GOVERNMENT ACCOUNTABILITY PROJECT

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November 14, 2024

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The Honorable Alejandro Mayorkas
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Office of the Immigration Detention Ombudsman
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VIA ELECTRONIC SUBMISSION

RE: Protected whistleblower disclosure of gross mismanagement of a federal contract, gross waste of federal funds, abuse of authority relating to a federal contract, substantial and specific danger to public health or safety, and violation of law, rules, and regulations related to a federal contract by the Baker County Detention Center in Florida

To Whom it May Concern,

Government Accountability Project submits this protected whistleblower disclosure and retaliation complaint on behalf of Ms. Vera Goodwin,[1] APRN, FNP-BC, FMACP (Provider Goodwin), with the U.S. Congress, the Office of Civil Rights and Civil Liberties (CRCL) of the Department of Homeland Security (DHS), and the DHS Office of the Immigration Detention Ombudsman (OIDO). Provider Goodwin has also submitted this disclosure to the DHS Office of Inspector General (DHS OIG) as a retaliation complaint and whistleblower disclosure, seeking investigation pursuant to 41 U.S.C. §4712.

Provider Goodwin, a Nurse Practitioner, is a whistleblower, and this disclosure is protected under federal whistleblower laws. Provider Goodwin, who served as a medical provider at the Immigration and Customs Enforcement (ICE)-contracted Baker County Detention Center in Macclenny, Florida, suffered reprisal in August 2023 by her employer, Armor Correctional Health Services, Inc. ("Armor") and its contracting partner the Baker County Sheriff's Office ("BCSO"), for her protected disclosures in violation of 41 U.S.C. §4712.

The Baker County Detention Center ("Baker") has a long history of abuse, dating at least as far back as its designation as an ICE facility in 2009. Provider Goodwin's disclosures illustrate that the abusive mismanagement by the BCSO and its contractors has systemically harmed those in its custody with impunity, including through medical mistreatment and neglect, falsification of medical records, violent treatment of noncitizens amounting to torture, violations of the Prison Rape Elimination Act, violations of ICE's guidance on the use of solitary confinement, and unsafe and unsanitary conditions of detention such as lack of drinking water, insufficient menstrual and other hygiene products, and denial of access to showers.

Recent inspection reports by ICE's own Office of Detention Oversight validate Provider Goodwin's disclosures, including findings of persistently deficient monitoring of detained persons placed on suicide watch, delayed responses to grievance complaints submitted by detained individuals, a lack of hunger strike training in 2023, and failures to complete required medical screening.[2] Additionally, a September 2024 report from the DHS OIG following an inspection at Baker both validates Provider Goodwin's disclosures and reveals that the OIG found many problems she identified to be ongoing, including failure to appropriately respond to requests of

[1] Vera Goodwin is a pseudonym for our client who wishes to remain publicly anonymous, fearing ongoing retaliation for her protected whistleblowing. Provider Goodwin is available for briefings with Congress and oversight entities with assurances that her identity will be kept confidential.

[2] "Office of Detention Oversight Follow-Up Compliance Inspection 2024-002-278," U.S. Department of Homeland Security, U.S. Immigration and Customs Enforcement, Office of Professional Responsibility (April 23-25, 2024), https://www.ice.gov/doclib/foia/odo-compliance-inspections/2024-BakerCounty-MacclennyFL-April.pdf; "Office of Detention Oversight Follow-Up Compliance Inspection 2024-001-002," U.S. Department of Homeland Security, U.S. Immigration and Customs Enforcement, Office of Professional Responsibility (October 17-19, 2024), https://www.ice.gov/doclib/foia/odo-compliance-inspections/bakerCoSheriffOffice_MacClennyFL_Oct17-19_2023.pdf; "Office of Detention Oversight Follow-Up Compliance Inspection 2024-004-112," U.S. Department of Homeland Security, U.S. Immigration and Customs Enforcement, Office of Professional Responsibility (April 25-27, 2023), https://www.ice.gov/doclib/foia/odo-compliance-inspections/bakerCoSheriffsOfficeMacclennyFL_Apr25-27_2023.pdf.

detained persons and failure to comply with use of force standards.[3] Provider Goodwin's disclosures also call into question the finding of the OIG that Baker complied with standards for medical care. As detailed further below, Baker has established a practice of falsifying medical records without repercussion. Of concern, the OIG's medical inspectors came to their misleading conclusions by speaking with medical staff and reviewing 19 health records; the report does not indicate that inspectors spoke to detained persons about their experiences of medical care at Baker.[4]

Reporting as recent as August 2024 indicates that the abhorrent conditions at Baker and the gross mismanagement and abuse of authority Provider Goodwin witnessed persist.[5] Two former guards from the detention center recently disclosed that conditions at the facility led many detained persons to engage in hunger strikes, usually a measure of last resort.[6] The guards reported that frequent hunger strikes were met with punishment by turning off water for the entire facility.[7]

Provider Goodwin's alarming disclosures of wrongdoing and retaliation at Baker do not occur in a vacuum; they are only the latest in a long history of whistleblower disclosures raised to DHS and the DHS OIG regarding inhumane, unlawful, and systemically problematic conditions of ICE detention. As early as 2014, for instance, attorney and former policy adviser at the Department of Homeland Security's Office of Civil Rights and Civil Liberties Ellen Gallagher raised concerns within DHS, including to then-Deputy Secretary Mayorkas, regarding ICE's excessive and abusive use of solitary confinement, particularly on mentally ill and medically vulnerable persons in custody.[8]

ICE's practice of using solitary confinement as a measure of first, rather than last, resort is violative of ICE's own policy, and continues to the present as evidenced by not only Provider Goodwin's disclosures but also a February 2024 report by the Harvard Immigration and Refugee Clinical Program, the Peeler Immigration Lab at Harvard Medical School, and Physicians for Human Rights.[9] This report echoed and validated Attorney Gallagher's early disclosures finding

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[3] "Results of an Unannounced Inspection of Baker County Sheriff's Office in Macclenny, Florida," U.S. Department of Homeland Security Office of Inspector General (September 27, 2024), https://www.oig.dhs.gov/sites/default/files/assets/2024-10/OIG-24-63-Sep24.pdf.

[4] *Id*. The report generally states that inspectors interviewed detained individuals and specifies that detained persons were interviewed about the ICE National Detainee Handbook. Since the report provides a specific example of a topic about which detained persons were questioned – the detainee handbook – it logically follows that if detained persons were interviewed about medical care, the report would say so. It does not.

[5] Jack Randall, *Former guards paint bleak picture of conditions inside notorious immigrant detention center in Baker County*, Florida Trident (August 19, 2024 at 7:00am), https://floridatrident.org/former-guards-paint-bleak-picture-of-conditions-inside-notorious-immigrant-detention-center-in-baker-county/.

[6] *Id*.

[7] *Id*.

[8] Ellen Gallagher, "The Use of Administrative and Disciplinary Segregation for Immigration Detainees," e-mail message with attachments to Deputy Secretary Mayorkas and Robert Silvers, July 23, 2014, https://www.documentcloud.org/documents/5998113-Mayorkas-Memo-07232014.html.

[9] Lee, Caroline H., Natalie Sadlak, Brian Benitez, Anand Chukka, Felicia Caten-Raines, Jiwon Kim, Ennely Medina, Sabrineh Ardalan, Philip L. Torrey, Avedian Avedian, Tessa Wilson, Katherine R. Peeler. "Endless Nightmare": Torture and Inhuman Treatment in Solitary Confinement in U.S. Immigration Detention. New York, NY: Physicians for Human Rights; 2024 Feb 6. Available at: https://phr.org/our-work/resources/endless-nightmaresolitary-confinement-in-us-immigration-detention/

that ICE routinely held people in solitary confinement for weeks or years, often for minor infractions, and underscored the medical risks associated with solitary confinement including lasting brain damage.[10]

A June 24, 2024 report of the American Civil Liberties Union, Physicians for Human Rights, and American Oversight illustrates that the cost of ICE's failures to adhere to its own policies, particularly regarding its use of solitary confinement and medical care, is death.[11] The report, based on independent review by medical experts of more than 14,500 pages of documents obtained through Freedom of Information Act requests from DHS and ICE, found that 95 percent of deaths of persons in ICE custody between January 1, 2017 and December 31, 2021 were preventable or possibly preventable had ICE provided clinically appropriate medical care.[12] Critically, the report found shortcomings in ICE's oversight and investigation of in-custody deaths.[13] These findings only underscore the urgent need for brave employees of conscience like Provider Goodwin to speak out about medical failures they witness in the course of their duties given the systemic oversight and accountability gaps in the ICE detention apparatus.

Additional whistleblowers have raised concerns about ICE's systemic shortcomings regarding adherence to legal standards and policies to support the health of persons in custody. In 2018, Drs. Scott Allen and Pamela McPherson, medical and mental health subject matter experts for DHS CRCL, made disclosures after conducting ten investigations of ICE family detention centers over four years which evidenced ICE's gross mismanagement and failures to comply with legal standards governing family detention facilities that resulted in direct harm to children.[14]

Two years later at the start of the COVID-19 pandemic in 2020, Dr. Allen and his colleague, Dr. Jody Rich, began to blow the whistle about the risk of "tinderbox" contagion in ICE's congregate detention facilities, with Dr. Allen testifying at a Senate Judiciary Committee hearing about the deficient provision of medical care in immigration detention facilities.[15] Their whistleblowing continued through 2021 as they along with Dr. McPherson raised concern that,

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[10] *Id*.
[11] Cho, Eunice Hyunhye, Tessa Wilson, Andrew Free, Anna Skarr. "Deadly Failures: Preventable Deaths in U.S. Immigration Detention." American Civil Liberties Union, American Oversight, Physicians for Human Rights. (June 25, 2024) https://phr.org/wp-content/uploads/2024/06/REPORT-ICE-Deadly-Failures-ACLU-PHR-AO-2024.pdf.
[12] *Id*.
[13] *Id*.
[14] Letter from Drs. Scott Allen and Pamela McPherson to Senators Grassley and Wylen (July 17, 2018), https://www.whistleblower.org/wp-content/uploads/2019/01/Original-Docs-Letter.pdf.
[15] Letter from Drs. Scott Allen and Josiah Rich to Congress (March 19, 2020), https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf; Written Statement of Dr. Scott A. Allen, MD, "Examining Best Practices for Incarceration and Detention During COVID-19," U.S. Senate Committee on the Judiciary (June 2, 2020), https://www.judiciary.senate.gov/imo/media/doc/Scott%20Allen%20Testimony.pdf; *See also* Dr. Scott Allen, ICE Detention Facilities: Failing to Meet Basic Standards of Care, House Committee on Homeland Security (September 21, 2020), available at: https://democrats-homeland.house.gov/activities/other-events/ice-detention-facilities-failing-to-meet-basic-standards-of-care.

among other issues, ICE failed to issue a federal mandate regarding vaccines in detention as the Federal Bureau of Prisons had done.[16]

Provider Goodwin's experience mirrors that of another nurse whistleblower, Dawn Wooten, who raised alarm regarding medical mistreatment of women in ICE custody at the Irwin County Detention Center in 2020.[17] Nurse Wooten's disclosures prompted oversight investigations by the DHS OIG and the Senate Homeland Security and Government Affairs Permanent Subcommittee on Investigations, and resulted in ICE severing its contract with the facility.[18] Provider Goodwin's disclosures similarly reveal shocking levels of abuse including harm that rises to the level of torture, along with systemic falsification of medical records.

Moreover, Provider Goodwin's disclosures once again demonstrate that whistleblowers—particularly those in the medical profession with ethical obligations to report abuse and to do no harm—are necessary to expose horrific mistreatment and dangerous mismanagement that continues unaddressed in ICE detention facilities because of weak oversight by DHS of ICE and its contractors. But for employees of conscience who choose to speak out about shocking fraud, waste and abuse, harms like those discovered and reported by Provider Goodwin would continue unabated. Brave whistleblowers like Provider Goodwin must be protected and supported as they too often suffer reprisal for reporting wrongdoing.

Meanwhile, the BCSO continues to manage the Baker facility, and Provider Goodwin's disclosures illustrate that BCSO and Armor's abuses occurred with impunity from the ICE inspector who dismissed the complaints of noncitizens at Baker as a matter of course. Though Armor is no longer the medical contractor, YesCare, another troubled medical staffing company, is now responsible for medical operations at Baker.

Further, the violations and abuses detailed in this complaint were perpetrated by or conducted with the knowledge of BCSO officers and leadership. Given the BCSO's ongoing mismanagement, abuse of authority, violation of law, rule, and regulation, committed without oversight from ICE, along with ICE's long demonstrated pattern of systemic policy violations and abuses, it is imperative that the conditions at Baker be promptly investigated and addressed.

Provider Goodwin and Government Accountability Project urge Congress to exercise its oversight authority to ensure prompt and thorough investigation, and the DHS CRCL and OIDO

[16] Letter from Drs. Scott Allen, Pamela McPherson, and Josiah Rich to Congress (June 25, 2021), https://whistleblower.org/wp-content/uploads/2021/06/062521-Ltr-to-Congress-fr-Allen-McPherson-Rich-FINAL-for-Dist.pdf.
[17] Letter from Dawn Wooten to Congress (September 17, 2020), https://whistleblower.org/wp-content/uploads/2020/09/ICE-ICDC-Whistleblower-Disclosure-to-Congress-091720-1.pdf.
[18] United States Senate Permanent Subcommittee on Investigations, Committee on Homeland Security and Governmental Affairs, "Medical Mistreatment of Women in ICE Detention," (November 15, 2022), https://www.hsgac.senate.gov/wp-content/uploads/imo/media/doc/2022-11-15%20PSI%20Staff%20Report%20-%20Medical%20Mistreatment%20of%20Women%20in%20ICE%20Detention.pdf; Department of Homeland Security, Press Release, ICE to Close Two Detention Centers (May 20, 2021), https://www.dhs.gov/news/2021/05/20/ice-close-two-detention-centers.

to closely review and consider Provider Goodwin's disclosures in the course of their oversight functions.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Ms. Vera Goodwin ("Provider Goodwin"), APRN, FNP-BC, FMACP a 23-year nursing veteran, worked as a Nurse Practitioner employed by Armor Correctional Health Services, Inc. ("Armor") at the Baker County Detention Center ("Baker") in Macclenny, Florida from June 5, 2023 to September 1, 2023, when she was removed from her position in retaliation for her protected whistleblowing.

During her time at Baker, a county jail managed by the Baker County Sheriff's Office ("BCSO") and a designated U.S. Department of Homeland Security (DHS) Immigration and Customs Enforcement ("ICE") detention center for individuals in immigration custody, Provider Goodwin observed multiple violations of patient care protocols and the treatment of detained individuals that she reasonably believes constituted fraud, waste, and abuse.

Specifically, Provider Goodwin reasonably believes BCSO staff, in violation of laws and regulations, including the IGSA, the DHS Prison Rape Elimination Act (PREA), and the 2019 ICE National Detention Standards ("NDS"), committed the following abuses, among others detailed in this complaint, with impunity from ICE:

- BCSO staff and Armor contractors falsified patient medical records, fraudulently stating noncitizens refused treatment prescribed by Provider Goodwin and forging noncitizen signatures.
- BCSO officers used solitary confinement as punishment, including against a woman with a known history of sexual assault who was held down, stripped naked, and strapped into a restraint chair by mostly male BCSO officers. This incident was videotaped, and the recording was played at a staff meeting as an example of effective restraint protocols.
- A patient reported to Provider Goodwin he was injured by BCSO officers when they took him to a private room and attacked him in a manner consistent with waterboarding.
- BCSO and Armor staff failed to report hunger strikes.
- A BCSO Officer engaged in PREA violations against detained women, including by taking pictures of a woman while she undressed and sexually harassing detained women and staff.
- BCSO maintained unsafe and unsanitary living conditions, including unreasonably cold temperatures, a constantly leaking roof, prolonged overcrowding, inadequate drinking water, and a lack of basic hygiene supplies such as toilet paper and menstrual products, requiring men and women to use their socks instead — one for urine, one for feces.

Provider Goodwin reported many of these violations to her superiors, including BCSO and Armor management officials, but observed no remedial actions taken. Rather, after raising concerns, she began experiencing an increasingly adversarial work environment, and ultimately retaliation on September 1, 2023, when the BCSO suddenly revoked her privileges to work at Baker with no clear justification. Armor formally terminated her four days later with no further inquiry or explanation.

Provider Goodwin requests the Department of Homeland Security Office of Inspector General investigate this whistleblower disclosure and retaliation complaint without delay.

I. BACKGROUND ON PROVIDER GOODWIN

Ms. Vera Goodwin has worked in nursing for 23 years, having become a Registered Nurse in 2000 and a Nurse Practitioner in 2012. As a Nurse Practitioner, she is certified to work autonomously, without a doctor's supervision, and she can prescribe and dispense medication. Throughout her career she has served in various medical settings, including primary care, oncology, pediatrics, and critical and intensive care. She has worked at private and government facilities, including Veterans' Affairs hospitals.

Provider Goodwin began working at the Baker County Detention Center ("Baker") in Macclenny, Florida on June 5, 2023, through Armor Correctional Health Services ("Armor"), a private company contracted to staff the medical unit. Baker is a county jail and a DHS/ICE detention center that holds noncitizens in immigration custody, and Provider Goodwin treated individuals in both criminal and immigration custody. Her employment at Baker was the first time she worked in a medical unit in a correctional setting.

Provider Goodwin worked at Baker from June 5, 2023, until September 1, 2023, when the BCSO revoked her facility privileges. Her last pay period was September 8, 2023.

II. HISTORY OF THE BAKER COUNTY DETENTION CENTER

The Baker County Detention Center ("Baker") in Macclenny, Florida, was built as a county jail more than forty years ago and was designated as an ICE detention facility in 2009, despite an announced ICE policy change that same year to shift away from using county and local jail facilities for civil detention of noncitizens.[19] By 2011, it was clear that this policy change had not materialized, and Baker was noted as a facility at which noncitizens in civil immigration custody were subjected to substantively the same conditions as criminal detention.[20]

Baker is important to the local economy, with Baker County depending on the BCSO's Intergovernmental Services Agreement ("IGSA") with ICE to help fund the operations at Baker and to provide employment. At a contract value of more than $6.2 million per year, ICE provides more than half of Baker's budgeted $13.3 million in revenue.[21]

Initial reporting following the designation of Baker as an ICE detention facility[22] pointed to several readily apparent issues at Baker, such as due process and access to counsel concerns because of

[19] "2009 Immigration Reforms," United States Immigration and Customs Enforcement (December 12, 2011), https://www.ice.gov/factsheets/2009detention-reform.
[20] Epstein, Ruthie, and Eleanor Acer. "Jails and Jumpsuits." Human Rights First (2011), https://www.prisonpolicy.org/scans/hrf/jails_and_jumpsuits.pdf.
[21] *See* Agenda, The Baker County Corrections Management Corporation (November 30, 2023), https://www.bakercountyfl.org/. The attachments to this Agenda include the BCCMC September 27, 2023 meeting minutes and related documents, which show ICE contributes more than $6.2 million per year, about half of Baker's revenue. *See* https://www.bakercountyfl.org/board/agenda/BCCMC_11302023_1.pdf. *See also* Joel Addington, *$6.2M annually for next four years from ICE; final contract awaits*, The Baker County Press (September 9, 2021), https://bakercountypress.com/2021/09/6-2m-annually-for-next-four-years-from-ice-final-contract-awaits/.
[22] *Id.*

the necessity of tele-video conferences with the Orlando immigration court located 200 miles away, limited natural sunlight inside the facility, and a lack of exercise facilities.

Baker is isolated from much of the state — it is more than 350 miles away from the most populated areas of Florida, Miami-Dade and Broward counties, making visitation burdensome on families or attorneys who would visit from those areas. In November 2012, the last time such data was publicly reported, 80% of detained noncitizens had no legal representation.[23] Moreover, persons in custody at Baker have faced difficulties in accessing legal resources, including inconsistent access to attorneys, an overcrowded and outdated law library, and a lack of security for their legal documents.[24]

Medical services and food at the facility have been frequently criticized since its opening. Persons detained at Baker have shared harrowing accounts of poor medical care, such as vital cancer medication not being provided.[25] Further, individuals in custody have reported that when they planned a hunger strike in response to inadequate food — a spoonful of meat, beans, and carrots — the BCSO threatened them with solitary confinement as punishment for a hunger strike.[26]

A pattern exists in which testimony of abuse is offered to agencies with oversight of Baker, such as the Civil Rights and Civil Liberties Office of DHS; the watchdog sets an action plan; and Baker fails to follow it with remedial action.[27] Conditions stay the same, and positive change is

[23] "Expose & Close Baker County Jail, Florida." Detention Watch Network (November 2012), https://web.archive.org/web/20130423101616/http://www.detentionwatchnetwork.org/sites/detentionwatchnetwork.org/files/ExposeClose/Expose-Baker11-13.pdf.

[24] Cho, Eunice Hyunhye, and Paromita Shah. "Shadow Prisons: Immigrant Detention in the South." Southern Poverty Law Center (November 21, 2016), https://www.splcenter.org/20161121/shadow-prisons-immigrant-detention-south#county%20contract.

[25] Alvarado, Monsy, Ashley Balcerzak, Stacey Barchenger, Jon Campbell, Rafael Carranza, Maria Clark, Alan Gomez, et al. "Deaths in Custody. Sexual Violence. Hunger Strikes. What We Uncovered inside Ice Facilities across the US." USA Today (April 23, 2020), https://www.usatoday.com/in-depth/news/nation/2019/12/19/ice-asylum-under-trump-exclusive-look-us-immigration-detention/4381404002/.

[26] "Immigrants at Florida Ice Detention Center Forced to Hunger Strike to Protest Insufficient Food." ACLU of Florida (November 17, 2023), https://www.aclufl.org/en/press-releases/immigrants-florida-ice-detention-center-forced-hunger-strike-protest-insufficient.

[27] "RE: Multi-Individual Complaint re: Baker County Detention Center for Inhumane Conditions - Physical Assault, Medical Neglect, Verbal Abuse, Racialized Harassment and Targeting, COVID-19 Negligence, and Retaliation." ACLU of Florida (July 21, 2022), https://static1.squarespace.com/static/5a33042eb078691c386e7bce/t/62d95e2af761ff08f169367f/1658412594632/Public_Copy_Multi-Individual+CRCL+for+Baker+County+Sheriff%27s+Office+July+21%2C+2022_Redacted.pdf; "RE: Multi-Individual Complaint Regarding Inhumane Conditions and Unlawful Treatment at Baker County Detention Center, Including Retaliation, Physical Assault, Medical Neglect, and Unsanitary Conditions." ACLU of Florida (September 13, 2022), https://www.aclufl.org/sites/default/files/crcl_complaint_-_baker_county_detention_center_-_final.pdf; "RE: PREA Complaints on Behalf of the Female Detained Individuals at Baker County Detention Center." ACLU of Florida (November 2, 2022), https://www.aclufl.org/sites/default/files/field_documents/women_at_baker_prea_complaint.pdf; "RE: Complaint No.005139-23-ICE." Office for Civil Rights and Civil Liberties U.S. Department of Homeland Security (February 6, 2023), https://www.aclufl.org/sites/default/files/field_documents/prea_crcl_response.pdf; "RE: Request for Immediate Action on Behalf of Individuals Detained at Baker County Detention Center Due to Systemic Medical Neglect." ACLU of Florida (May 4, 2023), https://www.aclufl.org/sites/default/files/field_documents/baker_letter_-_medical_neglect_0.pdf; "Summary of CRCL Expert Recommendations Memorandum and ICE's Response *Baker*

stonewalled. This lack of response prompts renewed complaints, which DHS then claims have been addressed, requiring another round of complaints for DHS to find that things have not actually changed, and so on. For the fifteen years Baker has operated as an ICE facility, it has accumulated a record of ongoing complaints of medical abuses, poor conditions, and due process concerns.

III. BACKGROUND ON BAKER MEDICAL UNIT OPERATIONS

Baker is run by Baker County Corrections Management Corporation (BCCMC), a nonprofit entity, which is a component of Baker County, Florida.[28] The facility is managed by the Baker County Sheriff's Office ("BCSO") through a Memorandum of Understanding with the BCCMC. BCSO entered into an Inter-Governmental Services Agreement ("IGSA") with DHS' Immigration Customs Enforcement ("ICE") on August 3, 2009 to use the facility to detain individuals in immigration custody.[29] The IGSA requires the BCSO to adhere to the current version of the ICE National Detention Standards ("NDS"),[30] the purpose of which is to "ensure that detainees are treated humanely; protected from harm; provided appropriate medical and mental health care; and receive the rights and protections to which they are entitled."[31]

The IGSA includes the BCSO's obligation to provide individuals in ICE custody with medical care in conformance with the IGSA.[32] Baker contracted with Florida corporation Armor Correctional Health Services, Inc. ("Armor") to staff the medical unit and provide medical services

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County Detention Center." Office for Civil Rights and Civil Liberties U.S. Department of Homeland Security (May 23, 2023), https://www.dhs.gov/sites/default/files/2023-05/close-summary-baker-county-detention-center-05-23-23_0.pdf; "Immigrants at Florida ICE Detention Center Forced to Hunger Strike to Protest Insufficient Food." ACLU of Florida (November 17, 2023), https://www.aclufl.org/en/press-releases/immigrants-florida-ice-detention-center-forced-hunger-strike-protest-insufficient.

[28] Ex. 1, Articles of Incorporation of Baker County Corrections Management Corporation with effective date January 24, 2017 and Amended and Restated Articles of Incorporation of Baker County Corrections Management Corporation with effective date May 3, 2017, also available here: Florida Department of State Division of Corporations: https://search.sunbiz.org/Inquiry/CorporationSearch/SearchResultDetail?inquirytype=EntityName&directionType=Initial&searchNameOrder=BAKERCOUNTYCORRECTIONSMANAGEME%20N170000008180&aggregateId=domnp-n17000000818-dcc37226-d229-4804-ac23-4d488c04b86f&searchTerm=Baker%20County%20Corrections%20Management%20Corporati&listNameOrder=BAKERCOUNTYCORRECTIONSMANAGEME%20N170000008180.

[29] Ex. 2, Inter-Governmental Service Agreement Between the United States Department of Homeland Security U.S. Immigration and Customs Enforcement Office of Detention and Removal and Baker County Sheriff's Department (IGSA), last signed Aug. 17, 2009, and its Amendments, including Amendment P00020 extending the period of performance to May 31, 2026.

[30] IGSA, at 5, § V. DHS ICE Detention Standards

> Satisfactory Performance:
> The Service Provider is required to house detainees and perform related detention services in accordance with the most current edition of ICE National Detention Standards… ICE inspectors will conduct periodic inspections of the facility to assure compliance with the ICE National Detention Standards.

Amendment P00015, signed February 26, 2020, incorporates the ICE NDS 2019 into the agreement. Ex. 3 at 72-73. The NDS is available at https://www.ice.gov/detain/detention-management/2019.

[31] NDS at § Overview at 1.

[32] *Id.* at 6-8, § VI.

to persons detained in both civil immigration and criminal custody.[33] Armor was required to follow all applicable laws and regulations, including ICE standards (e.g., NDS 2019). [34] Armor hired Provider Goodwin to work at Baker in connection with this contract.[35]

At Baker, Provider Goodwin reported directly to the Director of Nursing ("DON"), an Armor employee. The facility's Medical Director and the DON reported to Baker's Health Services Administrator ("HSA"), also an Armor employee. The HSA frequently represented the medical unit at administrative meetings, including meetings with the BCSO and ICE. The HSA, in turn, reported to the BCSO Security Ops. Lt., Director of Detention, who in turn reported to the BCSO Undersheriff. The BCSO leadership reported to ICE. The HSA was suddenly dismissed in mid-August, shortly before Provider Goodwin.

The BCSO terminated Armor's contract effective September 31, 2023. The BCSO now contracts with YesCare to staff the medical unit, another entity under fire in multiple jurisdictions for substandard patient care.[36] Among other contracts across the United States, Armor also held the medical staffing contract at the Duval County Jail in Jacksonville, FL. After reports of patient care mismanagement there, the Jacksonville Sheriff's Office cancelled Armor's contract effective September 1, 2023, replacing it with NaphCare, Inc.[37]

IV. CULTURE AND ENVIRONMENT AT BAKER

a. BCSO and Armor Foster a Culture of Contempt and Suspicion Toward People in Custody

Contrary to Provider Goodwin's experience in other medical facilities, Baker fostered a culture of contempt and suspicion of its patients. As part of Provider Goodwin's onboarding, her training included a session on detained individuals' conduct, which portrayed them as liars and

[33] Ex. 3, Health Services Agreement between BCSO and Armor commencing October 1, 2020 ("Baker-Armor Agreement".).
[34] Baker-Armor Agreement, § I(1.2). ("All services shall be in accordance with any applicable state and federal laws, regulations and standards, including the standards promulgated by ICE, Florida Corrections Accreditation Commission (FCAD), and Florida Model Jail Standards (FMJ).").
[35] Ex. 4, Formal Offer of Employment from Armor to Vera Goodwin and Job Description Acknowledgement, electronically signed by Provider Goodwin 3/9/2023 10:20:39 AM EST.
[36] *See e.g.*, Jacob Holmes, *New report recounts checkered history of Alabama's prison healthcare provider*, Alabama Political Reporter, (Oct. 19, 2023 at 7:45 am), https://www.alreporter.com/2023/10/19/new-report-recounts-checkered-history-of-alabamas-prison-healthcare-provider/; Beth Schwartzapfel, *A prison medical company faced lawsuits from incarcerated people. Then it went 'bankrupt.'*, USA Today, (Sept. 19, 2023), https://www.usatoday.com/story/news/nation/2023/09/19/corizon-yescare-private-prison-healthcare-bankruptcy/70892593007/; Elise Kaplan, *Two lawsuits filed in deaths at MDC in 2022*, Albuquerque Journal, (Feb. 27, 2023), https://www.abqjournal.com/news/two-lawsuits-filed-in-deaths-at-mdc-in-2022/article_ed8281d2-6342-558e-b973-08f783c635d4.html.
[37] *See e.g.*, Nichole Manna, *Jacksonville Sheriff's Office ending its Armor jail health care contract*, The Tributary, (Jul. 25, 2023), https://jaxtrib.org/2023/07/25/jacksonville-sheriffs-office-ending-its-armor-jail-health-care-contract/; Jim Piggot, *Sheriff announces ending of $98M contract with embattled jail healthcare provider*, News4 Jax, (July 25, 2023 at 4:22pm), https://www.news4jax.com/news/local/2023/07/25/sheriff-expected-to-announce-ending-98m-contract-with-jail-healthcare-provier-amid-controversy/.

manipulators who were not to be trusted. This session was conducted onsite at Baker via an online Armor training portal and included a PowerPoint-style presentation with a narrator and a short quiz at the end.

On the job, multiple BCSO officers also personally warned Provider Goodwin that those in custody could not be trusted, stating that noncitizens would use medical complaints to manipulate her. As Baker was the first detention and correctional facility at which she worked, Provider Goodwin did not initially question the warnings and only realized later how the onboarding process and the BCSO culture had initially colored her view of the patients and their medical complaints.

As she got to know the patients, Provider Goodwin never encountered one who appeared to be lying to her about a medical issue. To the contrary, quite a few were desperate for help after having been regularly ignored. Provider Goodwin soon rejected the culture of suspicion and became an advocate for her patients, pressing for care that had previously been denied, as further detailed below.

In response to her rejection of this culture, Provider Goodwin was verbally reprimanded several times by her Armor superiors, including once for having given a patient a nutritional drink following his hunger strike and again for high-fiving him when he told her he was finally being released from Baker. The patient-centered rapport she built with those in her care also apparently played a part in her termination, with the BCSO Lieutenant telling her as he escorted off the premises that her friendliness with patients made her a security risk.

b. Medical Understaffing

During Provider Goodwin's tenure at Baker, the medical unit was regularly inadequately staffed. The night shift, in particular, was routinely out of compliance with communicated staffing requirements. Overnight staff should have included two Licensed Practical Nurses (LPN) and one Registered Nurse (RN). Typically, however, only one LPN was present, with no RN. The DON was supposed to fill in if an RN was not available, but she would frequently skip the shift, leaving the LPN alone. Moreover, due to a personnel shortage, Armor frequently had to call in a temporary LPN from a staffing agency to work the night shift. As a temporary LPN, this person would be unfamiliar with the patients, unfamiliar with Baker's procedures, and would typically work unsupervised, which created a risk of errors in medications, patient treatment, and protocol. This inadequate staffing of the medical unit also violated PREA §115.13(a), which requires adequate levels of supervision and monitoring of the population to protect against sexual abuse.

c. Falsification of Records to Pass Audits

As detailed further in section VI below, Provider Goodwin both observed and reported falsified records, and on multiple occasions was instructed to manipulate records. It was well known among staff at Baker that the detention facility was critical to the local economy, and that the BCSO's contract with ICE was needed for the economic viability of the facility. In fact, leaders at Baker frequently stated that the ICE contract was Baker's "bread and butter." In this context, it was understood among staff at Baker that it was imperative for the facility to pass all ICE audits.

Therefore, on multiple occasions, both Armor and BCSO staff instructed Provider Goodwin not to notate information in medical charts, or to back date information in logbooks. Provider Goodwin also witnessed staff falsifying records by, for example, quickly electronically logging required observation of individuals in solitary confinement without actually observing those individuals, and forging medical records. Initially, the HSA both supported Provider Goodwin's efforts to report forged medical records and found and reported deficiencies in sample audits herself. Eventually though, she succumbed to the pressure to maintain files in a manner so as to pass audits and scolded Provider Goodwin for her efforts to report deficiencies.

d. No Hospital Contract for Those in ICE Custody

The Baker County Detention Center is about a four-minute drive from Ed Fraser Memorial Hospital in Macclenny, Florida. However, BCSO did not have a contract with Ed Fraser to treat patients in ICE custody. Individuals held in state criminal custody could be taken to Ed Fraser, but those in ICE custody could only be taken to a hospital in Jacksonville, Florida, about a 40 minute drive from the detention center. As detailed further in section VI below, this discrepancy resulted in BCSO and ICE staff either denying or delaying necessary medical care for persons held in ICE custody.

V. DETENTION CONDITIONS AT BAKER

In addition to a culture of hostility towards detained persons and severe medical understaffing, Provider Goodwin observed poor conditions that she reasonably believed amounted to gross mismanagement, abuse of authority, violation of law, rule, or regulation, and creation of a substantial and specific danger to public health and safety as described herein and which violate the NDS.

Baker held individuals detained in a variety of circumstances, including both state criminal custody and civil ICE custody. Those held on behalf of ICE were located separately from those detained by the state of Florida. Individuals in both groups could be placed in either the general population or solitary confinement.

Individuals in the general population were held in cells of two people per cell. The cells surround a communal area where those in custody could socialize during the day. Baker also has a solitary detention wing, (called special management unit (SMU) in the NDS[38]), where people are sent for either administrative reasons, such as medical monitoring, or disciplinary reasons.

The substandard conditions at Baker included prolonged overcrowding, inadequate supply of drinking water, lack of access to interpretation services for non-native English speakers, non-responsive grievance systems, and troubling solitary confinement practices that violate the NDS as further detailed below:

[38] *See generally* NDS at § Special Management Units 2.9.

a. Prolonged Overcrowding

In the general population section, Baker regularly held people in overcrowded conditions. The NDS sets standards for the living areas of those in custody, with temporary exceptions to respond to overcrowding conditions, such as the use of triple bunks for 90 days, with short extensions allowed subject to ICE approval.[39] At Baker, rather than triple bunking to accommodate the overcrowding, the BCSO required people to sleep in the communal area on mattresses on the floor. Provider Goodwin observed that about 20-30 people on average slept on the floor in the communal areas. During the day these individuals had no cell space of their own to which they could retreat. Provider Goodwin observed overcrowding conditions the entire time she worked at Baker, about 90 days, the maximum time for which a facility could exercise an exception to the standard bed space configuration.

b. Inadequate Drinking Water Supply

Those in custody were also deprived of access to drinking water in violation of the NDS.[40] The drinking water coolers in the general population area were not regularly filled and individuals were not provided a cup for water, requiring them to ask others for a spare cup, or look around for a vessel to hold the water. The jugs themselves were not cleaned, littered with dirt and bugs, so when water was poured into them, the water itself then became dirty, in contravention of the NDS which requires clean drinking water be provided. Provider Goodwin was concerned the insufficient access to clean drinking water posed dehydration and other health risks to those in custody at Baker.

c. BCSO and Armor Staff Fail to Use Interpretation Services with Non-English Speaking Individuals in ICE Custody

BCSO and Armor personnel often refused to use the available phone interpretation service with non-English speaking patients, in violation of the NDS, resulting in unwarranted disciplinary actions and delayed medical treatment. Staff are required to use an interpretation service for non-English speaking individuals in custody, whether in the general population or in solitary confinement.[41] This refusal to use the interpretation service with non-English speaking patients

[39] *Id.* at § 1.1(II)(I)(1) ("Facility Conditions. The facility shall ensure appropriate temperatures, air and water quality, ventilation, lighting, noise levels, and detainee living space, in accordance with any applicable state and local jail/prison standards. Under emergency circumstances, and only with ICE/ERO written approval, the facility may utilize emergency capacity/temporary bed space, to include triple bunks, on an as needed basis for an initial period not to exceed 90 days, with incremental 30-day extensions possible only with prior ICE/ERO authorization. Before using emergency capacity, the facility must certify to ICE/ERO that required medical, mental health, and security staffing are available to properly support the additional detainee population. The facility must stay within overall emergency capacity limits and ensure all local fire safety requirements are met.").

[40] *See e.g.,* NDS at § 4.1(II)(C)(1) ("Clean, potable drinking water must be available.") *and* NDS § 1.1(II)(F) ("Potable water shall be available throughout the facility.").

[41] *See e.g.,* IGSA, at 4, § III(D) ("The Service Provider shall make special provisions for non-English speaking, handicapped or illiterate detainees."); NDS, § 4.3(II)(G) ("Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. When appropriate staff interpretation

may also constitute a violation of PREA, which, likewise, requires an interpretation service be used with limited proficiency English speakers.[42]

Instead of using the available interpretation services, Provider Goodwin saw officers kicking cell doors, yelling at individuals to speak English. One Spanish-speaking person in disciplinary solitary confinement told Provider Goodwin through the interpretation service he was being disciplined because he took an extra pair of socks and a shirt from a clothing cart. He did not know he could not simply take fresh clothing because the officers never explained that prohibition to him in his native Spanish.

This same patient engaged in a hunger strike out of frustration over his treatment, and the day after ending it, Armor staff's failure to use the interpretation service almost resulted in this man being sent involuntarily to a psychiatric hospital. On this occasion, Provider Goodwin saw the patient in a closed-door office talking with the DON and the regional mental health officer, who only visited the facility about once a month. Concerned about her patient, she entered the room and heard the mental health professional asking questions in English that indicated he and the DON were trying to build a case to hold the patient in a psychiatric facility. Provider Goodwin had never observed this patient to have shown signs of mental health issues while he was in her care. Using a translation app on her phone in front of the DON and the mental health professional, Provider Goodwin informed the patient what was happening. The patient was shocked and stopped the interview.

Provider Goodwin routinely used the interpretation service when speaking with limited English proficiency patients. The interpretation service records the session and provides the user with a recording record number. Provider Goodwin noted this number in the medical chart for each conversation. The HSA told Provider Goodwin to stop noting the recording number in the chart because it could be used by lawyers against Baker in court. These recorded sessions would reveal inconsistencies between the patient's medical record as it was written and what the patient actually said to BCSO or Armor staff.

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 used in an emergency medical situation."); *Id*. at § II(A)(8) ("Staff or professional language services necessary to allow for meaningful access for detainees with limited English proficiency (LEP), and effective communication for detainees with disabilities, during any medical or mental health appointment, sick call, treatment, or consultation.").

[42] PREA, at 13168-13169, §115.16(b) ("The agency and each facility shall take steps to ensure meaningful access to all aspects of the agency's and facility's efforts to prevent, detect, and respond to sexual abuse to detainees who are limited English proficient, including steps to provide in-person or telephonic interpretive services that enable effective, accurate, and impartial interpretation, both receptively and expressively, using any necessary specialized vocabulary.").

d. Futile Grievance Systems

i. Baker: Both Transparent and Opaque Grievance Systems Equally Ineffective

To Provider Goodwin's knowledge, Baker had two grievance systems: one for those in custody and one for staff. The NDS mandates formal and informal grievance systems for those in ICE custody.[43] At Baker, in addition to being able to make informal verbal complaints, those in custody received a tablet, which has an application for filing grievances formally. The grievance is then automatically routed to the relevant recipient(s), e.g., food service, health, management, ICE, etc. The tablet, however, was taken away from people held in solitary for disciplinary reasons, leaving them only the option of complaining verbally to someone about a problem. Those held in medical solitary retained their tablets.

While the NDS prohibits officials from retaliating against a person for filing a grievance,[44] Provider Goodwin learned of at least two people who lost yard privileges after filing a grievance on behalf of another person in custody, as detailed in Section VI(b)(ii) below on hunger strikes. Numerous patients told Provider Goodwin they rarely ever received any meaningful follow up or response to their grievances.

In addition, the BCSO had a separate internal grievance process for those who work at Baker, including Armor staff, to report concerns. The HSA instructed Provider Goodwin to only report concerns or incidents through this internal process because such internal reports are kept separately and not disclosed to lawyers, ICE, or anyone else. In particular, she told Provider Goodwin to report any patient concerns via this internal process and to avoid writing anything in patient charts that would reflect poorly on Baker because patient records can be accessed by lawyers, ICE, or others, and used against Baker.

The internal grievance system itself appeared designed to avoid detection. The process consisted of a paper-only form, which the user completed by hand with a pen, and which was submitted and processed in paper version only. Nothing was submitted or tracked electronically. This process was managed by a quality control officer employed by Armor, but who worked directly with the BCSO. Provider Goodwin never used this system, so she did not have knowledge of what would happen after submission of a paper form through this system.

ii. ICE: Grievances Fall into a Black Hole

The ICE grievance process was non-responsive and symptomatic of ICE's failure to sufficiently oversee BCSO's management of individuals in ICE custody pursuant to the IGSA and the NDS. The NDS requires individuals in custody to have mechanisms to communicate and file grievances

[43] *See generally* NDS, at Grievance System 6.2.
[44] NDS, at 6.2(II)(D) ("Staff will not harass, discipline, punish, disclose sensitive information about, or otherwise retaliate against a detainee lodging a complaint.").

with ICE.[45] Further, PREA requires a level of responsiveness to grievances with which ICE failed to comply.[46]

At Baker, as described above, individuals in custody, except those in solitary for disciplinary reasons, were provided with tablets with a portal for filing grievances. Grievances were routed automatically to the appropriate recipient, including ICE. Grievances that reached ICE were investigated directly by ICE, with an ICE officer conducting a site visit to interview people. Provider Goodwin only ever saw one particular ICE officer visit Baker about once a week to respond to grievances.

Multiple patients, however, told Provider Goodwin they had filed grievances with ICE, but never received any follow up response. Rather, Provider Goodwin observed that this ICE officer appeared only to speak with Armor[47] and BCSO officials and not with the person who filed the complaint, resulting in an incomplete inquiry.

Provider Goodwin regularly saw the ICE oversight offer conduct his interviews with the medical staff. In these interviews medical staff would summarily dismiss any complaints by the detained persons who were the source of the complaint, and the ICE officer would agreeably accept these excuses at face value, appearing to close the complaint. In Provider Goodwin's estimation, no one in the medical unit faced consequences or accountability for complaints from ICE.

e. Conditions of Solitary Confinement

Provider Goodwin's office was in the solitary section, where she observed the living conditions and treatment of the people held there, who included those held in both state and ICE custody. Baker's solitary unit is referred to as having "front" and "back" sections. Those in medical solitary were held in the front area near Provider Goodwin's office. Those in disciplinary segregation were housed at the back of the unit. Provider Goodwin estimates the entire solitary unit contained about

[45] NDS, § Staff-Detainee Communication 2.10 "Procedures must be in place to allow for formal and informal contact between detainees, ICE staff, and facility staff. Procedures shall permit detainees to make written requests to ICE staff and receive an answer in an acceptable time frame." *Id*. at § 2.10(I); "Detainees shall have frequent opportunities for formal and informal contact with facility staff, including managerial and supervisory staff. Facility staff will address detainees in a professional and respectful manner. The facility shall also allow detainees to file grievances and communicate directly with ICE/ERO. Facility staff shall immediately refer any questions related to a detainee's immigration removal processes to ICE/ERO." *Id*. at § 2.10(II)(A).

[46] PREA, at 13172, §115.52(e)-(f) ((e)"The facility shall issue a decision on the grievance within five days of receipt and shall respond to an appeal of the grievance decision within 30 days. Facilities shall send all grievances related to sexual abuse and the facility's decisions with respect to such grievances to the appropriate ICE Field Office Director at the end of the grievance process.") ((f) "To prepare a grievance, a detainee may obtain assistance from another detainee, the housing officer or other facility staff, family members, or legal representatives. Staff shall take reasonable steps to expedite requests for assistance from these other parties.").

[47] Provider Goodwin was personally interviewed only once as part of an ICE grievance inquiry involving the mis-distribution of medicine to multiple individuals. That investigation involved numerous people, prompting a broad investigation. Otherwise, Provider Goodwin was never interviewed in connection with the many other individual grievances for which she might have had information, and none of her patients reported having been interviewed by ICE either, indicative of inadequate ICE oversight of its agreement with the BCSO.

30-40 solitary cells, with one person per cell, and she observed that it was always full during her time working at Baker.

The NDS permits those held in ICE custody to be placed in solitary for disciplinary reasons and for administrative segregation (e.g., for self-protection or other non-punitive reasons, including medical monitoring).[48] ICE's Segregation Directive specifies that administrative segregation should only be used as a last resort and is a non-punitive form of segregation, and that disciplinary segregation requires a hearing and a finding by a disciplinary panel.[49]

Though there were two distinct categories of detention in solitary – disciplinary and administrative, which included medical isolation - sometimes an overlap existed in the status of confinement for individuals in solitary. For example, an individual might initially be held in disciplinary solitary, then go on a hunger strike necessitating medical monitoring, which would then mean they were considered to be held in medical isolation. This overlap in classification may have led to ICE errors in reporting the number of ICE-detained persons in solitary at Baker. ICE is required to track, report, and maintain records related to the use of segregation, including by its IGSA facilities, such as Baker.[50] A 2021 DHS OIG report criticized ICE for its failure to properly track, report and maintain this segregation data.[51]

At Baker, the general population cells did not have electrical outlets, so anyone who needed electricity for medical reasons was held permanently in medical solitary. For example, the unit held two men who required CPAP breathing machines every night while sleeping. During Provider Goodwin's tenure, the unit also held patients engaging in hunger strikes, persons requiring dialysis, and those undergoing cancer treatment, who all needed ongoing medical monitoring. Provider Goodwin also observed at least three mental health patients in state criminal custody being held in the solitary disciplinary section.

i. Falsification of Safety Checks in Solitary

BCSO Officers were required to regularly monitor those in solitary confinement at regular intervals of time. The NDS specifies that "close supervision" is required for those in segregation, and that staff shall both "observe" and "log observations."[52] Therefore, in these monitoring checks, it was known that officers were meant look into each cell to ensure that each detained individual was stable. The officers had a cell phone that they would tap on the door of the solitary cell to record when the observation check was complete. However, Provider Goodwin regularly witnessed BCSO officers nearly running along the doors of the isolation cells quickly tapping their phone to the cell doors without stopping, much less looking into the cell to observe the detained person inside.

[48] NDS at § Special Management Units 2.9 (II)(A)-(B).
[49] ICE Directive 11065.1, *Review of the Use of Segregation for ICE Detainees*, September 4, 2013.
[50] *Id*.
[51] Department of Homeland Security, Office of Inspector General, *ICE Needs to Improve Its Oversight of Segregation Use in Detention Facilities*, October 13, 2021.
[52] NDS at § Special Management Units 2.9 (II)(K).

ii. Extreme Restrictions on Movement in Solitary

The NDS requires those held in administrative solitary, such as for medical reasons, retain the same privileges as those in the general population.[53] Provider Goodwin, however, observed that patients in solitary for non-punitive medical reasons were subjected to many restrictions on their movement and socialization, in violation of the NDS. Their cell doors appeared to be kept closed at all times, just as those for people held for disciplinary reasons. They had to ask for permission to use the phone, go to the library, or attend religious services. Some had yard recreation time, but not all. In particular, those on dialysis were denied yard time as the officers considered their visit to the dialysis unit as their outdoor time. The patients did have permission to attend certain activities offered to the general population. For example, the two CPAP patients participated in an on-line financial course in the general population section. They could also order from the Commissary.

Apparently, the norm at Baker was those held in solitary for disciplinary reasons had no privileges across the board, in violation of the NDS, which requires most restrictions (e.g., on recreation time, visits, access to the library, religious services, etc.) to be justified on a case-by-case basis.[54] For example, Provider Goodwin observed the cell doors of those in disciplinary solitary remained locked all day and she never saw anyone let out for yard time, including those held for lengthy 30-day terms, in violation of the NDS.[55]

iii. No Phone Access and Denied Access to Counsel in Solitary

Provider Goodwin also witnessed BCSO officers deny phone access to those in disciplinary solitary, even for attorney calls, in violation of the NDS, which allows those held in disciplinary solitary also to make calls to lawyers and family, among others.[56] The disciplinary section had only one portable phone that is brought to the individual's cell to make a call. In one example, a woman detained by ICE requested the phone to call her lawyer, but the BCSO officer refused her

[53] *Id*. at 2.9(II)(J)(1) ("Generally, these detainees shall receive the same privileges available to detainees in the general population, consistent with any safety and security considerations for detainees and facility staff. When space and resources are available, detainees in administrative segregation may be provided opportunities to spend time outside their cells (in addition to the required recreation periods) for such activities as socializing, watching TV and playing board games, and may be assigned to voluntary work details (e.g., as orderlies in the SMU).")
[54] *See generally Id.* at 2.9.
[55] *Id*. at 2.9(II)(V) ("Detainees in the SMU shall be offered at least one hour of recreation per day, outside their cells and scheduled at a reasonable time, at least five days per week…Denial of recreation privileges for more than seven days requires the concurrence of the facility administrator and a health care professional. It is expected that such denials shall rarely occur, and only in extreme circumstances.").
[56] *Id.* at § 2.9 (II)(W) ("Detainees in disciplinary segregation may be restricted, as part of the disciplinary process, from using telephones to make general calls. However, even in disciplinary segregation, detainees shall have telephone access for family or personal emergencies, and for calls to attorneys, other legal representatives, courts, and government offices as described below. All detainees, including those in disciplinary segregation, shall be permitted to place calls to attorneys, other legal representatives, courts, and government offices (including the DHS Office of the Inspector General, DHS Office for Civil Rights and Civil Liberties, ICE/OPR Joint Intake Center, and embassies or consulates), according to the facility schedule.").

saying the cell phone was being used by someone else. Provider Goodwin saw the phone laying right next to the officer on the officer's desk.

iv. Inadequate Access to Hygiene and Unreasonably Cold Temperatures on Suicide Watch in Solitary

Most of the substandard living conditions in solitary were similar to those of the general population, as described further in Section VI below. As in the general population, patients in solitary told Provider Goodwin worms crawled out of the showers and she observed they were deprived of adequate hygiene products, including having to use their socks to clean themselves of feces and urine when they ran out of toilet paper.

Other conditions, however, were worse. The 53-degree temperature in the general population and solitary cells was unreasonably cold, in violation of the NDS,[57] as further described in Section VI(c)(ii) below. Provider Goodwin was particularly concerned about the cold temperature's health impact on those under a suicide watch in solitary, as they are deprived of clothing, given only a smock and a mattress with no sheets or blanket.

The BCSO also deprived those held in the solitary unit access to showers. The NDS requires those held in solitary to be provided a shower three times a week.[58] Provider Goodwin observed that individuals in solitary, however, did not regularly shower. When she asked the BCSO officers why people did not seem to have showered, the officers said the individuals had refused. On at least one occasion, a patient, "Ana", told Provider Goodwin she had not been offered a shower in a week. When Provider Goodwin noticed a person in need of a shower, she would tell the BCSO officer to do so hastily.

v. Insufficient Access to Water in Solitary

The BCSO also unreasonably restricted access to liquids to those held in solitary in violation of the NDS, which requires drinking water to be available.[59] Provider Goodwin observed no water coolers available to those in the solitary unit, and noticed the only liquids individuals received were a juice box with meals and a small pill cup of water for taking medications. While those in medical solitary could exercise Commissary privileges to order more drinking water, those in disciplinary solitary could not. Concerned about the potential for dehydration, Provider Goodwin advocated for providing a pitcher of water to all those being held in the solitary unit. BCSO officials, however, rejected her idea because those in the general population would learn of it and likewise demand pitchers.

[57] *Id*. at 2.9(II)(H) ("Cells and rooms used for purposes of segregation must be well ventilated, adequately lit, **appropriately heated/cooled**, and maintained in a sanitary condition at all times, consistent with safety and security.") (emphasis added).
[58] *Id*. at § 2.9(II)(O) ("Detainees in SMU may shave and shower at least three times weekly…").
[59] *Id*. at § 4.1(II)(C)(1) ("Clean, potable drinking water must be available.") *and* NDS § 1.1(II)(F) ("Potable water shall be available throughout the facility.").

VI. PROVIDER GOODWIN OBSERVES AND REPORTS GROSS MISMANAGEMENT, GROSS WASTE, ABUSE OF AUTHORITY, SUBSTANTIAL AND SPECIFIC DANGERS TO PUBLIC HEALTH AND SAFETY, AND VIOLATION OF LAW, RULE, OR REGULATION RELATED TO THE BCSO'S IGSA WITH ICE

Based on her experience at Baker, Provider Goodwin reasonably believed leadership at BCSO and its contractor Armor committed acts of gross mismanagement, abuse of authority, gross waste of funds, a substantial and specific danger to public safety or health, and violations of laws, rules, and regulations jeopardizing medical care at DHS facilities, including: 1) mistreatment of detained individuals; 2) falsification of individuals' medical records; and 3) the maintenance of unsafe, unsanitary and unhygienic living conditions for ICE detainees; and, as follows:

a. Baker Mistreated People in Custody and Jeopardized Their Health

Provider Goodwin observed multiple violations of the NDS and other laws and regulations at Baker, including the mistreatment in those held in solitary confinement, lack of timely access to mental health care, and denial of prompt transport to hospitals for care, as detailed below:

i. Mistreatment in Solitary Confinement

BCSO officers regularly mistreated detained persons, especially those in solitary confinement, which jeopardized their physical and mental health. Provider Goodwin observed multiple incidents that constituted violations of the IGSA,[60] the NDS, and the ICE Performance-Based National Detention Standards (PBNDS),[61] including:

1. The BCSO Sent a Woman with History as a Sex Trafficking Victim to Solitary Confinement then Restrained and Stripped Her Naked

Provider Goodwin observed multiple potential violations of the PBNDS and PREA in the treatment of a woman at Baker who had been wrongfully detained by ICE. This woman's medical record noted she had been a victim of sex trafficking, a group for which the PBNDS §2.11 imposes specific protocols to protect against further trauma: "Staff sensitivity toward detainees who are victims of sexual abuse and/or assault is critical."[62] The PBNDS requires all detained persons must

[60] *See generally*, IGSA.
[61] Ex. 2, Amendment PXXXXX at 29, signed by Sheriff Joey B. Dobson October 18, 2012, incorporates ICE 2011 PBNDS 2.11 into the IGSA.
[62] PBNDS § 2.11(V)(J).

be screened to identify potential perpetrators and victims.[63] Detained individuals at risk of sexual victimization (e.g., by having previously been a victim of sexual abuse), must be placed in a "supportive environment"[64] and in the "least restrictive housing available."[65] The facility is also required to offer victim services to those in need.[66] Moreover, PREA §115.41(c)(8), also requires facility staff to consider whether the detained individual has self-identified as having previously experienced sexual victimization when assessing a detained individual's risk of sexual victimization.[67] Additionally, PREA §115.31(a)(5) requires, in part, staff be trained to recognize "physical, behavioral, and emotional signs of sexual abuse."[68]

When Provider Goodwin encountered her patient, "Ana,"[69] around the end of June 2023, Ana was being held in solitary confinement for 30 days because she broke a water sprinkler and flooded her cell in frustration over being wrongfully detained for months. Understanding that Ana had been a victim of sex trafficking, Provider Goodwin was concerned about the impact of solitary confinement on Ana's psychological well-being, particularly for a period of 30 days, locked away from others and prohibited from outdoor recreation time. Provider Goodwin witnessed ICE officers berate Ana, telling her, for example, "you're here because of YOUR decision!" Provider Goodwin knew these conditions were not a "supportive environment" and not the "least restrictive housing available" in accordance with the NDS and PREA.

Moreover, Ana appeared to deteriorate while in solitary. She told Provider Goodwin her husband was trying to terminate her parental rights and she had missed a child custody hearing while detained. Ana asked to call her attorney, but the BCSO officers in solitary refused. Frustrated, she banged her head repeatedly against the wall. Ana told Provider Goodwin that in response, the BCSO officers – mostly men – held her down on the bed, stripped her naked, put a "suicide smock" on her, then strapped her into a restraint chair. Ana, having survived sex trafficking, resisted the removal of her clothes as the officers snickered while she screamed in terror from the flash backs to her sex trafficking trauma.

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[63] *Id.* at § V(I)(1): ("[T]he facility shall assess all detainees on intake to identify those likely to be sexual aggressors or sexual abuse victims and shall house detainees to prevent sexual abuse, taking necessary steps to mitigate any such danger. …. The facility shall consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: … (h) Whether the detainee has self-identified as having previously experienced sexual victimization;…Detainees who are considered at risk shall be placed in the least restrictive housing that is available and appropriate.").

[64] *Id.* at § V(J) ("Care shall be taken to place the detainee in a supportive environment that represents the least restrictive housing option possible.").

[65] *Id.* at § I(1).

[66] *Id.* at § V(H).

[67] PREA, at 13171, §115.41(c)(8): ((c) "The facility shall also consider, to the extent that the information is available, the following criteria to assess detainees for risk of sexual victimization: (8) Whether the detainee has self-identified as having previously experienced sexual victimization[.]").

[68] PREA, at 13170, §115.31(a)(5): ("(a) The agency shall train, or require the training of, all employees who may have contact with immigration detainees, and all facility staff, to be able to fulfill their responsibilities under this part, including training on: […] (5) Recognition of physical, behavioral, and emotional signs of sexual abuse, and methods of preventing and responding to such occurrences[.]").

[69] "Ana" is a pseudonym for this patient.

This behavior violated the intent and purpose of PBNDS 2.11 and PREA §115.31(a)(5) and its requirement to recognize the signs of sexual abuse, as well as PREA §115.15(g). This latter PREA section mandates procedures that enable detained persons to change clothing without being viewed by staff of the opposite gender, except in exigent circumstances. In light of Ana's history of sexual trauma, her forced removal of her clothing by and in front of a crowd of mostly men contravened PREA §115.15(g) and the other aforementioned legal requirements.[70]

Though the Baker officers' treatment of Ana subverted the intent and purpose of PREA and PBNDS 2.11 to support sexual abuse victims, BCSO guards videotaped the incident using their body-worn cameras and shortly thereafter used it as a training tool during a weekly staff meeting, which Provider Goodwin and BCSO superiors the BSCO Undersheriff and the BCSO Lieutenant attended. During that meeting, the BCSO used the video to demonstrate what they deemed to be a "good example" of how to handle and control those in custody.

Provider Goodwin was in tears after watching the video. She told the group of Baker leaders and others in attendance at the staff meeting that the control tactic used, including stripping Ana naked, was particularly traumatizing for Ana, given her history of sex trafficking, and was unnecessarily aggressive regardless. She also alerted them that Ana told her she was legally in the United States and was wrongfully detained. Her superiors did not respond during the meeting, but the HSA admonished her afterward for voicing her concerns. Ana was later moved back to the general population after her 30-day period in solitary, then released from Baker about one month later.

2. Provider Goodwin Was Denied Physical Access to Patients in Solitary Confinement

Provider Goodwin was denied in-person access to patients held in solitary confinement, which jeopardized the health of her patients, in violation of the NDS. Individuals in the solitary unit are required to receive the same level of medical care as those in the general population.[71] Per the NDS, "[h]ealth care personnel shall conduct *face-to-face medical assessments at least once daily* for individuals in [a solitary unit]."[72] (emphasis added). Moreover, "the facility shall provide *out-of-cell, confidential assessments and visits* for detainees whenever possible, to ensure patient privacy and to eliminate barriers to treatment."[73] (emphasis added).

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[70] PREA, at 13168 §115.15(g): ("Each facility shall implement policies and procedures that enable detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing.").

[71] NDS § 2.9(II)(G) ("Detainees in the SMU shall be provided appropriate accommodations and professional assistance for disabilities and/or other special needs (e.g., medical, therapeutic, or mental health treatment), on an equal basis as those in the general population.").

[72] *Id*. at § II(M) ("Health care personnel shall conduct face-to-face medical assessments at least once daily for detainees in an SMU. Where reason for concern exists, assessments shall be followed up with a complete evaluation by a qualified health care or mental health provider, and a treatment plan developed.").

[73] *Id*. ("The facility shall provide out-of-cell, confidential assessments and visits for detainees whenever possible, to ensure patient privacy and to eliminate barriers to treatment.").

While Provider Goodwin was permitted to visit patients held in *medical solitary* inside their cells, just as she was with the general detention population, guards prevented her from opening the cell doors to more thoroughly check on patients held in solitary for *disciplinary reasons*. Provider Goodwin could only see patients in disciplinary solitary through the cell door's glass window and speak with them through the door. Without full face-to-face physical access, she could not examine the patient properly, impeding her ability to provide necessary medical care. This requirement applied to all persons held in disciplinary solitary, regardless of risk level.

Medical rounds also were not conducted in accordance with the NDS. Rather than daily, Provider Goodwin was told to conduct assessments twice a week among patients in disciplinary solitary – Mondays and Fridays. For any other medical needs, patients in disciplinary solitary had to request a sick call; however, no one held in custody in the solitary unit, whether for administrative, medical, or disciplinary reasons, had a call button for medical care. Instead, they had to bang on their cell doors and hope an officer was around to hear them. Provider Goodwin reasonably suspected some Armor nurses might not have been logging their sick calls as multiple patients complained to Provider Goodwin they had requested sick calls but did not receive any response.

ii. Detained Persons Denied Mental Health Care Access

Patients at Baker were denied proper access to mental health services, in violation of the NDS.[74] Provider Goodwin was aware of only one Psychiatric Nurse Practitioner at Baker. She observed that this Nurse Practitioner seemed to only see about two to three patients a day, far less than a full schedule. To confirm her suspicions, Provider Goodwin checked the mental health appointments calendar at the start and end of the day. While the calendar showed a full day of appointments at the start, by the end of the day, it showed that only few patients were actually seen and all the rest were cancelled or rescheduled, with the effect of denying detained persons treatment in violation of the NDS.

In addition, Provider Goodwin reasonably believed the BCSO avoided placing an at-risk individual on suicide watch as it did not want to pull an officer off regular duty to be dedicated to monitoring the person, at great expense to the facility. Relatedly, she observed in solitary the mental health Nurse Practitioner also did not visit patients face-to-face and only conducted a cursory inquiry of their health. He would stand outside the closed cell door of the patient, yell in "are you suicidal?", then move on if he didn't receive an affirmative response.

[74] NDS at § 4.3(I) ("All detainees shall have access to appropriate medical, dental, and **mental health care**, including emergency services.") (emphasis added); "Based on the intake screening, the comprehensive health assessment, medical documentation, or subsequent observations by detention staff or medical personnel, a detainee may be referred for mental health treatment or evaluation. Any detainee referred for mental health treatment shall be triaged for any emergency needs and receive an evaluation by a qualified mental health provider no later than seven days after the referral. The provider shall develop an overall treatment/management plan." *Id.* at § II(S)(2).

iii. Patients Denied Prompt Transport to Hospitals for Care

Officials regularly delayed or denied Provider Goodwin's requests to send patients off site for treatment that could not be provided at Baker, in violation of the NDS.[75] In addition to the patient with life-threateningly low hemoglobin levels mentioned in Section VI(b)(i) below, Provider Goodwin encountered a psychiatric patient in ICE custody being held at Baker who had shoved acrylic fingernails down her ear canals, requiring a higher level of care than Provider Goodwin could provide. Baker waited about one month before sending this patient to the hospital to have the fingernails extracted, exposing the woman to the risk of hearing loss. When Provider Goodwin enquired about the delay, an administrative assistant in charge of arranging transportation blamed the delays on ICE, saying she needed ICE pre-approval before transporting a patient, and ICE frequently delayed that approval. Provider Goodwin did not know whether the non-responsiveness to her transport requests was due to BCSO and/or Armor officials failing to submit her transport requests to ICE, or if ICE was delaying or denying them.

iv. Baker Patient Describes Waterboarding by BSCO Officers

A patient with shoulder and hand pain and a headache told Provider Goodwin he was injured when he had been taken to a closed-door room at Baker and was abused by BCSO officers, in violation of the NDS. The patient, a noncitizen detained by ICE, did not speak English, so Provider Goodwin used the interpretation service when treating him for his injuries. A certified nursing assistant, employed by Armor, was also present during treatment. Via this translation service, the patient told them he was injured shortly after arriving at Baker when guards handcuffed him behind his back, brought him to a private room, pushed him down to his knees, covered his face with a rag and poured water over it. This man described feeling unable to breathe during the incident. Provider Goodwin understood the man to be describing an experience of waterboarding. The NDS restricts the use of force to limited circumstances, such as to prevent harm to self or others.[76] It prohibits the use of force as punishment or to cause pain.[77] The NDS details what forms of force and restraints are allowed.[78] Waterboarding is not among them.[79] Provider Goodwin noted in the patient's chart the details he recounted of what sounded to her like waterboarding that led to his injuries.

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[75] NDS, § 4.3(II)(A) ("The HSA will negotiate and keep current arrangements with nearby medical facilities or health care providers to provide required health care not available within the facility. These arrangements will include appropriate custodial officers to transport and remain with the detainee for the duration of any off-site treatment or hospital admission.").
[76] *See generally* NDS 2.8 Use of Force and Restraints.
[77] *Id.*
[78] *Id.*
[79] Waterboarding, which is described as an act in "which water is poured over a cloth covering the face and breathing passages of an immobilized captive, causing the person to experience the sensation of drowning," is not universally prohibited across the United States, but nationally and internationally is commonly condemned as a form of torture. https://en.wikipedia.org/wiki/Waterboarding. Detained persons in a New York prison filed lawsuits this year alleging guards waterboarded them as a punishment. *See* Benjamin Weiser, *Guards Beat and Waterboarded Prisoners in New York, Lawsuits Say,* New York Times (Jan. 10, 2024), https://www.nytimes.com/2024/01/10/nyregion/new-york-prisoners-waterboarding.html.

v. PREA Complaints Filed against BCSO Officer

Two patients detained by ICE told Provider Goodwin they had filed complaints for violations of the PREA[80] against a certain BCSO officer. PREA, which is incorporated into PBNDS 2.11 and applies to the BCSO-ICE IGSA, prohibits officers from making sexual comments to detained individuals and from engaging in voyeurism, such as peering at them through their cell doors and/or taking pictures of them as they dress or perform bodily functions.[81] One woman said this officer took pictures of her while she dressed and would peek through her door at her while she was on the toilet, violating PREA §115.15(g)(h) and §115.31(a)(1)(2).[82] Another patient said this same officer made sexually suggestive comments to her and otherwise sexually harassed her. The same officer remaining in a position to sexually harass another patient, despite a previous PREA complaint, is itself a direct violation of PREA §115.66. [83] The patient told Provider Goodwin her PREA complaint arose during a previous detention at Baker. She was subsequently transferred, then recently returned to Baker, and feared retaliation for her previous complaint. The transfer subsequent to her PREA complaint, and the lack of response to her fear of further retaliation constitute violations of multiple anti-retaliatory provisions of PREA.[84] The HSA told Provider

[80] 28 C.F.R. §§115 *et seq*.
[81] PBNDS at 2.11(V)(B)(2).
[82] PREA, at 13168, 13170, §115.15(g) ("(g) Each facility shall implement policies and procedures that enable detainees to shower, perform bodily functions, and change clothing without being viewed by staff of the opposite gender, except in exigent circumstances or when such viewing is incidental to routine cell checks or is otherwise appropriate in connection with a medical examination or monitored bowel movement. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an area where detainees are likely to be showering, performing bodily functions, or changing clothing.") §115.31(a)(1)(2) ("(a) The agency shall train, or require the training of, all employees who may have contact with immigration detainees, and all facility staff, to be able to fulfill their responsibilities under this part, including training on[…] (1) The agency's and the facility's zero-tolerance policies for all forms of sexual abuse; (2) The right of detainees and staff to be free from sexual abuse, and from retaliation for reporting sexual abuse[.]").
[83] PREA, at 13173, §115.66 ("Staff, contractors, and volunteers suspected of perpetrating sexual abuse shall be removed from all duties requiring detainee contact pending the outcome of an investigation.").
[84] PREA, at 13172-13173, §115.51(a) ("The agency and each facility shall develop policies and procedures to ensure that detainees have multiple ways to privately report sexual abuse, retaliation for reporting sexual abuse, or staff neglect or violations of responsibilities that may have contributed to such incidents. The agency and each facility shall also provide instructions on how detainees may contact their consular official, the DHS Office of the Inspector General or, as appropriate, another designated office, to confidentially and, if desired, anonymously, report these incidents."). Furthermore, the transfer of this patient following her PREA complaint may constitute a violation of PREA §115.67(a)(b)(c) which prohibits retaliatory transfers and requires monitoring for potential adverse actions for a period of 90 days ("(a) Staff, contractors, and volunteers, and immigration detention facility detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force. (b) The agency shall employ multiple protection measures, such as housing changes, removal of alleged staff or detainee abusers from contact with victims, and emotional support services for detainees or staff who fear retaliation for reporting sexual abuse or for cooperating with investigations. (c) For at least 90 days following a report of sexual abuse, the agency and facility shall monitor to see if there are facts that may suggest possible retaliation by detainees or staff, and shall act promptly to remedy any such retaliation. Items the agency should monitor include any detainee disciplinary reports, housing or program changes, or negative performance reviews or reassignments of staff. DHS shall continue such monitoring beyond 90 days if the initial monitoring indicates a continuing need.").

Goodwin this same officer sexually harassed her as well, another instance of officers failing to meet the training standard laid out in PREA §115.31 and its subsections.[85]

b. BCSO and Armor Staff Falsified Patient Medical Records and Mismanaged Patient Care

Provider Goodwin observed that Armor and Baker personnel manipulated patient records in violation of the IGSA[86] and the NDS to avoid spending additional time and money on detained individuals' medical care. The NDS requires facilities to ensure individuals receive medical treatment in accordance with multiple industry and US agency standards. [87] As part of this requirement the facility must maintain health records[88] and "[t]he facility health care practitioner will obtain specific signed and dated consent forms from all detainees before any medical examination or treatment, except in emergency circumstances."[89] Baker's policies and procedures require all refusal forms to be signed by the patient and witnessed by a BCSO officer and a nurse.

By August 2023, however, Provider Goodwin noticed that patient records were being falsified by other medical staff. Provider Goodwin frequently ordered laboratory tests for patients, particularly those with chronic health conditions. Provider Goodwin noticed many of her ICE-detained patients, in particular, were not completing their lab tests, taking prescribed medications, or following up on mental health visits, thereby jeopardizing their health. In some cases, the medical chart included forms indicating they refused care six or seven times. When Provider Goodwin asked the patients why they were not following treatment plans, the patients reported they were never transported for their appointments or given their medications.

Provider Goodwin checked these patients' charts and noticed documents included signed refusal forms stating the patients allegedly had refused medical treatment. When she showed the signed refusal forms to patients, the patients told her the signatures on the forms were not theirs, and they reaffirmed they wanted treatment. Alarmed, Provider Goodwin reviewed the signatures on the forms against the signatures in her patients' files and discovered differences in the signatures that indicated the signatures on the refusal forms were forged. In almost all cases, the form carried the same squiggly line with an illegible name. In other incidents, the form contained a notation saying the patient refused to sign the form acknowledging they rejected treatment. Again, when she asked the patients about this refusal, they denied having refused treatment or being offered a form to sign.

[85] PREA, at 13170, §115.31(a)(1)(2), *supra* note 66, at 20.
[86] *See generally*, IGSA.
[87] NDS at § 4.3 Medical Care.
[88] *See e.g.,* NDS at § 4.3(II)(P).
[89] *Id*. at § 4.3II(O), which also discusses detailed procedures for obtaining informed consent, ensuring the patient understands the treatment options, including the use of interpretation and translation as elaborated upon in 4.3(II)(G), and how to handle informed consent refusals.

The non-English speaking patients also told Provider Goodwin that Armor and BCSO staff often refused to use the interpretation service when talking to them, so they did not know what treatments were being offered or what the forms said, if they were shown any forms.

Each of the forged refusal forms carried the signatures of a BCSO officer and nurse, but the signatures were illegible, so Provider Goodwin could not identify which officers and medical staff were responsible for these forgeries. The forgeries and refusal to provide the corresponding required treatment jeopardized patient health. In all, Provider Goodwin compiled a list of falsifications involving more than 30 patients.

Provider Goodwin reported the forged signatures and charting falsifications to the HSA in August 2023 when she discovered them. The HSA tried to address the record falsifications, helping to document instances and to identify involved Armor staff. Provider Goodwin and the HSA also personally met with the BCSO Lieutenant to report the falsifications, providing him with copies of the forged refusal forms. The BCSO Lieutenant told Provider Goodwin to continue providing any other such falsifications to the HSA. Provider Goodwin also requested the BCSO Lieutenant identify the officer or officers who were involved in the falsifications and to take remedial action. However, the BCSO Lieutenant expressed doubt at Provider Goodwin's suggestion his officers were involved, and did not appear to have conducted any investigation or take remedial action in response to her complaints. Indeed, after this meeting, Provider Goodwin observed an increase in the use of patient-refused-to-sign notations in the charts, and a decrease in signed refused care forms, indicating an effort to make it hard to identify a record falsification.

Provider Goodwin observed most of the forgeries and refused-to-sign notations involved ICE patients. Provider Goodwin understood that when an ICE-detained patient refuses care, that patient care is not subject to ICE audit, thus reducing BCSO's risk of a negative finding.

The medical unit was routinely subject to sample audits, and under the HSA, the medical unit regularly failed these sample audits because the HSA found frequent flaws in the audits, like falsified medical records. Provider Goodwin heard from staff that prior to, and following the HSA, other leaders of the Baker medical unit knew how to make records "look good" to pass audits.

Specific examples of the forgeries and chart falsifications Provider Goodwin documented for the HSA include:

i. Life-Threateningly Low Hemoglobin Levels Improperly Treated

Around August 2023, Provider Goodwin treated a female patient in ICE custody suffering from excessive menstrual bleeding causing a life-threatening, severely low hemoglobin levels that required a blood transfusion to treat. This individual bled so heavily it soaked through her mattress and onto the floor of her cell. The patient's file was marked with forged treatment refusals, which meant her condition was left untreated, thereby contributing to her deterioration. This negligence and forgery was a clear violation of the NDS, which requires individuals in custody be provided

appropriate medical care and women be provided appropriate women's health services specifically.[90]

Provider Goodwin discovered the forgeries when she noticed the patient's blood was not being drawn for testing of her hemoglobin levels weekly as required by her treatment plan. The chart noted that the patient had refused treatment, but when Provider Goodwin, using the interpretation service, asked the patient why her blood was not being drawn, the patient said no one ever came to do it and denied ever refusing treatment or signing a document refusing treatment. She also told Provider Goodwin other officers and employees did not use the interpretation service to speak with her.

Provider Goodwin drew the patient's blood and the lab results revealed a dangerously low hemoglobin level. Provider Goodwin had the patient transported to the local emergency room, but the local emergency room refused to admit and treat the patient because it had no contract with ICE. Provider Goodwin then requested Baker transfer the patient to an alternative hospital 40 miles away for the transfusion. BCSO officials, however, told Provider Goodwin no driver was available.

Provider Goodwin met with her superior the DON to press for the transfusion, but the DON dismissed her treatment plan, ordering the patient remain at Baker and be prescribed iron pills instead, a treatment Provider Goodwin, based on her years of experience, deemed inadequate given the severity of the patient's condition. When Provider Goodwin pushed back, the DON dismissed her complaints and accused her of undermining the DON's authority.

The BCSO also tried to release the patient to ICE for deportation, but Provider Goodwin refused to sign the medical clearance, saying the patient was not medically stable to travel. Provider Goodwin later learned from a colleague the woman was deported without ever receiving the transfusion.

ii. Hunger Strikes Were Not Reported in Charts or to ICE

Provider Goodwin discovered BCSO and/or Armor personnel falsified records about individuals on hunger strikes and the care being provided to them, in violation of the NDS[91] medical care, charting, and ICE reporting requirements.[92] The BCSO is required to report hunger strikes to ICE,

[90] *See e.g.,* NDS at § 4.3(I) ("All detainees shall have access to appropriate medical, dental, and mental health care, including emergency services.") and 4.3(II)(U) ("Female detainees shall receive routine, age appropriate gynecological and obstetrical health care, consistent with recognized community and clinical guidelines for women's health services.").

[91] NDS at § 4.2 Hunger Strikes. "This detention standard protects detainees' health and well-being by monitoring, counseling, and providing appropriate treatment to any detainee who is on a hunger strike." *Id* at 4.2(I); "Medical staff shall monitor the health of a detainee on a hunger strike." *Id.* at (II)(C); "Medical staff shall record all examination results in the detainee's medical file." *Id.* at (C)(4); and "Records shall be kept of all interactions with the striking detainee, the provision of food, attempted and successfully administered medical treatment, and communications between the CMA, facility administrator, and ICE/ERO regarding the striking detainee." *Id.* at § (C)(9).

[92] *Id.* at § 4.2(II)(B) ("Facilities shall immediately notify ICE/ERO when a detainee begins a hunger strike. 1. Staff shall consider any detainee observed to have not eaten for 72 hours to be on a hunger strike and shall refer him or her to the CMA for evaluation and management.").

which then performs a site visit to meet with the patient to try to resolve concerns. Provider Goodwin uncovered the record falsifications in mid-August 2023 when caring for a detained patient who told her via the interpretation service that he was on a hunger strike and had missed seven meals over two days. Provider Goodwin reviewed his chart, which falsely showed he had eaten those meals. The NDS defines a hunger strike as automatically occurring when a detained person does not eat for 72 hours (3 days/9 meals).[93] Provider Goodwin documented in the patient's chart that, contrary to the previous notations, the patient reported he had not been eating. Provider Goodwin reasonably believes BCSO officers were falsifying the records to avoid having to report hunger strikes to ICE and to prevent an ICE officer from conducting a site visit.

In response to her corrective charting, the HSA verbally reprimanded Provider Goodwin, telling her she must not note anything in the health records that could be used against Baker because those records could be accessed by lawyers, ICE, or others. The HSA told Provider Goodwin to not chart patient statements, only the fact that she used the interpretation service to speak with the patient. She told Provider Goodwin she could use the internal, paper grievance process if she wanted to report anything.

As to the patient, Provider Goodwin continued to follow protocol by documenting his hunger strike and kept him in the medical unit so she could monitor his health. This patient's hunger strike ultimately lasted around 15-16 days, although his chart only showed approximately 12 days due to the falsifications. When he ended the strike one evening, the patient flagged down Provider Goodwin and asked her for food, saying the BCSO officers refused him anything to eat. Provider Goodwin asked her superior the DON about providing him with a meal, and the DON told her to not feed him as she wanted to contact ICE first. Contacting ICE for permission to feed a patient who goes off his hunger strike was unusual and not standard procedure based on Provider Goodwin's experience at Baker. This situation arose around 6 p.m., so Provider Goodwin expected the DON would not hear back from ICE until the next day, meaning her patient would go one more night without food, an aggravating risk to his health. In Provider Goodwin's medical judgment based on her years of medical experience, accepted medical practice was to provide him food.[94] Rather than wait for the DON to contact ICE and, therefore, jeopardize her patient's health, Provider Goodwin called a superior at Armor, the Regional Vice President, who agreed with her plan to feed the patient. Provider Goodwin then found a nutritional drink and gave it to him. She also noticed the patient's uneaten lunch and dinner trays were still sitting next to his cell and asked the BCSO officer to give those meals to him as well. The HSA verbally reprimanded Provider Goodwin for having fed the individual and told her to stop engaging with him, despite him being her patient.

In addition to this incident, BCSO also falsified meal records for a mental health patient being held in solitary confinement who was not eating and, at times, being denied food. Provider Goodwin

[93] *Id.*

[94] NDS at 4.2(I) requires the facility to adhere to "accepted medical practice." "Nothing in this detention standard is intended to limit or override the exercise of sound medical judgment by the clinical medical authority (CMA) responsible for a detainee's medical care. Each case must be evaluated on its own merits and specific circumstances, and treatment shall be given in accordance with accepted medical practice." *Id.*

understood that he had been in solitary for at least a month, apparently sent to Baker from the state hospital. In mid-August 2023, the two CPAP patients in the solitary unit for medical reasons told Provider Goodwin this patient was not eating. The patient was in their sight line and they could observe his behavior. They said this patient was in desperate need of care, as he was frequently naked, refusing to wear his clothes, and he would smear his feces around the cell. One BCSO officer was particularly unsympathetic towards this patient's mental health needs. The officer would bring the patient a meal, open the cell door, taunt him with it, then pull the food back, slam the door closed, and leave the food outside the cell where the patient could not reach it to eat. The CPAP patients told Provider Goodwin the officer said if the patient didn't eat, he would not have any feces to smear. These two men also reported their concerns through the tablet grievance portal, which reached the BCSO Lieutenant. Provider Goodwin checked the patient's medical records, which showed the officers contradictorily reported the patient had been eating. Provider Goodwin followed up with the BCSO Lieutenant personally to make sure he was aware of the situation. While the BCSO Lieutenant acknowledged her concern, Provider Goodwin saw no action taken. Rather, the CPAP patients told her they lost their yard privileges after filing the grievance, in violation of the NDS prohibiting such retaliation.[95] The patient, meanwhile, was moved from the more heavily trafficked area near the patients with the CPAP machines to the back of the solitary unit where he was alone and his treatment could not be readily observed by these men or others.

iii. Chronic Medical Conditions Were Not Monitored

Provider Goodwin uncovered other health record falsifications while talking with her patients, then reviewing their patient records. Specifically, she discovered Armor nurses falsified records related to monitoring chronic health conditions, including blood pressure readings and insulin tests, which hid life threatening conditions of hypertension and diabetes, in violation of the IGSA[96] and NDS.[97] Charts Provider Goodwin reviewed showed blood pressure readings that do not exist through typical monitoring methods, indicating they were fake entries.

In addition, Armor and/or BCSO personnel falsified meal records by stating patients with special dietary needs, such as diabetes, for example, had received the medically appropriate meal. The NDS requires patients to be given therapeutic meals as prescribed by the Armor health practitioner. Baker is responsible for preparing the meals, which are delivered to the individuals in custody by the BCSO officers. In reality, multiple patients told Provider Goodwin they were given the same meal as the general population, regardless of medical requirements, in violation of the NDS.[98]

[95] NDS *Supra* note 15.
[96] IGSA at 6 § VI(F) ("Detainees with chronic conditions shall receive prescribed treatment and follow-up care.").
[97] *See e*.g., NDS at § 4.3(II)(M) ("The facility will notify ICE/ERO of any detainee who requires close medical supervision, including chronic and convalescent care. The facility shall develop a written treatment plan, including access to health care and other treatment, and coordination with nonmedical personnel as necessary.").
[98] NDS at § Food Service – Medical Diets 4.1(G) ("Detainees with certain conditions−chronic or temporary; medical, dental, and/or psychological−shall be prescribed special (therapeutic) diets, supplemental meals, or snacks as appropriate by authorized medical staff. If a prescribed medical diet conflicts with a common-fare diet, the medical diet takes precedence.").

Failure to provide the special medically-required meals jeopardized patients' health; for instance, a meal high in carbohydrates would disrupt the blood sugar levels of a patient with diabetes.

c. Unsafe, Unsanitary, and Unhygienic Living Conditions Endangered Health of Detained Individuals

The BCSO maintained unsafe, unsanitary and unhygienic living conditions leading to serious medical problems in violation of the IGSA[99] and NDS. Specifically, Provider Goodwin identified the following threats:

i. Leaking Roof Caused Slip and Falls, Pooled Water, and Mold

Provider Goodwin observed that Baker's roof was in disrepair, leaking water all over the facility every time it rained and presenting a slip and fall hazard, in violation of the IGSA's general safekeeping requirements and the NDS.[100] The problem of the leaking roof was so pervasive that Provider Goodwin sometimes observed buckets in the hallways to catch rainwater.

Each time it rained, Provider Goodwin cared for multiple patients with sprained ankles and other injuries who had fallen on the wet concrete floors. Facility staff were inattentive and failed to clean up wet floors and mitigate slip and fall hazards from the leaking roof as well as other spills.

In July 2023, Provider Goodwin treated one man who had slipped on a wet floor two weeks prior and injured his shoulder. He complained of persistent pain, but never received treatment. The patient needed an MRI, but his chart noted he had refused treatment. He denied refusing treatment and told Provider Goodwin he was never offered an MRI. Provider Goodwin and other providers are required to submit referrals for all such procedures to a clerk, who, in turn, submits it to ICE for approval. Provider Goodwin submitted the referral for an MRI, but never received approval for it. The person responsible for submitting treatment referrals told Provider Goodwin that ICE would never approve the MRI. Provider Goodwin does not know whether the MRI referral was denied or if it was even submitted to ICE.

Provider Goodwin reported her concerns about the unsafe, unsanitary, and unhygienic living conditions to BCSO and Armor superiors during weekly administrative meetings, which included the HSA, the DON, the BCSO Lieutenant and the BCSO Undersheriff. At those meetings, staff frequently discussed, in particular, how the roof had been leaking for years. BCSO officials discussed efforts to patch the roof to avoid repercussions from ICE, but these patches were not working, given the roof continued to leak. Provider Goodwin observed the leaking roof also caused

[99] IGSA, Article III(B) Basic Needs:

> The Service Provider shall provide ICE detainees with safekeeping, housing, subsistence, medical and other services in accordance with this Agreement. In providing these services, the Service Provider shall ensure compliance with all applicable laws, regulations, fire and safety codes, policies and procedures. The types and levels of services shall be consistent with those the Service Provider routinely affords other inmates.

[100] *See generally*, NDS at § 1.1 Environmental Health and Safety; "This detention standard protects detainees, staff, volunteers, and contractors from injury and illness by maintaining high facility standards of cleanliness and sanitation, safe work practices, and control of hazardous substances and equipment." *Id.* at § 1.1(I).

significant mold issues at Baker, in violation of the IGSA's general safekeeping requirements[101] and the NDS environmental health and safety standards.[102] For example, Provider Goodwin observed mold around sinks, on floors, and near toilets, and observed wet stains on ceilings.

The HSA also warned Provider Goodwin to stop reporting in the medical chart the cause of a patient's slip-and-fall injury, i.e., when due to a wet floor from the leaky roof, as that notation could be used against Baker in court.

In addition, shortly after joining Baker, the quality control officer, an Armor employee, told Provider Goodwin to backdate a notebook of area inspection reports, pre-filled to say confinement areas were clean, to make the notebook current. At that time, Provider Goodwin did not realize the significance of this request. She soon learned, however, that these forms were required to be kept up to date in case of an ICE audit and failure to do so could be a reason for Baker to fail its audit.

ii. Unreasonably Cold Cell Temperatures

The temperature in the general population and solitary cells throughout the facility were unreasonably cold, in violation of the NDS.[103] The NDS requires cells be maintained at "appropriate" temperatures.[104] Provider Goodwin observed blue lips due to the chill were common among those held at Baker. She was particularly concerned about those on suicide watch who only wore a smock and had no blanket for warmth, and for the mental health patients who sometimes stripped themselves naked in their cold cells. She asked a BCSO officer why the cells were kept so cold and the officer said the thermostat was held at 53 degrees and would not be changed. Provider Goodwin believes the reason for the cold temperature was to keep mold at bay for medical reasons because the leaky roof problems throughout Baker created a persistently damp environment conducive to growing mold. Provider Goodwin understands mold, in particular black mold, can cause permanent health problems or death. If mold is found, the BCSO would have to shut down the area to clean it out, meaning Baker would lose needed funding from its ICE contract.

iii. Insect Infestation and Bites

In addition to the safety hazards caused by the leaking roof, Provider Goodwin regularly reported during weekly administrative meetings that the detained individuals' living areas at Baker were infested with spiders. This infestation was in violation of the IGSA's safekeeping standards and the NDS.[105] Provider Goodwin routinely treated patients with spider bites, including some that had turned into large abscesses, which were consistent with the venomous brown recluse. Left

[101] IGSA, at 3, § III(B).
[102] *See generally* NDS at § 1.1; "Environmental health conditions will be maintained at a level that meets recognized standards of hygiene." *Id.* at § 1.1(II)(I); "Facility cleanliness and sanitation shall be maintained. All surfaces, fixtures, and equipment shall be kept clean and in good repair." *Id*. at § II(I)(2).
[103] *Id*. at 2.9(II)(H) ("Cells and rooms used for purposes of segregation must be well ventilated, adequately lit, **appropriately heated/cooled**, and maintained in a sanitary condition at all times, consistent with safety and security.") (emphasis added).
[104] *Id.*
[105] *Id*. at § (II)(E) ("Pests and vermin shall be controlled and eliminated.").

untreated, the brown recluse bite leads to necrosis, gangrene, and ultimately death. Multiple patients also told Provider Goodwin worms crawled up through shower drains into the facility.

iv. Poor Quality Bedding

The NDS requires Baker to provide detained persons with a mattress, a pillow, and bedding.[106] However, the "mattresses" Baker provided were actually thin foam mats, and no pillows were provided. Provider Goodwin was aware of several patients who had undergone back and hip surgery who were forced to sleep on this poor quality bedding which may have exacerbated their physical health condition. Some of Provider Goodwin's patients had health conditions that prevented them from laying flat on their backs, including individuals recovering from surgery, lung issues, and elderly persons all with limited range of motion. On more than one occasion Provider Goodwin submitted medical supply requests for pillows for detained persons who lacked them; however, these requests were frequently ignored or denied. The Baker officer who was in charge of supplies told Provider Goodwin that pillows would not be provided because "if you give it to one you gotta give it to everybody and we're not gonna start that." Additionally, those held in the solitary unit on suicide watch were denied sheets or a blanket, and women frequently slept in soiled bedding because of the insufficient menstrual hygiene products provided.

v. Insufficient Basic Hygiene Supplies

Provider Goodwin observed that Baker did not provide those in custody with sufficient toiletry and hygiene necessities, in violation of the NDS.[107] Instead, Baker rationed toilet paper at two thin, single-ply rolls per person each week, such that individuals in custody would run out within a few days. Provider Goodwin observed that in the women's housing unit, women used pairs of socks for toilet paper — one sock for urine and one for feces. Women would hand wash the socks to try to clean them and leave them out to dry. Many went without wearing socks so they could use them for hygiene needs.

The women also did not receive adequate menstrual products. They received about 30 pads or tampons a month, but they were too thin to handle normal menstrual bleeding. The pads were more akin to panty liners, with women needing to use three or four pads at a time. Provider Goodwin

[106] NDS at § Issuance and Exchange of Clothing, Bedding, and Towels (I) ("policy requires that all facilities housing INS detainees in accordance with this standard provide clean clothing, bedding, linens and towels to every INS detainee upon arrival. Further, facilities shall provide INS detainees with regular exchanges of clothing, linens, and towels for as long as they remain in detention.").

[107] *See e.g.*, NDS at § Personal Hygiene 4.4(I) ("Good hygiene is essential to the well-being of detainees in the custody of ICE/ERO."); *Id.* at (II)(F) ("Distribution of hygiene items shall not be used as reward or punishment. Each detainee shall receive, at a minimum, the following items: 1. One bar of bath soap, or equivalent; 2. One comb or equivalent; 3. One tube of toothpaste; 4. One toothbrush; 5. One bottle of shampoo, or equivalent; and 6. One container of skin lotion. The facility administrator may modify this list as needed (e.g., to accommodate the use of bulk liquid soap and shampoo dispensers)…Female detainees shall be issued and may retain sufficient feminine hygiene items, including sanitary pads or tampons, for use during the menstrual cycle, and may be permitted brushes to replace combs. The facility shall replenish personal hygiene items at no cost to the detainee on an as needed basis, in accordance with written facility procedures."); and *Id.* at § II(G) ("Detainees shall be provided with a reasonably private bathing and toileting environment in accordance with safety and security needs.").

personally saw that multiple women's bedsheets and clothing were often covered in blood. Provider Goodwin raised her concerns about the inadequate hygiene supplies with Armor and BCSO officials. She first tried requesting additional toilet paper and other hygiene supplies on behalf of the individuals in custody, but the supply room clerk denied her requests. She reported her concerns to superiors at the weekly administrative meetings, but no remedial action was taken while she was at Baker.

Unable to requisition more toilet paper and menstrual pads to meet patient demands, Provider Goodwin resorted to taking some from the employee bathroom on a case-by-case basis to help those with urgent needs.

Detained individuals also told Provider Goodwin they only received a fingertip toothbrush and no toothpaste for cleaning their teeth, which presented a dental health risk. Shocked by this report, Provider Goodwin checked with the supply clerk to verify what supplies were provided for dental hygiene. The supply clerk showed Provider Goodwin the toothbrushes indeed were the fingertip style, and stated the supply office only replaced these fingertip toothbrushes after several months. The supply clerk additionally confirmed to her that Baker regularly ran out of toothpaste.

VII. PROVIDER GOODWIN EXPERIENCED RETALIATION FOR HER REPORTING OF GROSS MISMANAGEMENT, GROSS WASTE, ABUSE OF AUTHORITY, SUBSTANTIAL AND SPECIFIC DANGERS TO PUBLIC HEALTH AND SAFETY, AND VIOLATIONS OF RULES AND REGULATIONS RELATED TO THE BCSO'S IGSA WITH ICE

a. The BCSO and Armor Retaliate against Provider Goodwin

Provider Goodwin experienced retaliation for her reporting of gross mismanagement, gross waste, abuse of authority, substantial and specific dangers to public health and safety, and violations of rules, and regulations related to Baker's IGSA with ICE. While at Baker, Provider Goodwin suffered increasingly hostile attitudes from her superiors before finally being terminated. As detailed above, Provider Goodwin reported multiple violations to the BCSO Lieutenant, her superior with BCSO, and the HSA, her superior with Armor, including the numerous falsifications and forgeries in patient health charts. She also regularly reported her concerns about the unsanitary and unsafe living conditions at Baker during the weekly staff meetings, which the HSA, the DON, and the BCSO Lieutenant attended.

Initially, the HSA seemed supportive of her reports and concerns about the quality of patient care, helping Provider Goodwin document and report chart forgeries and falsifications. Heading into mid-August, however, her attitude changed. The HSA verbally reprimanded Provider Goodwin several times for correcting inaccurate chart notes regarding a hunger striker and for innocuous interactions with patients, including providing one with a nutritional drink following a hunger strike, and for offering encouraging words of support to other patients in their efforts to get released from the facility.

Provider Goodwin's complaints to superiors, including the BCSO Lieutenant, about patient mistreatment and facility living conditions meanwhile went unanswered and unresolved. In late August, the HSA, who was helping Provider Goodwin document the medical record falsifications, was terminated from Baker.

Shortly thereafter, on Friday, September 1, 2023, Provider Goodwin's privileges to work at Baker suddenly were revoked for unknown reasons. She arrived at Baker that morning, and everything seemed normal. Provider Goodwin worked all day as usual. The only odd behavior she noticed was her superiors repeatedly asking her if she finished her work notes for the day. At the end of her shift the BCSO Lieutenant walked up to her and said her privileges were being revoked effective immediately and escorted her out the front door.

Provider Goodwin did not receive a written statement of reasons for the revocation of her privileges. When the BCSO Lieutenant was walking her out, he told her she was terminated because she presented a "security risk" and had developed friendly relationships with the detained persons. The BCSO Lieutenant cited an example of Provider Goodwin giving a high-five in congratulations to a patient upon being told he would be released. The BCSO Lieutenant's claim that Provider Goodwin was a security risk is dubious, particularly considering she was permitted to work at Baker all day before being escorted out at day's end.

After leaving Baker that afternoon, Provider Goodwin called superiors at Armor, including the Medical Director and the Regional Vice President, who reassured her Armor was not terminating her and would relocate her to another facility. By that Tuesday, however, Armor backtracked; the Regional Vice President called Provider Goodwin to say Armor was now terminating her contract because she was no longer hirable in a correctional setting after having been let go from Baker. Her last paycheck was September 8, 2023.

Provider Goodwin reasonably believes she was let go from Baker because of her complaints about the health record falsifications, living conditions, and violations of the medical rights of individuals at Baker.

b. Provider Goodwin Suspects Blacklisting

The BCSO's and Armor's retaliation appears to have continued into her next position of employment. Following her retaliatory termination, Provider Goodwin hunted for work for almost two months, finally obtaining a position with NaphCare on October 23, 2023 at Duval County Jail ("Duval") in Jacksonville, FL.[108] NaphCare took over as the medical contractor at Duval

[108] Provider Goodwin earned salary and benefits with Armor. With NaphCare, she earned approximately the same hourly rate, but overall earned less in overtime and could not afford benefits. Provider Goodwin incurred seven weeks of lost wages plus additional amounts in lost benefits, credit card interest charges, and other damages, due to the retaliatory termination.

September,1 2023[109] after Armor's contract was terminated for mistreatment of detained individuals and poor medical care.[110]

While at Duval, Provider Goodwin encountered BCSO officers on several occasions. The first instance occurred in December 2023 as BCSO officers were transporting persons in custody between Duval and Baker. Provider Goodwin spoke with one briefly and said hello to another. In early January 2024, Provider Goodwin then saw the BCSO Undersheriff in the hallway, and they nodded hello to each other. Given her history with the BCSO and her termination, Provider Goodwin was nervous to see the BCSO Undersheriff, but the moment passed without incident.

On January 14, 2024, however, Provider Goodwin received a call from NaphCare, telling her not to report for work. She was initially told she was being placed on administrative leave pending an investigation, but was not told the nature of the investigation. A week later, she received a letter by FedEx informing her she was terminated effective January 18, 2024, with no specific reason stated.[111] It merely quoted a clause from her contract that identified a list of grounds for immediate dismissal. Provider Goodwin was never offered the opportunity to participate in an inquiry or hearing, asked any questions about the alleged incidents, or offered a chance to rebut any allegations. Upon learning of Provider Goodwin's dismissal, her fellow nurses rallied around her in support, calling on NaphCare to reinstate her, but to no avail.

Provider Goodwin once again began looking for a job. Finally, on March 11, 2024, Provider Goodwin found new work at a correctional center three hours from her home and for less pay than what she made at Baker and Duval.

VIII. WRONGFUL RETALIATION OF PROVIDER GOODWIN FOR PROTECTED WHISTLEBLOWING

Provider Goodwin's revocation of privileges at Baker constitutes wrongful retaliation and is a prohibited personnel practice under 41 U.S. Code § 4712.

Federal law prohibits a federal contractor or subcontractor from discharging an employee in retaliation for the employee's disclosure to persons or entities with oversight authority, including a member of Congress, a "Federal employee responsible for contract or grant oversight or management at the relevant agency," or a "management official or other employee of the contractor, subcontractor, grantee, or subgrantee who has the responsibility to investigate, discover, or address misconduct," of "gross mismanagement" of a federal contract, "a gross waste of federal funds," "an abuse of authority," "substantial and specific danger to public health or safety," and/or "violation of law, rule, or regulation related to a federal contract." 41 U.S. Code § 4712(a).

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[109] Hanna Holthaus, *JSO canceled contract will jail healthcare provider Armor, hire NaphCare amid controversy,* Florida Times Union, (Jul. 25, 2023), https://www.jacksonville.com/story/news/politics/government/2023/07/25/jso-will-cancel-contract-with-armor-healthcare-hire-naphcare-amid-state-investigation-controversy/70463675007/.
[110] Nichole Manna, *From Armor to NaphCare: Unraveling the Jacksonville Sheriff's Office's jail health deals*, The Tributary, (Sept. 20, 2023, updated Sept. 21, 2023), https://jaxtrib.org/2023/09/20/from-armor-to-naphcare-unraveling-the-jacksonville-sheriffs-offices-jail-health-deals/. *See also Supra* note 11.
[111] Ex. 5, NaphCare notice of termination of Vera Goodwin's Contract, January 18, 2024.

To prove retaliation under 41 U.S.C. § 4712, the complainant must demonstrate that a disclosure or protected activity was a contributing factor in the personnel action which was taken against such employee.[112] The employee can demonstrate the disclosure or protected activity was a contributing factor in the personnel action through circumstantial evidence,[113] such as evidence that the official taking the personnel action knew of the disclosure or protected activity; and the personnel action occurred within a period of time[114] such that a reasonable person could conclude that the disclosure or protected activity was a contributing factor in the personnel action. The burden then shifts to the employer to demonstrate by clear and convincing evidence[115] that it would have taken the same personnel action in the absence of such disclosure.[116]

Provider Goodwin's reports of medical record falsifications and forgeries, substandard patient care, the hazardous living conditions, mistreatment of individuals in custody, and other violations of laws, rules, and regulations were protected activity under 41 U.S.C § 4712, and the retaliatory revocation of Provider Goodwin's privileges by the BCSO Lieutenant and other Baker officials and termination by Armor, constituted illegal reprisal under 41 U.S.C § 4712.

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[112] 41 U.S.C. § 4712(c)(6) applies the legal standards for burdens of proof specified in 5 U.S.C. § 1221(e), which governs claims for retaliation filed under the Whistleblower Protection Act, codified at 5 U.S.C. §§ 2302(b)(8) & 2302(b)(9).

[113] It is well established that nexus can also be established through circumstantial evidence. Criteria that can be used to establish the nexus between protected activity and the personnel action include: whether the proposing or deciding official was a target of the disclosures; the employer's hostile reaction to protected disclosures; discriminatory treatment compared to before making the disclosure; extent of disclosures; significance of the charges; strengths and weaknesses of the agency basis for a personnel action; adequacy of agency investigation and corrective action on alleged, confirmed misconduct; and the chilling effect. *See, e.g., Rumsey v. Dep't of Justice*, 120 M.S.P.R. 259, 273 (2013); *Valerino v. Dep't of Health and Human Services*, 7 M.S.P.R. 487, 489-90 (1981); *Fellhoelter v. Dep't Agriculture*, 568 F. 3d 965, 971 (Fed. Cir. 2009); *Daniels v. Dep't of Veterans Affairs*, 105 M.S.P.R. 248, 259 (2007); *Stiles v. Dep't of Homeland Security*, 116 M.S.P.R. 263, 273-74 (2011); accord *Sheehan v. Dep't of Navy*, 240 F.3d 1009, 1014 (Fed. Cir. 2001); *Webster v. Dep't of the Army*, 911 F.2d 679, 689-90 (Fed. Cir. 1990).

[114] As a matter of law, after a deciding official acquires knowledge of the disclosure, any prohibited personnel action taken "within a period of time such that a reasonable person could conclude that the disclosure was a contributing factor in the personnel action," can satisfy the nexus requirement. 5 U.S.C. § 1221(e)(1)(B). Prior Board precedent has ruled, for example, that a personnel action occurring within one to two years of the protected activity is sufficient to meet this test. *See Schnell v. Dep't of Army*, 114 M.S.P.R. 83, 93 (2010). Thus, events occurring within a shorter amount of time sufficiently meet the test.

[115] An agency can overcome the whistleblower's *prima facie* case if it demonstrates by "clear and convincing evidence" that it would have taken the same action anyway in the absence of protected conduct. In *McCarthy v. International Water Boundary Commission*, MSPB No. DA-1221-09-0725-W-1, 116 MSPR 594 (2011), the Board reaffirmed that:

> Clear and convincing evidence is that measure or degree of proof that produces in the mind of the trier of fact a firm belief as to the allegations sought to be established; it is a higher standard than preponderant evidence. 5 C.F.R. S. 1209.4(d) (2009). In determining whether an agency has shown by clear and convincing evidence that it would have taken the same personnel action in the absence of whistleblowing, the Board will consider the following factors: (1) the strength of the agency's evidence in support of its action; (2) the existence and strength of any motive to retaliate on the part of the agency officials who were involved in the decision; and (3) any evidence that the agency takes similar actions against employees who are not whistleblowers but who are otherwise similarly situated.

[116] See 5 U.S.C. § 1221(e).

During her tenure at Baker, Provider Goodwin reported multiple violations about patient rights and the quality of medical care and living conditions to superiors including, the HSA, the DON and the BCSO Lieutenant, all of whom were management officials with their respective entities. The timing of her dismissal by the BCSO Lieutenant, which occurred within a month of her escalating reports to these superiors, indicates her whistleblowing was at least a contributing factor to her dismissal. Baker leadership had not addressed any of Provider Goodwin's reports by the time she was terminated. Instead, by mid-August, the HSA did an about-face of her prior support in early August for Provider Goodwin's complaints, verbally reprimanding her for correcting health charts regarding hunger strikes and other falsified or misleading medical notes.

Neither Baker nor Armor officials provided any formal justification for her revocation of privileges. The BCSO Lieutenant told Provider Goodwin informally as he marched her out the door on her last day that she presented a "security risk" because she was friendly with patients, citing as an example giving an inmate a high-five, for which she was verbally reprimanded by the HSA. The BCSO Lieutenant's stated reason appears pretextual. The alleged incidents of friendliness dated back several weeks and he cited no specific security incident as having occurred on her last day or even in the past week. Additionally, Provider Goodwin was not contacted about any investigation into a security incident. Rather, she was permitted to work all day as usual, except for superiors pressing her to make sure her notes were completed. The inconsistency between actions by Baker and Armor – permitting Provider Goodwin to work a full day – and the purported reason for her dismissal do not meet the high burden to prove by clear and convincing evidence that Baker and Armor would have dismissed Provider Goodwin in the absence of her disclosures.

Moreover, Provider Goodwin was dismissed shortly after the HSA, who had been helping her document the health chart falsifications about which they complained together to the BCSO Lieutenant. The two people who reported these falsifications to the BCSO Lieutenant were both suddenly dismissed almost back-to-back. With the complaints and dismissals primarily occurring within a month, a reasonable person must conclude Provider Goodwin's complaints were a contributing factor to her termination.

In addition, the retaliation apparently continues. Provider Goodwin has encountered unusual obstacles to finding a reliable new employer – the sudden dismissal from Duval with no justification within a few months of her employment and her general difficulty in finding a similarly situated job in Florida. The occurrence of these incidents involving facilities and employers with connections to the BCSO and Armor raise questions about whether those two respective entities are interfering with her job search and ability to earn a living are engaging in ongoing wrongful retaliation against her.

Provider Goodwin's dismissal might also have violated §115.67(a) of PREA, which prohibits retaliation against staff and contractors who report, complain about, or participate in an investigation into an allegation of sexual abuse. Her complaint regarding Ana's treatment in solitary and the forced removal of her clothes could be considered such a complaint as envisioned

by §115.67(a), and is just one instance that Provider Goodwin complained of, leading to her retaliatory termination.[117]

IX. CONCLUSION

The BCSO continues to manage the ICE detention facility at the Baker County Detention Center, providing medical care via a third-party subcontractor, formerly Armor and now YesCare. The behavior of BCSO representatives towards Provider Goodwin and others shows a culture of contempt that lead to abuse, neglect, and retaliation towards workers and persons in custody that cannot and should not be ignored. While Armor is no longer the subcontractor, the culture of wrongdoing can be expected to continue under the new provider as BCSO drives that culture and ICE failed to exercise proper oversight to deter this conduct and ensure the BCSO's compliance with the IGSA.

On behalf of Provider Goodwin, the undersigned counsel requests that the Department of Homeland Security Office of Inspector General investigate this whistleblower disclosure and retaliation complaint without delay.

Ms. Vera Goodwin is represented by Andrea Meza and Dana Gold of Government Accountability Project, 1612 K Street NW, Suite 1100, Washington, DC 20006. Ms. Meza may be reached at AndreaM@Whistleblower.org or (202) 463-1312; Ms. Gold may be reached at and DanaG@whistleblower.org or (202) 926-3306.

Sincerely,

/s/ Andrea Meza

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[117] PREA, at 13173, §115.67(a): ("(a) Staff, contractors, and volunteers, and immigration detention facility detainees, shall not retaliate against any person, including a detainee, who reports, complains about, or participates in an investigation into an allegation of sexual abuse, or for participating in sexual activity as a result of force, coercion, threats, or fear of force.")