023, through February 8, 2023, Daniel remained chained to the hospital bed and was not permitted to walk, stretch, move, use the bathroom, or shower. The GEO officers kept Daniel restrained in handcuffs during his repeated seizures, causing injury and severe pain to his back, legs, and arms. The restraints prevented Daniel from moving and resulted in wounds and bruises to his wrists and ankles, as well as an injury to his thumb. During this five-day period, Daniel was forced to urinate and defecate on himself while strapped to the hospital bed and was denied access to the shower. He was also severely restricted in his ability to eat and drink due to the restraints. The inability to move, lack of hygiene, and repeated injury during his seizures caused Daniel acute emotional distress.

During his hospitalization at the Rapides Regional Medical Center, on February 6, 2023, Daniel asked the GEO officers if he could use the bathroom to defecate. The officer replied, "No,

captain's orders" and refused to allow Daniel to access the bathroom. After Daniel, strapped to the hospital bed, was forced to urinate and defecate on himself, a hospital technician approached him and stated: "We have to clean you grandma-style." Daniel then repeatedly asked the hospital technician if he could clean himself. The technician and the GEO officers refused to temporarily release Daniel from his restraints so he could clean himself. Instead, the technician pulled down Daniel's pants without his consent. The technician then groped Daniel's testicles and used his fingers and hands to touch his genitals. The technician also inserted his finger into Daniel's anus. This was an emotionally and psychologically traumatic incident for Daniel, who endured a vivid post-traumatic stress disorder ("PTSD") episode because of the nonconsensual touching and penetration of his genitals. Following this incident, Daniel began to experience debilitating anxiety, depression, and suicidal ideation. The next day, on February 7, 2023, in a "post-ictal" state (the period of time after a seizure when a person is recovering), Daniel attempted suicide by wrapping a nearby IV cord around his neck and repeatedly slamming his head into the side rails of his hospital bed.

On February 8, 2023, Daniel was examined by a neurologist at the Rapides Regional Medical Center who performed an EEG test and confirmed that suspected seizure activity had been detected in Daniel's brain. The neurologist increased Daniel's dosage of Keppra and Depakote and prescribed Ativan, a third medication to manage seizures. The neurologist also referred Daniel for further diagnostic testing and treatment during a follow up appointment to be scheduled by ICE. The discharging physician further recommended an inpatient psych placement to address Daniel's suicidal ideation and adjustment to his psychiatric medication treatment plan. That same day, Daniel was discharged from Rapides Regional Medical Center and returned to CLIPC. During processing, two GEO officers, including upon information and belief, Sergeant Parrot, ordered Daniel to strip naked. The officers then began recording Daniel using a video camera and began to mock and harass him, instructing him to "pose" state who he is "for the camera." Daniel refused and the officers escorted him to the housing unit. CLIPC failed to provide Daniel with sufficient mental health treatment following his suicide attempt at the hospital. Daniel then filed a Prison Rape Elimination Act ("PREA") complaint detailing this camera incident during processing and the February 6, 2023 incident at Rapides Regional Medical Center.

On February 9, 2023, Daniel verbally reported the February 6, 2023, incident to Commander Krug, upon information and belief, an IHSC medical provider, and Melissa McClain, upon information and belief, a Licensed Social Worker employed by ICE at CLIPC. Neither individual took any further action. That same day, Daniel began a hunger strike to protest his medical neglect and mistreatment by ICE, including ICE's failure to schedule a follow up appointment with a neurologist. He continued this hunger strike for five days, until February 14, 2023. On February 23, 2023, Daniel was escorted to an appointment with an external neurologist, who was unable to reach a definitive diagnosis and noted that additional diagnostic testing was required.

On February 24, 2023, a medical provider at CLIPC administered Daniel his seizure medication mixed with a crushed blue pill that Daniel believed to be a psychiatric anxiety medication. Daniel had previously stopped taking this medication because it caused severe negative side effects, including increased suicidal ideation. When Daniel asked the medical provider what was in his medication, she replied "none of your business." Daniel then

communicated that he did not want to take the anxiety medication because of the negative side effects but did want to take his seizure medication. The nurse refused and entered an order that Daniel had "refused all medication," denying him access to his seizure medication. Daniel then spoke with an ICE officer, upon information and belief, Officer Miller, who dismissed his concerns and took no further action. The next day, on February 25, 2023, a GEO officer approached Daniel and said: "You got any complaints? I hear you like to complain a lot. Keep your mouth shut and stop complaining."

On March 1, 2023, Daniel was taken to the LaSalle General Hospital in Jena, Louisiana to receive emergency care after having another series of seizures in ICE custody. At the hospital, the GEO officers stated "Let's see if your seizures are fake." The two GEO officers then held Daniel down as medical personnel inserted a needle into the right side of his tibia (shin bone just below the knee) and inserted an IV port into the bone marrow of his leg using a drill without any anesthesia or pain management. They used the port to administer Ativan, a medication used to treat seizures. This caused Daniel excruciating, debilitating pain. He screamed and begged the officers to release him before losing consciousness. The procedure was performed without consent. When Daniel regained consciousness, a medical provider at the hospital said to him "I bet you won't have seizures again." The next day, Daniel experienced continued, severe pain radiating down his leg. He was unable to walk and his leg and knee became visibly swollen and bruised. A doctor at LaSalle General Hospital ordered an x-ray but Daniel was never taken to receive the scan.

Daniel was discharged from LaSalle General Hospital on March 2, 2023 and returned to CLIPC. At CLIPC, three nurses and a paramedic entered the medical unit in the facility. When Daniel attempted to issue a verbal complaint about the medical neglect and mistreatment he had endured, they replied: "Calm down. If not, we are going to send you back to the hospital and they'll stick a needle into your bone again." On March 7, 2023, Daniel received an auto reply closing the approximately 20 grievances and complaints he submitted to ICE via the facility tablet grievance system. On March 10, 2023, Daniel did not receive his seizure medication for the entire day. The next day, he submitted an additional complaint via phone call to OIDO's hotline. During the call, several ICE officers listened in on Daniel's conversation and then went to his unit and searched his belongings, including his legal documents. From March 11-14, 2023, Daniel engaged in another hunger strike to protest the summary denial of his grievances by ICE.

On March 12, 2023, Daniel requested medical treatment at CLIPC after experiencing symptoms indicating the onset of seizure activity. A nurse came to examine him at approximately 4:00 pm but told Daniel that he was "fine" and mockingly asked him "Are you having your spells again?" The nurse refused to provide him with medical treatment. Approximately one hour later, Daniel suffered a severe seizure and the medical personnel called the paramedics. The IHSC nurses and local paramedics then told Daniel that if he "didn't cooperate" they would "drill a hole through his knee bone again."

On March 14, 2023, Daniel did not receive his morning dose of seizure medication until 12:45 pm. He then suffered a severe seizure and was taken to the hospital for emergency medical care. From March 17-22, 2023, Daniel engaged in another hunger strike to protest CLIPC's refusal to provide him with copies of his medical records. On March 20, 2023, a nurse at CLIPC again attempted to administer Daniel's seizure medication mixed with an anxiety medication. As a result,

Daniel was again denied access to his seizure medication. On March 22, 2023, Daniel endured another series of severe seizures. Two GEO officers began to verbally harass Daniel by mocking him and imitating his physical reactions to the seizures. They told Daniel "We are doing the '*Dan Shuffle-Truffle*,' the dance you do when you are having your seizures." Daniel was seizing and in medical distress for approximately 40 minutes before the facility staff finally called an ambulance. He overheard a paramedic say to a GEO officer, "He's just faking it, you need to deport him." During this month, Daniel made repeated attempts to connect with local reporters interested in documenting his abuse. Upon information and belief, CLIPC blocked Daniel's calls and repeatedly prevented him from speaking with reporters.

On April 2, 2023, Daniel had multiple seizures that required emergency treatment. Daniel regained consciousness in the medical unit at CLIPC, where officials had left on the floor on a urine-soaked mattress. The room that Daniel was held in, Room 2 in the CLIPC medical ward, was in egregiously unsanitary condition. The mattress in the room was covered in black stains, old vomit, and urine. Daniel observed black mold throughout the perimeter of the room. The porcelain toilet in the room was covered in black fecal matter. When Daniel requested a clean mattress, the facility forced him to lie on the naked steel frame of the bed for over three hours. After two days in the medical ward, Daniel was approached by medical and facility staff who told him that they "needed the bed for other sick people" and that they "did not have room for him in the medical ward." They then transferred Daniel to a solitary confinement cell in the Segregated Housing Unit, where he was held for at least four days with limited medical monitoring and in punitive conditions without access to the recreational yard.

On, April 5, 2023, Daniel had another seizure at CLIPC while in solitary confinement. After the seizure, Daniel experienced severe pain in his head, wrist and elbow. The next morning, a GEO officer told Daniel, "You hit your head yesterday when you had your seizure." CLIPC medical staff did not provide Daniel with any medical or diagnostic care for his head injury.

On April 6, 2023, at approximately 2:00 pm, Daniel was approached by a PREA Supervisor, upon information and belief, Officer Butler. Officer Butler approached Daniel while he was in the medical unit waiting for treatment. She said "I hear you are making these accusations" and approached Daniel in an aggressive and extremely hostile manner. As a result of Officer Butler's demeanor, Daniel did not feel safe and stated that he would like to be accompanied by his legal representative before proceeding with the PREA intake. Officer Butler replied, "I'm done," and walked away. As a result of Officer Butler's hostile and aggressive behavior, the PREA intake – a legally mandated requirement of the PREA investigation under PREA Standard 115.22(a) – was never conducted.

On April 6, 2023, CLIPC also prevented Daniel from attending a legal rights presentation provided by non-profit legal service providers. After intervention with the facility, Mr. Cortes De La Valle was permitted access to the non-profit attorneys for a legal visit. During the legal visit, Daniel had a seizure and required emergency treatment. During his seizure, two legal service providers witnessed a CLIPC nurse and a GEO officer mocking and imitating Daniel and failing to provide an appropriate and timely response to his medical emergency.

On April 8, 2023, after a seizure, at approximately 9:00 pm, Daniel experienced sharp pain in his lower back that radiated up to his shoulder and down his arm. He began to lose sensation and mobility in his arm and observed that his hand began to turn purple because of lack of circulation. He also experienced tingling in his face. From his solitary confinement cell, Daniel was forced to bang on his cell door for over 15 minutes before an official came to his cell. A nurse entered Daniel and told him "you are fine," at which point the nurse left Daniel in his solitary confinement cell, without any further medical treatment or evaluation. Again, on April 15, 2023, Daniel felt a burning and tingling sensation on the right side of his face again. He lost the ability to speak or read, and lost consciousness in his cell. CLIPC did not provide any medical treatment to Daniel during this time and he was left unattended in the solitary confinement cell.

On May 12, 2023, Daniel was taken to an outside medical provider, a neurologist at the Louisiana State University Health, Shreveport, Monroe Medical Center ("LSU Shreveport"). In the morning before being put on the transportation vehicle, Daniel asked an officer to be provided with his medication for his epilepsy. Daniel tried to explain that he must take his medication at specific times. The medication is necessary and critical to prevent seizures. Daniel was not provided with his seizure medication and as a result, had a seizure while at the medical provider. When Daniel had the seizure at the medical provider, officials kept him fully shackled and the medical provider had to repeatedly ask that ICE/GEO remove the shackles. Daniel experienced severe pain and had visible cuts on his wrists as a result of having the seizure while fully shackled.

On May 18, 2023 at approximately 9:00 am, Daniel suffered from a seizure and lost consciousness for four hours. He regained consciousness at 1:00 pm and was in a medical isolation cell. An ICE agent (upon information and belief "Agent Mike") stuck his head through the food slot in the door and began harassing Daniel. The ICE officer repeatedly referred to a grievance Daniel had previously filed with ICE about his medical care and other violations of his rights. The ICE officer then told Daniel in a threatening and hostile manner, "You are going to apologize to everyone in this unit." Daniel replied "Yes sir" and asked to go back to his dorm. Approximately one hour later, a GEO officer escorted the same ICE officer into the cell. The ICE officer entered the cell screaming and repeatedly and intentionally clapping his hands loudly in Daniel's face. By making these loud repeated noises, the ICE officer triggered Daniel to have a seizure and he again lost consciousness until 3:00 pm. On May 20, 2023, the same ICE officer approached Daniel in the recreation yard in an aggressive and hostile manner and said "Hey Danny, what's up? How are you feeling?" This was witnessed by several other detained individuals in the Owl-Alpha dorm.

After he was examined by the neurologist on May 12, 2023, a Nurse Practitioner at LSU prescribed Daniel with a new seizure medication, Lamictal 25 mg tablet with the instruction that "if a rash develops while taking, stop immediately." On May 30, 2023, Daniel developed a severe, painful rash on his face and body and experienced significant pain and an increase in the frequency of his seizures. His symptoms also include increased loss of the ability to speak and extreme sensitivity to light and sound. He had at least five seizures in the three day time period between May 29, 2023 through June 1, 2023. The significant increase in Daniel's seizure activity and severe complications were related to his recent change in medication, which required monitoring and follow up care with the external neurologist. CLIPC denied Daniel's multiple requests for medical treatment that week, including the need for urgent evaluation and contact with his neurologist at LSU Shreveport.

On May 29, 2023, after suffering from a seizure, Daniel overheard two nurses taking his vitals. One nurse instructed the other to “use this number not that one” referring to Daniel's blood pressure reading and forging the results in order to deny access to medical care.

On May 31, 2023, Daniel reported having a severe seizure and was unconscious and left unattended by CLIPC officials in the dorm Owl-Alpha for over one hour. After fellow detained people in Daniel's dorm repeatedly requested medical assistance, CLIPC personnel and medical staff came to the dorm an hour after Daniel began seizing. They instructed the detained individuals to put Daniel on a plastic stretcher and, as they took him out of the housing unit, the other detained people in Owl-Alpha witnessed CLIPC personnel and medical staff laughing and joking and making mock ambulance noises as they removed Daniel from the dorm. Daniel regained consciousness over one hour later on the floor of a cell in the medical unit.

On June 2, 2023, after experiencing multiple severe seizures, Daniel woke up in a medical isolation cell covered in his own urine at approximately 7:30 am. He immediately requested that medical personnel provide him with access to the shower, cleaning supplies, clean sheets, clean clothes, and a bag for his soiled clothing. After approximately 45 minutes, a nurse provided Daniel with only a handful of sanitizing wipes but refused to provide clean sheets, clean clothes, or a bag for his soiled clothing. The odor in his cell became so putrid, that when medical staff came to Daniel’s cell three times to deliver his medication, instead of providing Daniel with a clean environment, they wore face masks to shield themselves from the odor. Daniel did not receive access to a shower or a clean cell until 9:30 am the next day, on June 3, 2023. For a full 24 hours, he was forced to lie in his own urine without access to the shower, clean clothing, a clean mattress or clean sheets.

On June 11, 2023, CLIPC officials failed to provide Daniel with the proper dosage of his seizure medication, Lamotrigine. Instead of receiving the full dose of three 25 mg pills, Daniel only received one pill. CLIPC personnel told Daniel that he was only receiving one pill because the facility “forgot to order the medication.” Daniel did not receive any additional doses of his seizure medication on that day and as a result, he did not receive his full dosage of seizure medication for over 24 hours. The next day, on June 12, 2023, again, CLIPC personnel told Daniel that they could not provide him with his seizure medication because they “forgot to order the medication.” As a direct result of this denial of medication, Daniel began to feel sick and developed symptoms including dizziness and lightheadedness. He then had a severe seizure in the late morning and lost consciousness until 3:00 pm. During his seizure, Daniel suffered an injury to his back and leg, causing severe pain and bruising. In addition, ICE failed to provide Daniel with his prescribed 30-day follow up appointment with his neurologist at LSU.

On June 23, 2023, Daniel had a seizure and woke up in solitary confinement in a medical isolation cell. The cell had black mold on the toilet, green mold covering the walls, rotting food on the floor, and thousands of ants crawling on the floors and bed. Daniel woke up covered in ant bites. He repeatedly complained to officials, including IHSC Commander Harris and NOLA ICE AFOD Reaves, and facility personnel came and mopped the room hours later.

On July 6, 2023, Daniel had recurring back-to-back seizures for over one hour. Instead of overseeing Daniel's medical care in the medical unit, medical personnel at CLIPC placed Daniel back in his housing unit, Owl-Alpha, because the medical unit was "at full capacity." In the housing unit, Daniel again suffered a severe seizure and was transported to LaSalle General Hospital for emergency medical care. At LaSalle General Hospital, Daniel was given Ativan, a seizure medication, and Percocet, a prescription pain medication. He was discharged from the hospital at approximately 5:00 am. Upon being returned to CLIPC on July 7, 2023, instead of being provided with care and monitoring in the medical unit, Daniel was taken back to the housing unit Owl-Alpha where he was wheeled into the dorm in a wheelchair while unconscious by two GEO officers. Other detained individuals witnessed these GEO officers dump Daniel out of the wheelchair, where he was left unconscious in the housing unit without any monitoring, observation, or medical care.

Three hours later, at approximately 8:00 am, detained individuals in Daniel's dorm observed that he remained unresponsive and unconscious and made multiple requests for an emergency medical response. Two GEO officers then came to the dorm and began shaking and slapping Daniel across the face. Detained individuals overheard the officers say, "Is he alive? Is he breathing?" The officers did not provide an appropriate medical response and did not take Daniel to the medical unit. After approximately 20 minutes, Daniel regained consciousness and was instructed by the officers that he had to go to immigration court, despite Daniel's request to see medical. At the time, he had a severe headache, debilitating pain in his skull, back, and shoulders, and was unable to walk without assistance. Instead of providing Daniel with access to medical care, the GEO officers forced him to go to immigration court. He walked to court with the assistance of another detained individual. Daniel then suffered another severe seizure in immigration court while waiting for his master calendar hearing. Daniel lost consciousness for the next 5 hours and was taken back to the housing unit at CLIPC.

On July 11, 2023, Daniel suffered a seizure while in ICE custody at CLIPC and severely injured his head and shoulder after losing consciousness and falling. CLIPC did not place Daniel in the medical unit because the "medical unit was full" and instead placed him in his housing unit, where he suffered another severe seizure. At approximately 9:00 pm, Daniel attempted suicide at CLIPC by wrapping a sheet around the window of a medical isolation cell and attempting to hang himself. He told CLIPC personnel that he wanted to harm himself but CLIPC personnel did not provide Daniel with any mental health treatment and instead took him to LaSalle General Hospital for emergency medical treatment for his seizure where he received Ativan, a seizure medication. Daniel was discharged that evening and taken back to CLIPC. Instead of being provided with access to mental health care, Daniel was placed back in the housing unit.

On July 12, 2023, Daniel suffered another seizure in the morning and regained consciousness fully restrained and strapped to a stretcher in the hallway of the medical unit in the afternoon. He was left in the hallway of the unit because, according to CLIPC officials, there was no available space for him in the medical unit. In a post-ictal (post-seizure) depressive state, Daniel again attempted suicide in the hallway of the medical unit by attempting to suffocate himself by pushing his neck against the strap of the stretcher. The officers called "code blue" and a nurse responded by grabbing the strap of Daniel's stretcher and violently shaking him. The nurse then placed his hand over Daniel's mouth and face and violently slammed his head into the stretcher

using excessive force. The officers then called a "code red" and told Daniel that they were "pressing assault charges" because Daniel "assaulted a nurse," despite the fact that Daniel was fully restrained during this incident and was himself physically assaulted by the nurse. Daniel did not touch the nurse or any officer during this incident and was fully restrained, indicating no threat of harm to the nurse or any other individual. Upon information and belief, there is a stationary video camera in the CLIPC medical unit hallway that recorded and documented this incident. The officers then put Daniel in a wheelchair and handcuffed him behind his back. Daniel suffered a severe seizure while handcuffed in the wheelchair and, because he was handcuffed and could not catch his fall using his arms, his head and face slammed into the floor when he fell. He was then taken back to LaSalle General Hospital for emergency treatment.

On July 13, 2023, Daniel regained consciousness at LaSalle General Hospital in the evening. He told LaSalle General Hospital medical staff that he was suffering from severe suicidal ideation and needed mental health assistance. LaSalle General Hospital medical personnel told Daniel "we can't do anything about that here but we will tell ICE to put you on suicide watch." During his transport from LaSalle General Hospital to CLIPC, Daniel began to experience intense medical distress and began screaming "I want to die, I want to kill myself." He began slamming his head into the wall of the vehicle, resulting in further injury to his head. Upon his arrival at CLIPC, Daniel was placed in a suicide watch medical isolation cell. From July 13, 2023 through July 17, 2023—a period of over 96 hours—Daniel was held in a solitary confinement cell with the lights on 24 hours per day, further aggravating his seizure condition. On July 15, 2023, Daniel heard a Licensed Social Worker at CLIPC say to an officer "He [Daniel] wants to control everything, so leave the lights on." After Daniel filed multiple grievances, CLIPC personnel finally shut the lights off in his cell at night on July 17, 2023.

During this time, Daniel was held in a medical isolation cell in punitive conditions, without access to recreation time, the shower, or running water for at least five days. In addition, the cell Daniel was held in was in egregious condition. The walls were covered in black mold, there was blood and fecal matter in the cell, and the cell was infested with biting ants. On July 14, 2023, a GEO officer commented to Daniel "there are ants all over the floor" but that officer did nothing to clean the cell or address the ant infestation. Daniel's arms, legs and face were covered in inflamed and painful ant bites. During this time period, Daniel was also denied access to the phone, including calls to his legal representatives.

On or about July 18, 2023, ICE sentenced Daniel to 30 days in disciplinary segregation for "threatening a staff member" and "interfering with staff duties." He was not permitted to have undersigned counsel present at his disciplinary panel hearing. Daniel participated in a hunger strike from July 18, 2023, through August 6, 2023 to protest his placement in disciplinary segregation.

On July 18, 2023, Daniel suffered a seizure in immigration court while handcuffed, resulting in severe injury to his arms and head. As a result, he was unable to attend his immigration court hearing. Again at approximately 6:00 pm, Daniel had another seizure while on a legal phone call with his legal counsel, Sarah Decker. Undersigned counsel witnessed a GEO officer inadequately respond to Daniel's medical emergency. The officer slowly approached Daniel, who was seizing on the floor in view of the camera, and used his foot to repeatedly prod him without taking his vitals or providing any medical response. The officer then ended the video call. Daniel's

uncontrolled seizure condition repeatedly prevented him from attending his immigration court hearings. On July 7, 2023, and July 18, 2023, Daniel was unable to participate in his immigration court master calendar hearings because he had severe seizures during immigration court.

On July 19, 2023, an ICE officer, upon information and belief, Officer Mendez, came to Daniel's cell, opened the door slot and stated: "We are going to sit here and talk all day. I can also lay on the floor, spit out of my mouth and shake all day. I have a really bad temper and you should know that by now. How come I haven't deported you yet?" After this incident, Daniel filed a grievance and requested to have no further contact with Officer Mendez. The next day, Officer Mendez returned to Daniel's cell and said "You have to speak with me. I'm the officer here." He then turned the lights on in Daniel's cell and told the nearby officers "Make sure his light always stays on." Daniel filed another grievance. The light in his cell remained on for 24 hours per day, causing Daniel pain and psychological distress. The constant light further aggravated his seizure condition.

During this time, in late July 2023, Daniel began experiencing increased neurological degradation as a result of his frequent, uncontrolled seizures. He began to experience increasing speech and memory issues, loss of vision and lost the ability to control the left side of his body.

On September 25, 2023, after suffering a seizure, Daniel was returned to the Hawk-Alpha housing unit and was assigned to a top bunk, despite his medical accommodations for a lower bunk. When he informed a GEO officer, Sergeant Dubois, that he needed a bottom bunk because of his seizure disorder, he refused and replied "Try not to fake one tonight." Daniel then suffered a seizure in the housing unit that night and was moved to a medical observation cell, where officials put him, unconscious, on a mattress on the floor. On September 26, 2023, Daniel began to experience suicidal ideation and reported it to the medical providers at CLIPC. Officers brought him to the medical unit but Dr. Fort said "I don't want him here" and the officers put Daniel in a solitary confinement cell instead in the Segregated Housing Unit. In that cell, Daniel attempted suicide by hanging himself. Officials then brought him to a suicide watch cell in the medical unit where he endured another seizure. Daniel was held in the suicide watch cell for five days with no mattress and the lights on 24 hours per day. Despite repeated requests to speak with mental health providers, Daniel was denied access to sufficient mental health care. He continued to suffer near daily seizures in the solitary confinement cell.

On October 6, 2023, Daniel began to experience symptoms of a seizure while in the Hawk-Delta housing unit. Officials placed him in a medical observation cell for three hours and then sent him back to the housing unit. Daniel started to feel sick and told an official that he needed to go back to the medical unit. He then collapsed, hitting his head on the floor, and lost the ability to move his limbs, though he remained conscious. The officials called "code blue" and a nurse asked the official "He didn't hit his head, right?" The official replied "no," despite the fact that Daniel had hit his head on the floor. The nurses and official then put Daniel on the stretcher and jokingly remarked "We have to pick him up again." As the nurses and officials transported Daniel down the hall to the medical unit, Daniel felt sharp pain in his legs and feet. He then opened his eyes and saw that his feet were hanging off the stretcher and the officials were repeatedly and intentionally slamming the stretcher against the wall in the hall between the Hawk-Delta housing unit and the

medical unit. Upon information and belief, there is a stationary security camera that recorded and documented this incident. The nurse then replied "Look at him, he's up. I bet he felt that shit."

When the nurses arrived with Daniel at the medical unit, the CLIPC medical providers said "Who is it?" to which the nurses replied "Guess who?" When the medical personnel said "Daniel" the nurses jokingly cheered and said "Ding, ding, ding! Winner, winner, chicken dinner!" The medical personnel did not take his vitals or access his head injury. Instead, they dumped Daniel off of the stretcher and onto a mattress in a medical observation cell. Daniel began to experience severe chest pain and started banging on the cell door to request medical attention. After 30 minutes of pleading for medical treatment, the medical personnel provided him with an EKG test and told Daniel they would follow up. They then brought Daniel back to the Hawk-Delta housing unit and did not further testing. Daniel never received any diagnostic care or treatment for his head injury.

On November 5, 2023, Daniel had a seizure in the CLIPC recreational yard while playing soccer and hit his head on the metal goal post. He regained consciousness in the medical unit but was not provided with any diagnostic care or treatment for his head injury.

Abuse by ICE during the deportation process

Following months of life-threatening medical neglect, physical abuse, verbal threats, placement in solitary confinement, and retaliation, Daniel relinquished his claims for immigration relief from removal and was granted pre-conclusion voluntary departure by an immigration judge pursuant to 8 C.F.R. § 1240.26. On November 22, 2023, at approximately 2:30 am, ICE transported Daniel from CLIPC to the Alexandria Staging Facility ("Alexandria") in Alexandria, Louisiana. At Alexandria, Daniel was forced to remain in an unventilated, freezing cold van, fully shackled, for approximately 14 hours while he waited to be transported to the airport for his removal to Colombia. During this time, ICE failed to provide Daniel with access to any of his medications, including his seizure medications. He was also denied access to food, water, and the bathroom for 14 hours. He was then placed on a bus from Alexandria to Texas. Daniel was then boarded into a transportation van and driven five hours to an ICE facility in Houston, Texas, the Houston Processing Center. He was shackled in five-point restraints for the duration of his transportation by ICE. During this time, he experienced severe pain in his wrists and back and experienced emotional distress. He witnessed as fellow detained people were denied access to the bathroom and were forced to soil themselves. During this transportation process, ICE denied Daniel access to his seizure medications, from 2:30 am on November 22, 2023, until 10:00 pm on November 23, 2023—a total period of 20 hours.

Once Daniel arrived at the Houston Processing Center ("Houston"), an ICE facility operated under a contract with private prison company, CoreCivic, he made multiple requests for access to his seizure medication. He received access to one of his medications, Keppra, at approximately 10:00 pm. Daniel then had a severe seizure in Houston a few days later on or about November 26, 2023, and was hospitalized for approximately two days. He was then discharged from the hospital and held in the medical unit at Houston. He had another severe seizure a few days later on or about December 1, 2023, and was taken back to the hospital for emergency care. Approximately two days after his discharge from the hospital, on December 5, 2023, Daniel was

processed for removal. He was again shackled in five-point restraints and transported back to Alexandria by bus, where he boarded a removal flight to Colombia. ICE again denied Daniel access to his medication during the transportation process.

When deporting Daniel, ICE failed to provide him with a 30-day supply of his medications, including his seizure medication, as is required by ICE's Performance Based National Detention Standards. As a result of ICE's failure to provide Daniel with a 30-day supply of his medications, following his removal to Colombia, Daniel was unable to access his seizure medication for approximately four weeks and suffered at least three seizures during this time period. In April 2024, a neurologist at a medical provider in Colombia conclusively diagnosed Daniel with frontal lobe epilepsy.

Legal Basis of FTCA Claim

A. Medical Negligence

ICE had a duty to ensure adequate medical care. As a direct and proximate result of the inadequate, substandard medical testing, treatment, and supervision provided by physicians and other health care providers employed by and/or agents of ICE, Mr. Cortes De La Valle suffered extreme physical, mental, and emotional pain and distress.

B. Negligence, Gross Negligence and Recklessness

ICE had a duty to maintain safe conditions for Mr. Cortes De La Valle. ICE also had a duty to ensure that those detained received adequate medical care. ICE breached its duties by failing to ensure safe, and humane conditions. As a direct and proximate result of ICE's negligent, grossly negligent, and reckless acts, omissions, and conduct, Mr. Cortes De La Valle was subjected to months of suffering without access to medical care or adequate supervision to ensure his safety and wellbeing. ICE's negligence, gross negligence, and recklessness caused Mr. Cortes De La Valle to suffer extreme and extended physical, mental, and emotional pain and distress.

C. Negligence Per Se

ICE had a duty to ensure that those detained received adequate care and supervision that adhered to standards. ICE breached its duty by failing to meet these standards. As a direct and proximate result, Mr. Cortes De La Valle suffered extreme and extended physical, mental, and emotional pain and distress.

D. Negligent Supervision

ICE had a duty to prevent its employees or agents from causing physical harm to a third party. ICE breached its duty by failing to ensure safe, humane, and sanitary conditions when Mr. Cortes De La Valle was in their custody. As a direct and proximate result of ICE's acts, omissions, and conduct, Mr. Cortes De La Valle was subjected to medical neglect, physical abuse, threats and retaliation, and the inhumane use of solitary confinement. ICE's negligence

and gross negligence caused Mr. Cortes De La Valle to suffer extreme physical, mental, and emotional pain and distress.

E. Intentional Infliction of Emotional Distress

ICE is responsible for intentional or reckless conduct that was extremely outrageous and caused severe emotional distress to Mr. Cortes De La Valle.

F. Intentional Infliction of Physical Harm

ICE is responsible for conduct that caused a physical impact on Mr. Cortes De La Valle that caused physical injury, and the injury caused Mr. Cortes De La Valle mental suffering or emotional distress. ICE's acts, omissions, and conduct directly resulted in severe physical pain and suffering to Mr. Cortes De La Valle.

G. False Imprisonment

ICE is responsible for conduct that constitutes false imprisonment, which is the intentional confinement or detention of another, without his consent and without proper legal authority.

H. Assault and Battery

ICE is responsible for intentional conduct involving the use of physical violence, which constitutes battery. Assault is an attempt to commit a battery, or the intentional placing of another in reasonable apprehension of receiving a battery.

I. Other Causes of Action

This is not intended to be an exhaustive list of possible causes of action, including attorneys' fees, *Bivens* claims, violations of 42 U.S.C. §§ 1983 and 1985, violations of 18 U.S.C. § 242, violations of Section 504 of the Rehabilitation Act, violations of the Fifth Amendment Due Process Clause, and violations of the Convention Against Torture. Mr. Cortes De La Valle reserves the right to assert these and other claims in an appropriate forum at an appropriate time, to the extent not already asserted.

11. Witnesses

Other individuals who were detained at CLIPC between December 12, 2022 and November 22, 2023 are witnesses to these incidents. Some individuals working at CLIPC during between December 12, 2022 and November 22, 2023 are witnesses to these incidents.

Upon information and belief, some of the incidents described above were captured by stationary security cameras at the facility and video footage exists to substantiate these claims of abuse. On March 29, 2023, through undersigned counsel, Mr. Cortes De La Valle submitted an record preservation request to NOLA ICE, including Field Office Director Mellissa Harper and Deputy Field Office Director Scott Ladwig. This letter requested recipients take prompt and

affirmative measures to maintain, preserve, and safeguard against the disposal, destruction, or damage of any and all records related to Mr. Cortes De La Valle's allegations or involving any party in the incidents described.

13B. Phone Number of Person Signing the Form

Sarah Decker, (908) 967-3245