June 30, 2022

Via Electronic Mail and USPS

Robert K. Lynch
Director, Detroit Field Office
U.S. Immigration and Customs Enforcement
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Re: The Tragic Death of Jesse Jerome Dean Jr. Shows ICE Must End Its Contract with Calhoun County and Replace Detention with Alternative Forms of Supervision.

Dear Director Lynch:

On behalf of a coalition of racial justice and immigrant rights organizations, we are writing in response to the tragic death of Jesse Jerome Dean Jr., who died of a bleeding ulcer and hypertension while in immigration detention at the Calhoun County Correctional Facility ("CCCF"). ICE's own documents, which we recently received through a Freedom of Information Act request, make it clear that Mr. Dean, a Black man from the Bahamas, would not have died if CCCF had provided him even basic levels of medical care for his treatable conditions. His death demands accountability and change.

Our hope for this letter is to honor Mr. Dean's life by identifying how ICE can prevent such needless tragedies from re-occurring in the future. In that spirit, we urge you to start with **terminating your Intergovernmental Service Agreement (the "Contract") with CCCF, a facility with a long track record of abysmal treatment of people detained there.**

The Tragic and Unnecessary Death of Mr. Dean

For years our organizations have received complaints about CCCF's abhorrent medical care. However, not until we finally obtained 1590 pages of ICE records related to Mr. Dean's death, were the abysmal conditions inside CCCF put in stark relief. The records depict a completely dysfunctional medical system with callous disregard for the welfare of people held for ICE at CCCF, including Mr. Dean, who died because of these conditions.

A full chronology of Mr. Dean's tragic detention at CCCF is attached as Exhibit A. In short, the records show that:

- Mr. Dean began complaining of stomach pain and other medical issues almost immediately after arriving at CCCF on December 31, 2020. Less than two weeks into his time at CCCF, his stomach pain was so bad that he could not eat his meals. By week four, he had lost nearly twenty pounds and was telling staff that he felt like he was going to die.

- Over the course of a month, Mr. Dean complained to CCCF staff about his medical needs at least 27 times. Staff either improperly responded to these complaints or ignored them altogether. In fact, staff said that Mr. Dean's complaints were a behavioral problem and warned him that if he continued to seek medical attention, he would be disciplined.

- On the night before Mr. Dean's death, he collapsed in his cell and was finally transferred out of his cell. But instead of taking Mr. Dean to a medical unit, staff placed him in administrative segregation. No medical staff checked on Mr. Dean through the entire night he was in administrative segregation. He died in the morning.

These are just a few of the many harrowing details these documents we received reveal. For a detailed chronology outlining the medical neglect that resulted in Mr. Dean's death, see Exhibit A below.

ICE's Investigation of Mr. Dean's Medical Care

Our conclusion that the medical care at CCCF was terribly inadequate in Mr. Dean's case is confirmed by ICE's own internal investigation. ICE concluded that CCCF and its medical provider, Corizon Health, violated nine of ICE's National Detention Standards. ICE also identified eight additional "areas of concern." Among those violations and concerns were:

1. A failure to conduct a timely comprehensive health assessment and a dental screening.

2. A failure to provide Mr. Dean with necessary medicine.

3. A failure to properly respond to Mr. Dean's high blood pressure readings, including the failure of nursing staff to notify a physician, the failure to monitor Mr. Dean for side effects, and the failure to recheck his blood pressure for ten days.

4. A repeated failure to conduct medically indicated exams (i.e., abdominal exams in response

to Mr. Dean's numerous complaints about abdominal pain).

5. A failure to have medical staff check on Mr. Dean during the night that he was in administrative segregation (the night before his death), despite specifically putting him there for medical observation.

6. The lack of proper certification or medical licenses by multiple members of the medical staff at CCCF. One nurse who treated Mr. Dean even resigned after refusing to verify her CPR certification.

This list is just a selection of the many violations and concerns ICE identified. It is rare for the public to see—as we can here through the released documents—ICE making such clear and numerous conclusions about medical neglect at a facility holding people detained by ICE. ICE cannot simply ignore its own findings and carry on allowing CCCF to provide the same abject medical care to others detained there.

ICE Must End its Contract to Warehouse Human Beings at CCCF

Warehousing human beings for profit is as immoral as it is counterproductive. These types of detention arrangements further the punitive schemes of incarceration and immigration enforcement that perpetuate racism against Black and brown communities in the United States. Today, the U.S. deportation machine disproportionately detains and deports Black immigrants.[1] Mr. Dean was one of the people targeted by that system. And he paid with his life.

ICE's decision to warehouse human beings at CCCF is even more immoral because it is clear that CCCF cannot hold people safely. ICE bears responsibility for the conditions at the locations it chooses to send people. CCCF has long been a particularly troublesome immigration detention facility. Detainees have frequently complained of mistreatment by staff and abysmal health services—complaints that have only increased during the COVID-19 pandemic. It is abundantly clear that CCCF is incapable of meeting its most basic health care obligations under the Contract it has with ICE, making termination of the Contract a moral and legal imperative.

ICE also has an obligation to ensure the safety of the people in its custody. Under the Contract, CCCF has agreed to take on that obligation by providing appropriate medical services to detained people. It did not do so. And that cost Mr. Dean his life. Yet despite that tragic outcome, and despite ICE's own scathing internal review of the circumstances around Mr. Dean's death, ICE has kept its Contract with CCCF. If ICE takes seriously its obligation to protect the people in its custody, ICE must terminate its Contract with CCCF.

[1] Morgan-Trostle, M., Zheng, K. & Lipscombe, C. (2016). The State of Black Immigrants. Black Alliance for Just Immigration and NYU School of Law Immigrant Rights Clinic. Available at https://stateofblackimmigrants.com/assets/sobi-fullreport-jan22.pdf.

Regrettably, Mr. Dean's medical mistreatment is not an isolated incident. But hopefully it can be the last death at CCCF. We urge ICE to acknowledge its responsibility for Mr. Dean's death and terminate its Contract with CCCF. The Contract provides that either party may terminate the contract for any reason upon 60 days prior written notice. It is entirely within ICE's own power to terminate its relationship with CCCF, and ICE should immediately notify CCCF of its decision to terminate the Contract.

People Should Be Supervised in the Community Instead of Needlessly Detained

Mr. Dean died not just because CCCF neglected his medical care, but because ICE detained him there in the first place. Indeed, Mr. Dean begged to be allowed to go to the hospital and pay for his own care—something he could have done if he were not behind bars—but that request was ignored. If ICE had not insisted on keeping Mr. Dean behind bars, he almost certainly would still be alive today.

In 2016, the Homeland Security Advisory Council recommended that ICE "reduce reliance on detention in county jails," noting that according to both immigrants' rights advocates and current and former ICE officials, "county jails are, in general, the most problematic facilities for immigration detention."[2] As Mr. Dean's case shows, jails like CCCF are often inadequately prepared to provide proper medical care and are indifferent to the life-threatening hazards that result from such poor care. Because ICE selects its service providers, it cannot absolve itself of their deplorable practices and is responsible for the failures of the agents it chooses to work on its behalf.

In the longer term, the only viable solution is to replace immigration detention with community-based case management for people in immigration proceedings. In the shorter term, though, ICE itself can supervise people in the community, rather than detaining them at CCCF.

Conclusion

Nothing can bring Mr. Dean back to his family. But ICE can honor the life that was lost, take responsibility for what happened, and act now to prevent more such needless tragedies from occurring. We urge ICE to end its Contract with CCCF, move to a system of community supervision, and ensure safety and medical care for anyone it detains in the interim.

We respectfully request a response to this letter by July 15, 2022.

Sincerely,

Seydi Sarr
African Bureau for Immigration and Social Affairs (ABISA)

[2] "Report of the Subcommittee on Privatized Immigration Detention Facilities," Homeland Security Advisory Council, Dec. 1, 2016, https://www.dhs.gov/sites/default/files/publications/DHS%20HSAC%20PIDF%20Final%20Report.pdf.

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Exhibit A:

A Chronology of an Unnecessary Death

The Events Leading Up to Mr. Dean's Death.

Jesse Jerome Dean Jr. arrived at Calhoun County Correctional Facility ("CCCF") on December 31, 2020. An immigration judge had found that he could not remain in the U.S., and he himself wished to return to his native Bahamas. ICE, instead of allowing him to leave voluntarily, detained him at CCCF. Issues with Mr. Dean's medical care began almost immediately. During an intake screening on that day, Mr. Dean reported to a nurse that he had a history of hyperlipidemia and hypertension. But despite notifying the nurse of these pre-existing conditions, Mr. Dean's hypertension medications were inconsistently administered, and the nurse failed to properly list his hyperlipidemia on his medical record until January 21, 2021, almost a month later.

Mr. Dean's blood pressure was also taken twice on December 31, when he arrived. Despite both readings meeting the American Heart Association's parameters for hypertensive crisis, medical staff did not notify a physician, order additional blood pressure checks, or monitor him for side effects. In fact, they did not even check his blood pressure again for ten days (January 10, 2021).

On January 2, 2021, Mr. Dean's medical complaints began. He complained of gas pain and belching and was provided with antacid tablets. While the tablets initially helped, his pain returned and persisted. The next week, when Mr. Dean's stomach pain worsened to the point of nausea and vomiting, a nurse simply documented Mr. Dean's vital signs (again ignoring his high blood pressure) and ordered him over-the-counter stomach relief chew tablets. By January 12, his pain was so bad that he could not eat his meals. He requested a liquid diet and stronger medicine. Inexplicably, medical staff responded to his request in Spanish, a language Mr. Dean does not speak.

Despite being put on a liquid diet and being given different chew tablets, his pain persisted. By January 20, Mr. Dean was asking to be deported to the Bahamas so he could get out of CCCF. That same day, Mr. Dean complained of ten-out-of-ten sharp abdominal pain. Again, a nurse simply gave Mr. Dean over-the-counter medication and told him to notify medical staff if his conditions worsen.

By January 21, Mr. Dean had lost sixteen pounds. He was only able to drink a few cups of water a day. He had not had a bowel movement for days. During a chronic care appointment that day, he was told that he should simply drink more water and exercise in order to alleviate his constipation. Once again, he was given an over-the-counter solution and was told to return for a follow-up appointment in three months.

Mr. Dean's complaints of severe abdominal pain increased to multiple times a day. When he submitted a complaint on January 24 stating that he could not eat regular meals and had lost twenty pounds, a nurse told him "if you feel hungry you are more than welcome to eat something out of the vending machines or off of commissary or have someone send in a care package for you." The nurse did not order any follow-up or even assess Mr. Dean. When Mr. Dean complained again that same day, a nurse responded that "[r]epeated and excessive request[s] on the same topic may result

in" disciplinary action.

On January 25, Mr. Dean complained that he felt like he was going to die, and even offered that his family could pay for a visit to the emergency room. Despite the serious nature of the complaint, a nurse refused to send him to the hospital or provide any additional immediate care, reasoning that Mr. Dean's vital signs were within normal limits. And despite being promised that a physician would check on him the next day, no provider ultimately came.

Ten days and numerous unsatisfied medical requests later, Mr. Dean nearly collapsed in his unit and was finally transferred out of his cell for medical observation. However, deputies did not place Mr. Dean in a medical unit—they took him to a non-medical administrative segregation unit. During the entire night that he was in non-medical segregation, no medical staff checked on Mr. Dean's well-being despite him being on a medical observation status. As a particularly harrowing example of CCCF's utter failure to treat Mr. Dean that night, Mr. Dean knocked on his cell window five times to ask a deputy for water. He was willfully ignored four of those times, with deputies looking his way and taking no action. When a deputy finally decided to respond, he simply directed Mr. Dean to get water out of the sink in his cell, even though Mr. Dean indicated that he could not get up. Left with no other choice, Mr. Dean was forced to crawl to the sink to get a sip of water.

The Morning of Mr. Dean's Death.

The next morning, on February 5, a nurse finally checked on Mr. Dean. He reported feeling ill, weak, and dizzy. He urged the staff he was serious about his concerns despite knowing that the staff believed he was joking. Ignoring Mr. Dean's blood pressure issues, his numerous complaints about stomach pain, and his severe weight loss, a physician's assistant told Mr. Dean that he was not showing any signs that pointed to a medical issue. At 7:45 AM, Mr. Dean was finally moved to the medical unit and given intravenous fluids (IV).

Still, his issues persisted. By 10:39 AM, Mr. Dean was moaning, groaning, and complaining that something did not seem right. In a rare occasion of taking Mr. Dean's complaints seriously, a deputy finally called in a medical emergency over the radio, stating that Mr. Dean needed to be sent to a hospital. While waiting for an ambulance, a nurse examined Mr. Dean and found that he was hypoxic (deficient in oxygen), diaphoretic (sweating profusely), had a decreased level of consciousness, and had high blood sugar and low blood pressure.

When the ambulance arrived, paramedics documented that Mr. Dean was in critical condition, unresponsive to stimuli, pale, and diaphoretic, despite having a regular pulse. Minutes later, Mr. Dean went into cardiac arrest, and they began administering cardiopulmonary resuscitation (CPR). Tragically, thirty minutes of manual and electronic chest compressions proved unsuccessful.

At 11:38 AM on February 5, 2021, Mr. Dean was pronounced dead. Mr. Dean's death certificate noted the causes of death as "Gastrointestinal hemorrhage due to duodenal ulcer" and "Hypertensive cardiovascular disease." Our documents show ICE employees recognizing "a very direct correlation" between the causes of death and "what Dean was complaining to medical staff about/experiencing over and over for at least a month before his death." One ICE employee even questioned whether ICE was going to "challeng[e] the Calhoun County/Corizon" over their terrible treatment of Mr. Dean.