ATTACHMENT A
Supplement of Claim Form 95

1. Submit to Appropriate Federal Agency

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2. Claimant Information:

- Mabel Estanislada Alvarez Benedicks, in her individual capacity as mother and heir, in her capacity as wrongful death beneficiary, and in her capacity as putative representative of the heirs and Estate of Anadith Danay Reyes Alvarez.
- Rossel Doney Reyes Martinez, in his individual capacity as father and heir, in his capacity as wrongful death beneficiary, and in his capacity as putative representative of the heirs and Estate of Anadith Danay Reyes Alvarez.

6-7. Date and Time of Injury:

- Dates of Injury: May 9, 2023 – May 17, 2023
  Anadith was apprehended by Customs and Border Protection (CBP) on May 9, 2023. Between May 9 and May 17, 2023, Anadith was in the custody of CBP and its chosen third-party medical contractor. Anadith was pronounced deceased on May 17, 2023, at 2:50 p.m. CST at a hospital in Harlingen, Texas.

8. Basis of Claim:

Eight-year-old Anadith Danay Reyes Alvarez died on May 17, 2023, because U.S. Customs and Border Protection (CBP) agents refused over the course of eight days to provide her with proper medical treatment. After contracting the flu in overcrowded and unsanitary conditions in CBP custody, Anadith's condition deteriorated for several days, but CBP repeatedly refused to provide Anadith the care she needed. CBP failed to provide adequate care for Anadith resulting in her death.

Anadith's tragic death was entirely preventable. As Anadith's symptoms, which included vomiting, bone pain, chest pain, and difficulty breathing, drastically worsened, her mother Mabel repeatedly sounded the alarm. Mabel took Anadith to the CBP medical unit at least nine times. Mabel repeatedly asked for Anadith to be taken to the hospital for emergency treatment. Mabel repeatedly tried to provide information about Anadith's medical conditions.

As Anadith's illness became increasingly urgent, CBP officers dismissed Mabel's pleas. CBP refused to call an ambulance. CBP refused to review medical records documenting Anadith's medical history that Mabel carried and tried repeatedly to show to CBP as her daughter's condition deteriorated. CBP refused to consult with both the on-call physician *and* the on-call pediatrician.

The day Anadith died, Mabel took Anadith to the medical unit at least four times and continued to beg for help from anyone who would listen. But no one did. Only when Anadith fainted and suffered a seizure did CBP finally call for an ambulance. Mabel cried out that Anadith had died in her arms. Even then, CBP did not allow Mabel to ride in the ambulance with her dying daughter. Mabel was forced to ride separately and stay in the hospital waiting room, where she prepared to receive the worst news of her life.

Anadith arrived at the hospital too late. Shortly after Anadith arrived, doctors at the hospital in Harlingen, Texas, pronounced Anadith dead. Had Anadith received the medical treatment and

life-saving emergency care that she deserved and was entitled to under the law, she would have celebrated her tenth birthday on December 8, 2024.

I. Background of Anadith's Life and Death

A. Anadith's Life.

Anadith's family identifies as Garifuna, an Afro-Indigenous population in Honduras who have suffered an ongoing history of discrimination and persecution. While Anadith's mother, Mabel, was pregnant with Anadith, the family left Honduras to seek refuge in Panama. Anadith was born in Panama.

At a very young age, Anadith was diagnosed with sickle cell disease (SCD) and a heart condition. SCD is a genetic disorder that affects the stability of red blood cells. SCD can cause chronic anemia known as sickle cell anemia, painful occlusion of blood vessels, acute injury to the lungs, bones, and brain, such as strokes, as well as long-term damage to the eyes and kidneys.[1] SCD can also damage the spleen, which renders an affected child highly vulnerable to serious infections.[2] According to the Sickle Cell Disease Association of America, numerous studies have shown that "sickle cell disease has a high risk for complications and high morbidity from influenza."[3] Acute chest syndrome (a reduction in oxygen leading to chest pain, shortness of breath, and coughing) is a leading cause of death of people with SCD in the United States.[4]

When Anadith was only five years old, she had open-heart surgery to repair a congenital heart defect.[5] She traveled to Spain with her father, Rossel, for the surgery. Shortly after Rossel and Anadith returned from Spain, the coronavirus pandemic broke out globally. Because she was recovering from heart surgery, Anadith did not attend school in person during the pandemic and instead took classes virtually via Zoom. Anadith dreamt of continuing her studies to one day become a doctor so she could help others.[6] Seeking safety and opportunity for their young family, and with the hope that their smallest daughter's dreams might one day come true, Anadith's parents made the difficult decision to bring Anadith and their other children to the United States in May 2023.

B. CBP Takes Anadith into Custody.

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[1] *Flores v. Garland*, Notice of Filing of Juvenile Care Monitor Report by Dr. Paul H. Wise, Doc. 1352 at 36, CV 85-4544-DMG (C.D. Cal.), *available at* https://youthlaw.org/sites/default/files/2023-07/2023.07.18_Flores%20Juvenile%20Care%20Monitor%20Report.pdf [hereinafter *Flores* report].

[2] *Id.*

[3] MARAC Statement on Influenza, National Shortage of Oseltamivir (Tamiflu) and the Influenza Vaccine, Sickle Cell Disease Ass'n of Am., Inc. (Dec. 6, 2022), https://www.sicklecelldisease.org/wp-content/uploads/2022/12/MARAC-Statement-Flu_LO.pdf.

[4] AM. LUNG ASS'N, Learn About Acute Chest Syndrome (Oct. 23, 2024), https://www.lung.org/lung-health-diseases/lung-disease-lookup/acute-chest-syndrome/learn-about-acute-chest-syndrome.

[5] Jessica Botelho, *Border Patrol Didn't Review Medical File of Girl with a Heart Condition Before She Died*, ABC 334 (June 2, 2023), https://abc3340.com/news/nation-world/border-patrol-didnt-review-medical-file-of-girl-with-a-heart-condition-before-she-died-medical-staff-seizure-blood-disorder-health-texas-custody-internal-investigation-death-panama.

[6] Camilo Monto-Galvez, *Official Concedes 8-Year Old Who Died in U.S. Custody Could Have Been Saved as Devastated Family Recalls Final Days*, CBS NEWS (July 20, 2023), https://www.cbsnews.com/news/anadith-danay-reyes-alvarez-8-year-old-migrant-died-border-patrol-custody-family/.

On May 9, 2023, Anadith crossed the United States-Mexico border near Brownsville, Texas. She crossed the border with her immediate family members: her mother Mabel, father Rossel, and two older siblings, who were fourteen and twelve at the time. Although Anadith lived with chronic health conditions, her conditions were properly managed by her doctors at the time she entered the United States with her family.

Upon crossing the border, Anadith and her family were taken into CBP custody, along with over forty other non-citizens. When the family arrived at the first CBP tent, Anadith's mother, Mabel, told a CBP officer about Anadith's medical conditions. She also provided the officer with two medical documents: a record from Anadith's doctor in Panama documenting her sickle cell anemia and a surgeon's record of Anadith's congenital heart defect and successful heart surgery in Spain. The records also documented the nature of Anadith's heart defect: a heart murmur caused by sub-valvular aortic stenosis.

CBP officers took Anadith and her family to the Camp Monument facility in Brownsville, Texas. There, the family and several others awaited transportation to the Donna Central Processing Center (Donna CPC) in Donna, Texas.

Under CBP's National Standards on Transport, Escort, Detention, and Search (TEDS), when a detainee enters into "any CBP hold room, officers/agents must ask detainees about, and visually inspect for any sign of injury, illness, or physical or mental health concerns and question the detainee about any prescription medications."[7] Additionally, "[o]bserved or reported injuries or illnesses should be communicated to a supervisor, documented in the appropriate electronic system(s) of record, and appropriate medical care should be provided or sought in a timely manner."[8] Here, contrary to TEDS requirements, no records indicate that Anadith's conditions were communicated to a supervisor or that appropriate medical care was sought when she was initially taken into CBP custody.[9]

C. CBP Fails to Conduct and Oversee a Complete Medical Assessment of Anadith.

On Wednesday, May 10, 2023, at 7:50 a.m., Anadith and her family arrived at the Donna CPC. CBP put the family through various intake and in-processing procedures for over four hours, but they still failed to complete a full medical assessment. At 12:20 p.m., CBP's contracted medical provider, Loyal Source Government Services (LSGS), conducted a medical assessment of Anadith in the medical intake unit but failed to follow the procedures prescribed by TEDS.

During this LSGS intake, Anadith's mother again reported Anadith's medical history, including her chronic conditions and treatment. Anadith's mother also provided the same two documents: medical records brought from her home country, Panama, documenting her sickle cell

[7] U.S. Customs & Border Prot., National Standards on Transport, Escort, Detention, and Search § 4.3 (2015) [hereinafter TEDS]; *see also* OFF. OF IMMIGR. DET. OMBUDSMAN, U.S. DEP'T OF HOMELAND SEC., Ombudsman Alert: Critical Medical Understaffing on the Border, Case No. 22-003, at 1 (2022).
[8] TEDS, *supra* note 7 at § 4.3.
[9] *See id.*

anemia and a record of Anadith's successful heart surgery in Spain. This information was entered into the electronic medical record, which is operated by CBP.[10] However, the record does not reflect any consultation with an on-call physician, either by LSGS nor CBP—despite Anadith's existing medical history that should have triggered such consultation.[11]

After LSGS completed an initial medical assessment, CBP officers escorted Anadith, her mother Mabel, and her older sister to their housing cell in the Donna CPC. Anadith's father and brother were taken to a separate housing cell. According to Mabel, there were other people in the station who were clearly ill. The housing cell was dirty—with sanitary pads on the floor and only mylar blankets for warmth. Detainees were prohibited from bathing daily, and the cells stank. Additionally, the drinking water CBP officers gave them smelled like chlorine and was undrinkable. Yet, Anadith and her family were forced to endure these conditions for days.

D. Anadith Contracts the Flu.

On or about May 14, 2023, a CBP officer took a sworn statement from Anadith through her mother Mabel. The agent incorrectly reported on the I-213 form, despite Anadith's previous medical intake, that Anadith had no medical conditions.

Later that same day, Anadith first complained of illness. Her symptoms included abdominal pain, nasal congestion, and a cough. Medical staff recorded that Anadith had a fever and tested positive for Influenza A.

The records do not reflect that the LSGS staff member who assessed her consulted with an on-call physician at this time, nor did CBP intervene to address her declining condition. And despite Anadith's conditions and risk of serious illness and death, CBP officers did not transfer Anadith to a local health facility. Instead, she "remained in CBP custody as her health continued to deteriorate."[12] CBP transferred Anadith and her family to the U.S. Border Patrol Station in Harlingen, Texas (HRL), where CBP sent detainees with contagious illnesses.

Moreover, CBP officers did not require additional supervision or monitoring by LSGS, despite Anadith's increased risk factors. CBP officers remained the main point of contact and supervision while Anadith and her family were in their cell at HRL. Records show that Anadith received medication at HRL, including Oseltamivir (Tamiflu) and pain- and fever-reducing medications. According to Mabel, CBP officers did not tell her what medication Anadith received. As a child with SCD and a fever ranging from 101 to 104.9 degrees Fahrenheit at its peak, Anadith

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[10] GOVERNMENT ACCOUNTABILITY PROJECT, *Protected Whistleblower Disclosures Regarding the Performance and Oversight Failures of the Medical Services Contract of U.S. Customs and Border Protection with Loyal Source Government Services* 8 (Nov. 30, 2023), *available at* https://whistleblower.org/wp-content/uploads/2023/11/11-30-2023-Hendrickson-Congressional-Disclosure.pdf [hereinafter Nov. Whistleblower Disclosure]; *see also* Aaron Boyd, *CBP Built and Deployed an In-House Electronic Health Record System in Under 2 Years*, NEXTGOV (July 21, 2022), https://www.nextgov.com/modernization/2022/07/cbp-built-and-deployed-house-electronic-health-record-system-under-2-years/374777/.

[11] *Flores* report, *supra* note 1, at 36.

[12] *Id.*

should have received emergency treatment by a doctor immediately.[13]

E. CBP Repeatedly Denies Anadith Emergency Treatment.

Anadith's condition quickly worsened at HRL. She and her mother repeatedly asked CBP officers for medical attention. Although Anadith consulted with medical staff *nine times*, the records are unclear as to whether Anadith was ever treated or seen by a doctor. While CBP officers allowed her to see LSGS medical personnel at least nine times, her care was never escalated.[14] Accordingly, Anadith continued to deteriorate, reporting difficulty breathing, bone pain, chest pain, and abdominal pain.

On May 16, 2023, LSGS recorded that Anadith's fever peaked at 104.9 degrees Fahrenheit. For children with sickle cell disease, a fever of 101 degrees Fahrenheit is a medical emergency that should be treated by a doctor immediately.[15] However, Anadith was only treated with ice packs, a cold shower, and fever-reducing medication. CBP also failed to intervene and provide any sort of emergency medical care.

Desperate, Mabel begged CBP to call an ambulance to take Anadith to the hospital. They refused. CBP agents were even rude and dismissive of Mabel's pleas for help.[16] Mabel told one CBP officer that Anadith had bone pain—a symptom related to sickle cell disease crisis—and he responded that it was part of growing up, and she should drink more water. A CBP agent also told Anadith: "Tell me how you can't breathe, because a girl that can't breathe would be passing out and you're not passing out, you're fine."[17] CBP continued to ignore and dismiss Mabel during the critical time that Anadith's condition further deteriorated.

F. Anadith Dies in Her Mother's Arms.

On May 17, 2023, Anadith's mother, Mabel, struggled to get CBP officers' attention to again beg for a doctor and emergency treatment. The officers and guards ignored her. When Mabel was finally able to get the officers' attention, they spoke to her rudely and aggressively. The officers refused emergency treatment and instead sent Anadith with Mabel to the medical station at least four times that day. When Anadith and Mabel arrived for the fourth time that day, the nurse practitioner made a face at them.

During that final visit, Anadith again complained of pain in her chest and abdomen. Medical staff did a cursory check, claimed she was fine, and gave her an electrolyte drink. Mabel

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[13] *Sickle Cell Disease and Fever*, NATIONWIDE CHILDREN'S HOSP., https://www.nationwidechildrens.org/family-resources-education/health-wellness-and-safety-resources/helping-hands/sickle-cell-disease-and-fever (last visited Feb. 13, 2025) [hereinafter *Sickle Cell Disease and Fever*, NATIONWIDE CHILDREN'S HOSP].
[14] *See June 1, 2023 Update: Death in Custody of 8-Year-Old in Harlingen, Texas*, U.S. CUSTOMS & BORDER PROT. (June 1, 2023), https://www.cbp.gov/newsroom/national-media-release/june-1-2023-update-death-custody-8-year-old-harlingen-texas [hereinafter CBP Update June 1, 2023].
[15] *Sickle Cell Disease and Fever*, NATIONWIDE CHILDREN'S HOSP.
[16] U.S. Senate Comm. on the Judiciary, THE FAILURE TO PROVIDE ADEQUATE CARE TO VULNERABLE INDIVIDUALS IN CBP CUSTODY: MINORITY STAFF REPORT 4, 118th Cong. (2025) [hereinafter U.S. Senate Comm. on the Judiciary].
[17] *Id.* at 4.

begged a man whom she believed was a doctor to call an ambulance, explaining that Anadith could not breathe and had vomited. According to Mabel, the man said, in a harsh tone, that Anadith just needed a pill, some food, and water. He claimed that Anadith was stable and that he would only call an ambulance if she fainted.

Because Anadith could not walk, Mabel began to carry Anadith back to her cell from the medical station. They passed Rossel's cell, and Mabel told Anadith to look at her dad. At that moment, Mabel said she felt Anadith go limp in her arms and die.[18]

Anadith became unresponsive. Mabel cried and yelled that her daughter had died. Staff started administering CPR, and Anadith coughed up blood. Rossel recalled feeling helpless because he "couldn't do anything." "Medical staff only called an ambulance after Anadith suffered a seizure and was unresponsive."[19] The ambulance arrived and took Anadith to the hospital. CBP did not allow Mabel to ride in the ambulance with Anadith. Instead, Mabel was forced to ride in a separate CBP vehicle. Anadith's father, Rossel, remained locked in his cell throughout it all. At the hospital, Mabel was also not allowed in the room with her daughter and had to wait in the waiting room. Doctors at the hospital pronounced Anadith dead at 2:50 p.m. CST.

G. CBP Failed to Report Camera Outage in Violation of Federal Law.

There are no videos showing what happened to Anadith the day she died because, according to CBP, the station's camera system was out of order. Despite knowing the camera was not operational for more than a month prior, CBP did not report the outage: a clear violation of federal law.[20] According to a DHS Office of Professional Responsibility report, "CBP records revealed the camera system at Harlingen Station was flagged for repair/replacement on April 13."[21] However, "[t]he outage was not reported to CBP OPR as required by H.R. 1158, Fiscal Year 2020 DHS Consolidated Appropriation."[22] Closed circuit television recording capabilities were restored at Harlingen Station on May 23, 2023, just days after Anadith's death.[23]

II. CBP's Numerous Failures to Fulfill Its Duties to Anadith Are Well-Documented in Official Reports.

Official government reports clearly show that CBP failed to uphold its duties to Anadith while holding her in custody. These reports include: a report from CBP's own Office of Professional Responsibility (OPR), a report from Dr. Wise, the court-appointed monitor tasked with assessing the medical safety of children in immigration custody pursuant to the *Flores* settlement; whistleblower reports of several former CBP staff members; and a report by the Senate Judiciary Committee. All of these reports reach the same conclusion: CBP failed to provide adequate medical care to Anadith. The cost of that failure was eight-year-old Anadith's life.

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[18] Monto-Galvez, *supra* note 6.
[19] U.S. Senate Comm. on the Judiciary, *supra* note 15, at 11.
[20] *See* H.R. 1158, 116th Cong. § 426 (2020); *see also* CBP Update June 1, 2023, *supra* note 13.
[21] CBP Update June 1, 2023, *supra* note 13.
[22] *Id.*
[23] *Id.*

A. The CBP Office of Professional Responsibility (OPR) Investigation Revealed Critical Failures in CBP's Treatment of Anadith.

OPR issued two statements on its investigative findings into CBP following Anadith's death, on May 21, 2023, and June 1, 2023.[24] Moreover, CBP acknowledged its own failures in a June 1, 2023, media release following the OPR investigation.[25]

First, in its May 21, 2023, report, OPR noted CBP's reckless failure to communicate Anadith's medical conditions to the agents and medical staff responsible for her care. According to the report, OPR's investigation uncovered video footage showing Anadith's family arriving at the medical screening area, and specifically showing Anadith's mother, Mabel, "handing several papers to the medical provider."[26] The OPR report also confirmed "CBP records indicate that . . . the family did report a medical history including the chronic conditions of sickle cell anemia and heart disease."[27] Notwithstanding CBP's knowledge of Anadith's conditions, OPR determined in its June 1, 2023 report that "none of the CBP contracted medical personnel or U.S. Border Patrol personnel at Harlingen Station who interacted with the girl, or her mother, acknowledged being aware she suffered from sickle cell anemia or had a history of congenital heart disease."[28]

The June 1, 2023, OPR report also revealed CBP's failure to properly supervise its contracted medical provider, LSGS, in treating Anadith. OPR reported that "[b]etween the time the family arrived at Harlingen Station on the evening of May 14th and the early morning hours of May 17th, CBP contracted medical personnel reported having approximately nine encounters with the girl and her mother, who complained of fever, flu-like symptoms, and pain."[29] Although Anadith's fever "peaked at 104.9 degrees during the early morning hours of May 16," contracted medical personnel did not seek emergency care but instead simply continued to administer Tamiflu. Her fever was treated "with a combination of ice packs, antipyretic (fever reducing) medications, and a cold shower."[30]

Moreover, CBP admitted to its own failures. In the June 1, 2023, OPR media release, CBP plainly acknowledged its refusal to transfer Anadith to a hospital, despite Anadith's mother repeatedly begging for an ambulance. [31] CBP likewise admitted that its medical staff refused to

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[24] *Update: Death in Custody of 8-Year-Old in Harlingen, Texas*, U.S. CUSTOMS & BORDER PROT. (May 21, 2023), https://www.cbp.gov/newsroom/national-media-release/update-death-custody-8-year-old-harlingen-texas [hereinafter CBP Update May 21, 2023]; CBP Update June 1, 2023 *supra* note 13; *see also* GOV'T ACCOUNTABILITY PROJECT, Protected Whistleblowers' Disclosures Regarding Failure of CBP Leadership and CBP Office of Acquisition to Oversee Its Medical Services Contract with Loyal Source Government Services and Ongoing Wrongdoing by Acting CBP Chief Medical Officer 8-9 (Feb. 16, 2024) [hereinafter Feb. Whistleblower Disclosure].
[25] CBP Update May 21, 2023, *supra* note 23; CBP Update June 1, 2023, *supra* note 13.
[26] CBP Update May 21, 2023, *supra* note 23.
[27] *Id.*
[28] CBP Update June 1, 2023, *supra* note 13.
[29] *Id.*
[30] *Id.*
[31] *Id.*

review Anadith's medical documents and later denied being aware of her medical conditions.[32] CBP also conceded that it violated federal law by failing to report a camera system outage at Harlingen Station.[33]

As the events leading up to Anadith's death escalated, these reports plainly show that CBP failed to oversee and intervene in Anadith's medical care.

B. Dr. Paul Wise, the Court-Appointed Monitor under the *Flores* Settlement, Reported CBP's Blatant Failures Both Before and While Treating Anadith.

The *Flores* settlement agreement, finalized in 1997, established binding national standards for the detention, treatment, and release of immigrant children in United States custody.[34] The *Flores* court appointed Dr. Paul Wise to monitor and assess the medical safety of children in immigration custody to ensure the government met its settlement obligations.

Months before Anadith's death, Dr. Wise reported numerous shortcomings in CBP's provision of medical care to children in custody.[35] These failures were a breach of CBP's duties to all children in its custody, including Anadith.

In January 2023, Dr. Wise, tasked with examining custody conditions to "ensure safe treatment of child migrants," reported concern that "child migrants held in medical isolation may be overlooked when Border Patrol Stations get too crowded."[36] Dr. Wise further observed the crowding of children in medical isolation and that "one medical team in El Paso was responsible for 125 ill patients, a number that far surpasse[d] the team's capabilities."[37]

Dr. Wise also raised concerns about CBP's failure to conduct required medical assessments of children "when they came in families and were in crowded stations."[38] He observed that the important medical protocol was "given relatively low priority" due to "other important demands on available medical staff."[39] Further, Dr. Wise reported that chronic conditions were going undetected and relevant medical information was often unknown or not shared among staff.[40]

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[32] *Id.*
[33] *Id.*
[34] *Flores v. Reno*, No. CV-85-4544-RJK (pX), Stipulated Settlement Agreement (C.D. Cal. Jan. 17, 1997), available at https://www.aclu.org/sites/default/files/assets/flores_settlement_final_plus_extension_of_settlement011797.pdf [hereinafter *Flores* settlement].
[35] Valerie Gonzalez & Elliot Spagat, *Court Monitor Warned of Medical Care Issues at Border Patrol Stations Before Girl's Death*, ASSOCIATED PRESS (May 26, 2023), https://apnews.com/article/border-patrol-death-immigration-anadith-report-56cf91e8dbf2005f87bbd5f5f81fb4bd.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*

Tragically, Dr. Wise's fears came to fruition. Following Anadith's death, Dr. Wise conducted an additional investigation and filed another report in June 2023.[41] In conclusion, Dr. Wise called the tragedy "preventable."[42]

In the June 2023 report, Dr. Wise noted several failures in CBP's treatment of Anadith, including the failure to consult with a physician, the failure to communicate Anadith's elevated medical risk to those treating her, and the failure to transfer Anadith to a hospital.[43] According to Dr. Wise, had a physician been consulted, "the need for enhanced concern regarding any change in medical status could have been discussed . . . and entered into the [electronic medical record]," and "could have guided the decision-making of medical providers, including the need for transfer to a health facility, on subsequent shifts and in the Harlingen BP Station."[44]

Dr. Wise also highlighted the "failure to notify" the personnel responsible for Anadith's care of her elevated medical risk.[45] Noting that CBP "is ultimately responsible for the well-being of all individuals of custody," Dr. Wise called this failure a "breach of essential communication."

Dr. Wise also reported on CBP's failure to transfer Anadith to a hospital, which he said raised "profound concerns regarding not only the direct care [Anadith] received but also the custodial and medical systems that failed to prevent [her] clinical deterioration and death."[47] Dr. Wise made "no judgment as to the reasons why the health providers responsible for [Anadith's] care in the Harlingen Station were so reluctant to transfer [Anadith] to a local hospital."[48] Nevertheless, Dr. Wise observed that CBP "personnel have, on occasion, questioned a medical provider's decision to transfer a patient to a local hospital, stressing the drain on [CBP] manpower."[49] Dr. Wise further emphasized that "[t]he decision to transfer an ill individual to a local health facility should be based on medical criteria *alone*" (emphasis added).[50]

Finally, Dr. Wise urged that "there should be little hesitation about sending ill children to the hospital, especially those with chronic conditions."[51] His report noted that as Anadith's health declined, Mabel "repeatedly reported that her daughter's condition was deteriorating and that she needed to be transported immediately to a local hospital."[52] CBP's chosen medical staff and CBP agents delayed calling an ambulance as long as possible: until Anadith "lost consciousness and

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[41] *See generally Flores* report, *supra* note 1.
[42] *Id.*
[43] *Id.* at 38-41.
[44] *Id.* at 39.
[45] *Id.*
[46] *Id.*
[47] *Id.* at 40.
[48] *Id.*
[49] *Id.*
[50] *Id.* at 41.
[51] Valerie Gonzalez, *Border Patrol Wouldn't Review the Medical File of a Girl with a Heart Condition Before She Died*, ASSOCIATED PRESS (June 1, 2023), https://apnews.com/article/cbp-immigration-custody-death-anadith-harlingen-texas-ab1433ceb9224e1c1e146ade2d7c568d; *see also Flores* report, *supra* note 1, at 6.
[52] *Flores* report, *supra* note 1, at 37.

suffered an apparent cardiac arrest."[53] As confirmed by Dr. Wise's reports, CBP has systemically failed in upholding its duty to children in custody for years. Anadith's case is not a tragic exception.

C. CBP Whistleblowers Reported Concerns About Medical Care and CBP Retaliated Against Them.

Before Anadith died, multiple whistleblowers, both current and former employees of CBP and LSGS, came forward to share critical information and shed light on the shortcomings of medical services in CBP custody.[54] CBP retaliated against some of the whistleblowers. For instance, CBP retaliated against Mr. Troy Hendrickson, the former Contract Officer Representative assigned to the CBP Medical Services Contract. Mr. Hendrickson, along with Dr. David Tarantino, who was the CBP Chief Medical Officer at the time, and colleagues at the CBP Office of the Chief Medical Office (OCMO), exposed numerous problems with the provision of medical services.[55] Specifically, these whistleblowers shed light on CBP's failure to hold LSGS accountable for CBP's "underperformance in the provision of medical services at the border," including: unjustified billing in the millions of dollars; unremedied, dangerous levels of understaffing; and serious medical quality management concerns.[56]

Rather than heed these warnings, CBP responded to these concerns by removing Mr. Hendrickson from his position in April 2022.[57] After Anadith's death in May 2023, CBP retaliated against another whistleblower, Dr. Tarantino, by also removing him from his position.[58]

These whistleblower disclosures demonstrate that CBP was on notice, *years* prior to Anadith's death, of its third-party contractor's perilous underperformance.[59] Moreover, "[t]hroughout 2022, OCMO leadership raised concerns detailed in Mr. Hendrickson's . . . disclosure . . . internally within CBP."[60] Despite CBP's clear knowledge of LSGS's deficiencies, it continued to use LSGS as its medical contractor, and it continued to entrust LSGS with providing medical care for children in custody. CBP has failed to oversee LSGS, and as of the date of this SF-95, LSGS remains the medical contractor for CBP facilities in the Rio Grande Valley.

D. The U.S. Senate Committee on the Judiciary's Investigation Confirmed CBP's Critical Failures in Its January 2025 Report.

The U.S. Senate Committee on the Judiciary (SJC) also conducted an investigation of CBP's failures in treating Anadith. On January 24, 2025, the SJC released a report entitled: "The Failure to Provide Adequate Care to Vulnerable Individuals in CBP Custody."[61] This report

[53] *Id.* at 38.
[54] Feb. Whistleblower Disclosure, *supra* note 23, at 2.
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] *Id.* at 7.
[60] *Id.* at 12.
[61] U.S. Senate Comm. on the Judiciary, *supra* note 15, at 35.

included numerous investigative findings regarding Anadith's death. The SJC unequivocally concluded that CBP was responsible for her death: "The circumstances that resulted in Anadith's death were unfortunately not an aberration, but indicative of systemic problems with the provision of medical care in CBP facilities and CBP's broader failure to properly oversee that case."[62] The SJC further noted: "Transparency is key to maintaining public trust and holding CBP accountable for the care provided in its facilities."[63]

The SJC further elaborated on these "systemic problems," concluding that CBP's systemic delivery of inadequate medical care led to Anadith's death: "The Committee's investigation revealed longstanding failures in the provision of medical care in CBP custody. Despite efforts to draw attention to CBP's inability to provide adequate medical care, including by CBP's Office of Chief Medical Officer (OCMO), many concerns were not sufficiently addressed, leading to the conditions that caused Anadith's death in 2023."[64]

CBP failed in its crucial duty to properly medically assess Anadith while she was in CBP custody. As the SJC report confirmed, even though Anadith's "medical history was documented in the EMR system when her family was first taken into custody and transported to the Donna Centralized Processing Facility," CBP did not check the EMR system.[65] Instead, CBP claimed to be "unaware Anadith had sickle cell anemia or a history of congenital heart disease."[66] Her case demonstrates how CBP's failure to properly record and check medical records can be lethal.

The report continued: "compounding the problem, at this time, CBP did not have adequate agency guidance describing how to identify and consistently monitor children in custody who were considered medically at-risk."[67] The SJC also reported CBP's failure to communicate Anadith's medical conditions and risk to the CBP staff treating her. The SJC report confirmed CBP's finding in its own report: that despite CBP's knowledge of Anadith's conditions, "none of the CBP contracted medical personnel or U.S. Border Patrol personnel at Harlingen Station who interacted with the girl, or her mother, acknowledged being aware she suffered from sickle cell anemia or had a history of congenital heart disease."[68] This was an oversight by CBP that the SJC report concluded ultimately led to Anadith's death.[69]

The SJC confirmed CBP's failure to transfer Anadith to a hospital was a critical shortcoming. Citing Dr. Wise's January 2023 *Flores* report, the SJC noted that "the admission of a young child with sickle cell disease and a fever to the Harlingen Station should have triggered a close consultation with an on-call physician or an evaluation at a local hospital."[70]

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[62] *Id.* at 10.
[63] *Id.* at 43.
[64] *Id.* at 1.
[65] U.S. Senate Comm. on the Judiciary, *supra* note 15, 3–4.
[66] *Id.*
[67] *Id.*
[68] CBP Update June 1, 2023, *supra* note 13.
[69] U.S. Senate Comm. on the Judiciary, *supra* note 15, at 1.
[70] *Id.* at 29.

The SJC report further noted that CBP's "failure to capture video of medical contractor staff interacting with Anadith and her family at the Harlingen station has complicated the investigation of her death."[71] In addition to having violated federal law, CBP's failure to maintain video cameras has partially obfuscated the truth of its wrongdoing: "[s]ome questions may never be answered without video evidence."[72]

Finally, the SJC report reiterated the CBP whistleblowers' concerns about substandard medical care and oversight: CBP "whistleblowers have alleged that CBP's Office of Acquisitions failed to hold [LSGS] accountable for deficient medical care over a number of years."[73] Whistleblowers and DHS oversight offices "attributed inadequate medical care in CBP facilities to, among other factors, understaffing, an inadequate electronic medical records system, and a lack of clarity related to roles and responsibilities in the delivery of medical care."[74]

The SJC report confirmed what CBP itself, CBP whistleblowers, and Dr. Wise, the *Flores* monitor, have known for years: as a matter of course, CBP's provision of adequate medical care falls pitifully short. Anadith died, her family witnessed her death, and they continue to suffer for CBP's shortcomings.

III. The United States Government Knew of the Dangerous Detention Conditions for Children Like Anadith.

The United States Government knew or should have known that it placed Anadith at risk of severe harm by detaining her and refusing to provide emergency medical treatment when she became severely ill. International organizations have long warned that children should "not be detained at all," due to the "devastating effect it may have on their physical, emotional, and psychological development."[75] For instance, the World Health Organization (WHO) has emphasized "that the experience of detention, even for a brief period, has a detrimental effect on the mental and physical health of children."[76] Because of these proven dangers, the United Nations Refugee Agency (UNHCR) published a Global Strategy to end the detention of immigrant children, including in the United States.[77]

For years, it has been widely known that several children have died in immigration detention due to infectious diseases they contracted in custody.[78] For example, a 16-year-old boy

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[71] *Id.* at 35.
[72] *Id.*
[73] *Id.* at 5.
[74] *Id.*
[75] U.N. HIGH COMM'R FOR REFUGEES, 2014-2019 BEYOND DETENTION: A GLOBAL DETENTION TO SUPPORT GOVERNMENTS TO END THE DETENTION OF ASYLUM-SEEKERS AND REFUGEES 5 (2014), https://www.unhcr.org/53aa929f6 [hereinafter UNHCR].
[76] WHO, REPORT ON THE HEALTH OF REFUGEES AND MIGRANTS IN THE WHO EUROPEAN REGION 55 (2018), https://who.int/iris/bitstream/handle/10665/311347/9789289053846-eng.pdf?sequence=1&isAllowed=y.
[77] UNHCR, *supra* note 74, at 5.
[78] Franco Ordoñez, *Deaths of Migrant Children Haunt Former Official as Border Surge Increases*, NATIONAL PUBLIC RADIO (Mar. 17, 2021), https://www.npr.org/2021/03/17/977978891/deaths-of-migrant-children-haunt-former-official-as-border-surge-increases.

from Guatemala died in 2019 of complications from the flu he contracted in CBP custody.[79] Tragically, he was one of several children who died "in custody or after being detained by federal immigration agents at the border" in 2018 and 2019.[80]

Between December 2018 and May 2019, five Guatemalan children died after being taken into CBP custody.[81] Autopsy reports showed that at least three of the children, aged 2, 6, and 16, died in part as a result of the flu.[82] A group of doctors from Harvard and Johns Hopkins who studied the deaths emphasized that across the general population, child flu deaths are rare and should be preventable.[83] The doctors further reported in a letter to Congress that "[p]oor conditions at the facilities may be amplifying the spread of influenza and other infectious diseases, increasing health risks to children."[84]

The United States government has known for at least the past decade that the overcrowding and unhygienic conditions in immigration detention are the perfect breeding grounds for dangerous infectious diseases. Additionally, CBP was fully aware of the insufficiency and understaffing of its chosen medical contractor, LSGS. In fact, several whistleblowers at CBP raised critical concerns about LSGS's provision of medical care to detained immigrants. Instead of addressing these life-or-death concerns, CBP retaliated against the whistleblowers by terminating them. Moreover, a court-appointed monitor tasked with assessing the medical safety of children in immigration custody echoed the whistleblowers' concerns about LSGS months before Anadith's preventable death.

A. The United States Government Knew that Overcrowding, Unsanitary Conditions, Poor Quality Health Care, and Limited Access to Health Care in Detention Facilities Are Closely Linked to Infectious Disease Transmission.

Over the past decade, U.S. and international organizations have shed light on a global pattern where immigrants detained in crowded and unsanitary facilities contract and sometimes die from communicable diseases.[85] The WHO has declared that "inadequate shelter and overcrowding are major factors in the transmission of diseases."[86] In 2015, the European Centre for Disease Prevention and Control (ECDC) identified that "the risk to refugees arriving in Europe of contracting communicable diseases has increased due to the current overcrowding at reception

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[79] *Id.*
[80] *Id.*
[81] Robert Moore, *Doctors Urge Probe of Child Migrant Deaths, Warn "Poor Conditions" at Border Increase Risk of Spreading Flu*, TEXAS TRIBUNE (Aug. 1, 2019), https://www.texastribune.org/2019/08/01/doctors-urge-probe-child-migrant-deaths/.
[82] *Id.*
[83] *Id.*
[84] *Id.*
[85] Ordoñez, *supra* note 77; *see also* Moore, *supra* note 80.
[86] WHO, *Environmental Health in Emergencies: Water Sanitation Hygiene* (last accessed Dec. 4, 2024), https://www.who.int/teams/environment-climate-change-and-health/water-sanitation-and-health/environmental-health-in-emergencies/humanitarian-emergencies.

facilities, resulting in compromised hygiene and sanitation arrangements."[87]

In October 2020, the American Public Health Association (APHA) even noted that "[i]mmigration detention centers, particularly crowded facilities, enhance the spread of infectious diseases."[88]

In May 2022, the WHO again emphasized the health dangers of immigration detention, noting that the conditions "place migrants at risk of communicable diseases" and other harms.[89] Additionally, the WHO reported that "[o]ften, access to health care is limited, interpreters are lacking training and support for health-care providers and detention staff are insufficient, mistrust prevails, and medical records are inadequate or incomplete."[90] Further, staff at immigration detention facilities function as "gatekeepers to available support, health care, and much-needed medicines."[91] In conclusion, the WHO called for alternatives to immigration detention because of frequent poor health outcomes for detainees.[92]

Moreover, in its January 2025 report, the SJC noted that DHS "oversight entities have highlighted dangers associated with longer stays in CBP custody."[93] Longer times in custody "may exacerbate existing medical care needs, create additional challenges for medical staff attending to the needs of large numbers of migrants, and create dangerous and untenable conditions in CBP facilities that were not designed for long-term detention."[94] For that reason, CBP requires a 72-hour detention limit.[95] In Anadith's case, CBP entirely disregarded this limit, putting Anadith at heightened medical risk, as she was held long past the legal limit in unhealthy conditions that threatened, and ultimately took, her life.

For years, public health organizations have unanimously expressed concerns that overcrowded, unsanitary conditions in immigration detention have led to the spread of infectious diseases.[96] The United States government has known of these dangerous conditions.[97] Moreover, the United States was also aware that these conditions could lead to children's deaths, especially for children with chronic health conditions, like Anadith.[98]

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[87] EUR. CTR. FOR DISEASE PREVENTION & CONTROL, RAPID RISK ASSESSMENT: COMMUNICABLE DISEASE RISKS ASSOCIATED WITH THE MOVEMENT OF REFUGEES IN EUROPE DURING THE WINTER SEASON 1 (Nov. 10, 2015), https://www.ecdc.europa.eu/sites/portal/files/media/en/publications/Publications/refugee-migrant-health-in-european-winter-rapid-risk-assessment.pdf [hereinafter ECDC].
[88] *Id.*
[89] WORLD HEALTH ORGANIZATION REGIONAL OFFICE FOR EUROPE, *Immigration Detention Is Harmful to Health – Alternatives to Detention Should Be Used* (May 4, 2022).
[90] *Id.*
[91] *Id.*
[92] *Id.*
[93] U.S. Senate Comm. on the Judiciary, *supra* note 15, at 5.
[94] *Id.*
[95] TEDS, *supra* note 7, at § 4.1.
[96] *See* WHO, *Environmental Health in Emergencies, supra* note 85; ECDC, RAPID RISK ASSESSMENT, *supra* note 86; WHO, Immigration Detention Is Harmful to Health, *supra* note 88.
[97] *See* Ordoñez, *supra* note 77; *see also* Moore, *supra* note 80.
[98] *Id.*

In 2021, John Sanders, the former CBP commissioner, expressed, reflecting on the deaths of several minors in CBP custody, that his "greatest fear and the hardest thing . . . was the death of children," noting that "that's what [he thought] we have to make sure never happens."[99] Sanders further called it "heartbreaking . . . that history is repeating itself," observing that "there is no surprise to people that this was going to occur."[100] But knowing full well of these preventable realities, just like the United States failed the children who died of communicable diseases before Anadith, the United States also failed her.[101] CBP failed to respond to the tragic and preventable deaths of children in custody years before Anadith ever entered the United States. In these critical oversights, CBP failed to uphold its duty to Anadith. If CBP had taken action years ago, Anadith would be alive today.

B. The United States Government Knew for Years Before Anadith's Death that Its Contracted Medical Staff was Critically Insufficient.

For years, the United States government itself has reported that its own medical teams caring for people in CBP custody are insufficient and understaffed. In July 2020, the Government Accountability Office (GAO) issued a report highlighting, among other issues, a need for increased oversight and review by CBP on contracted medical services.[102] The GAO noted that it conducted this study because "[t]hree children died in CBP custody between December 2018 and May 2019, prompting questions about CBP's medical care for those in its custody."[103] Despite receiving emergency funding of nearly $87 million specifically appropriated for food, hygiene, and medical care, the GAO revealed that CBP spent some of the emergency funds on other purposes, in violation of federal appropriations law.[104]

On September 3, 2020, the DHS Office of the Inspector General (OIG) issued a Management Alert, calling attention to the fact that CBP had not yet released a solicitation for a new medical services contract, though the existing contract was set to expire on September 29, 2020.[105] On September 28, 2020, CBP ultimately met the deadline by signing a new contract with LSGS to provide medical services along the Southwest Border.[106]

Between the spring of 2021 and May 2022, the Office of the Immigration Detention Ombudsman (OIDO) conducted numerous site visits, observations, and inspections at CBP facilities along the Southwest border.[107] On July 12, 2022, OIDO released an Ombudsman Alert about critical medical understaffing on the Border, revealing that LSGS had a shortfall of

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[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] U.S. GOVT' ACCOUNTABILITY OFF., GAO-20-536, Southwest Border: CBP Needs To Increase Oversight of Funds, Medical Care, and Reporting of Deaths (2020).
[103] *Id.*
[104] *Id.*
[105] U.S. DEP'T OF HOMELAND SEC., OFF. OF INSPECTOR GEN., OIG-20-70, Management Alert - CBP Needs to Award a Medical Services Contract Quickly to Ensure No Gap in Services (2020).
[106] OFF. OF IMMIGR. DET. OMBUDSMAN, U.S. DEP'T OF HOMELAND SEC., Ombudsman Alert: Critical Medical Understaffing on the Border, *supra* note 7.
[107] *Id.* at 3.

approximately 35% in contracted medical services being provided to CBP at the sampled locations.[108] OIDO warned that these shortages "could jeopardize the health and safety of noncitizens in CBP custody."[109]

Moreover, CBP has repeatedly failed to resolve systemic issues with medical records systems and staff's usage of those systems. In its January 2025 report, the Senate Committee on the Judiciary recommended that, due to various technical challenges and other problems, CBP should replace its current electronic medical records (EMR system).[110] However, the Committee also urged that "systemic issues cannot be resolved by implementing a new EMR system" alone.[111] The Committee's report further noted that CBP and LSGS have "not always properly reported medical records in CBP's current EMR system nor checked the EMR system when treating a patient," calling "Anadith's case [ ] a tragic example."[112] Although Anadith's "medical history was documented in the EMR system when her family was first taken into custody . . . [LSGS] staff and [CBP] personnel . . . who interacted with the girl and her mother . . . claimed to be unaware Anadith had sickle cell anemia or a history of congenital heart disease."[113]

These staffing shortages and systemic misuse of medical records systems contributed to Anadith's death. In any litigation, Counsel is sure that discovery will produce records demonstrating that CBP's contracted medical team was understaffed at the time of Anadith's death. However, the chronic understaffing in the years leading up to Anadith's death, combined with the repeated neglect of Anadith's medical crisis and failure to consult with a physician, suggest that Anadith's death was preventable. By inadequately overseeing its chosen medical contractor and failing to ensure adequate staffing, the United States government failed to provide Anadith the medical care she was entitled to receive.

IV. CBP Failed to Fulfill Its Duties to Anadith.

Anadith and her family were detained in crowded and unsanitary conditions in CBP custody for nine days—exceeding and violating the agency's 72-hour detention limit under TEDS Section 4.1.[114] This extraordinarily long detention period also violated the requirements of the *Flores* settlement.[115] It was during this excessive detention period that Anadith became ill and died.

CBP's refusal to transfer Anadith to a hospital denied her the elevated level of care she desperately needed. According to publicly available resources, there are many emergency

[108] *Id.* at 4.
[109] *Id.*
[110] U.S. Senate Comm. on the Judiciary, *supra* note 15, at 3.
[111] *Id.*
[112] *Id.*
[113] *Id.* at 3-4.
[114] TEDS, *supra* note 7*,* § 4.1.
[115] *Flores* settlement, *supra* note 33.

treatment options for influenza and fever in a child with sickle cell disease.[116] A hospital might have monitored vital signs frequently and performed thorough physical examinations, done laboratory tests to check Anadith's blood and bone marrow, ordered a chest X-ray, provided antibiotics or fluids, or both, through an IV, or even given supplemental oxygen or performed a blood transfusion.[117] The critical decision of how to treat Anadith and save her life should have been made by informed doctors providing emergency care at a hospital—*not* by uninformed CBP staff unilaterally deciding, without a doctor, that despite all the evidence, including medical history, Anadith's severe condition at the time, and her mother's desperation, that Anadith was "fine." CBP denied Anadith and her family the basic medical care required to save Anadith's life.

V. Legal Basis of the Claim

Claimants, Anadith's parents Mabel and Rossel, assert claims arising under Texas's survival statute, Tex. Civ. Prac. & Rem. Code § 71.021, and Texas's Wrongful Death statute, Tex. Civ. Prac. Rem. Code § 71.002, as well as individual claims for their own emotional distress. Claimants assert that CBP officers committed the following torts: A) Negligence; B) Negligent Undertaking; C) Negligent Supervision; and D) Intentional Infliction of Emotional Distress.

A. CBP's *Negligence* in Treating Anadith Proximately Caused Her Death.

CBP was negligent in medically treating Anadith. CBP had a duty to provide adequate medical care to Anadith while she was in CBP's custody.[118] CBP breached that duty when its provision of medical care fell far below the standard of care.

First, CBP officers failed to communicate basic information about Anadith's conditions to those responsible for her care. Second, CBP's medical treatment of Anadith was inadequate. Third, the officers failed to act reasonably when they did not call for an ambulance or emergency care to save Anadith's life, despite her mother's numerous, repeated pleas for Anadith to be taken to the hospital. The failure to consider Anadith's medical conditions and her risk of serious harm, along with the refusal to transfer Anadith to the hospital or otherwise seek emergency care as her condition deteriorated, proximately caused her death.

As a result of the U.S. government's negligent conduct, Anadith suffered great physical harm and ultimately died. Anadith's family also suffered extreme mental and emotional pain and distress, as well as loss of love and companionship, funeral expenses, and other harms.

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[116] *How Is Sickle Cell Disease Treated?*, SEATTLE CHILDREN'S HOSP., https://www.seattlechildrens.org/conditions/sickle-cell-disease/treatment/ (last visited Feb. 13, 2025); *Sickle Cell Disease and Fever*, NATIONWIDE CHILDREN'S HOSP, https://www.nationwidechildrens.org/family-resources-education/health-wellness-and-safety-resources/helping-hands/sickle-cell-disease-and-fever; *Pediatric Sickle Cell Disease Fever Management in the Emergency Department*, UNC DEP'T OF PEDIATRICS, https://www.med.unc.edu/pediatrics/cccp/wp-content/uploads/sites/1156/2022/12/PED-Sickle-Cell-Disease-with-Fever-Pathway.pdf (last visited Feb. 13, 2025); *Sickle Cell Disease in Children*, UNIV. OF ROCHESTER MED. CTR., https://www.urmc.rochester.edu/encyclopedia/content?contenttypeid=90&contentid=P02327 (last visited Feb. 13, 2025).

[117] *Id.*

[118] TEDS, *supra* note 7, at §§ 4.3, 4.10.

B. CBP's *Negligent Undertaking* of Duties to Anadith Proximately Caused Her Death.

CBP assumed duties that created an obligation to provide medical care to Anadith, and breached those duties in its interactions with Anadith.

First, CBP officers failed to adhere to the duties set forth in the *Flores* Agreement to care for children in CBP custody by providing inadequate medical care and deliberately refusing to provide immediate emergency care to Anadith.

Second, CBP adopted National Standards Transport, Escort, Detention, and Search (TEDS), which the officers failed to follow. More specifically, CBP officers violated Section 4.3 of TEDS by neglecting to conduct their own inquiry of relevant illnesses and physical health upon Anadith's entry into CBP detention.[119] Further, the officers failed to document Anadith's medical conditions in their records and take appropriate precautions to protect Anadith, which is also in violation of Section 4.3.[120] Additionally, the officers violated Section 4.10 of the TEDS standards by failing to provide emergency care.[121] Anadith experienced difficulty breathing, which is explicitly listed as a medical emergency under the TEDS standards. Despite Anadith's medical conditions and severe illness while in custody, which constituted a medical emergency, CBP failed wholly to uphold its obligations to Anadith under TEDS.

Under TEDS and the *Flores* Agreement, CBP created and accepted a duty to provide care for individuals like Anadith. Their failure to exercise reasonable care in performing these duties resulted in significant harm to Anadith, ultimately causing her death and numerous harms to Anadith and her family.

C. CBP's *Negligent Supervision* of Its Medical Staff Proximately Caused Anadith's Death.

CBP has a duty to ensure adequate medical treatment to all children in its custody, and that duty includes proper supervision of its contracted medical staff, LSGS. CBP breached its duty to Anadith by allowing LSGS to continue providing healthcare services without consequence for its critical performance failures. Long before Anadith's death, CBP was aware of LSGS's serious understaffing issues, inadequate supervision, and medical documentation issues, all of which impacted the facilities that housed Anadith and her family. Disregarding LSGS's critical performance failures, CBP refused to intervene in LSGS's provision of medical care, declined to oversee and supervise LSGS on the most basic aspects of its tasks, and failed to take *any action* to protect the children that it *knew* LSGS was failing.

CBP was aware that these issues posed a dangerous risk to the health and life of all detainees, but *especially* to children like Anadith, who have chronic conditions. CBP failed to take the necessary corrective actions urged by members of its own staff, as documented in the whistleblower disclosures.

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[119] *Id.* at § 4.10.
[120] *Id.* at § 4.3.
[121] *Id.* at § 4.10.

Instead of correcting deficient medical services in the months and years before Anadith's death, CBP stood idly by and did nothing. CBP acted unreasonably, breached its duty, and foreseeably caused Anadith's death. This failure was negligent and grossly negligent and was the proximate cause of Anadith's tragic and preventable death.

D. CBP Officers Recklessly or *Intentionally Inflicted Emotional Distress* on Anadith and Her Family.

CBP officers acted recklessly or intentionally in providing inadequate medical care to Anadith, including denying emergency care and transportation to a hospital when Anadith was in severe medical distress. Instead, agents repeatedly dismissed Anadith's mother, Mabel, claiming that Anadith's health concerns were normal symptoms of growing up or her illness. The officers' conduct was extreme and outrageous, and caused the severe emotional distress of Anadith and her family.

VI. Other Causes of Action and Information Are in the Possession of U.S. Government and Agents.

This is not intended to be an exhaustive list of possible causes of action arising from the same incident. Furthermore, Claimants explicitly incorporate other documentation maintained in CBP, DHS, and other agencies' records about this incident, including records available through CBP's contractor, LSGS.

9. Property Damage: None to Claimants.

10. Personal Injury/Wrongful Death

The decedent suffered extreme personal and emotional injuries while she was mistreated and neglected while in custody, which led to her death. Before her death, she suffered serious pain in her chest, bones, and abdomen, and struggled to breathe for multiple days. Her condition continued to deteriorate, during which she was repeatedly ignored and denied adequate care. Claimants also suffered mental anguish while their daughter was mistreated and neglected while in custody and mental anguish and loss of companionship and society as a result of and since Anadith's death.

11. Witnesses

In addition to Claimants, other witnesses include:

- Other individuals who were detained in CBP custody with Anadith and her family.
- CBP officers working at the facilities where Anadith was detained, including those whose names are unknown.
- LSGS medical staff at the facilities where Anadith was detained, including those whose names are unknown.
- Medical professionals who were involved in responding after Anadith became unresponsive, transporting her to the hospital, and pronouncing her deceased, including those whose names are unknown.

- Elizabeth J. Miller, M.D., who performed the autopsy at Cameron County Forensic Pathology.
- David K. Arboe, II, M.D., who performed the autopsy at American Forensics.

  American Forensics: 2452 US Highway 80E
  Mesquite, TX 75149
- Dr. Paul Wise, the monitor appointed by the *Flores* court to investigate provision of medical care to children in CBP facilities to ensure CBP meets its obligations under the *Flores* settlement.
- Dr. David Tarantino, former CBP Chief Medical Officer, a whistleblower who raised concerns about CBP's provision of medical care.[122]
- Troy Hendrickson, a former Contracting Officer Representative at the CBP Office of the Chief Medical Officer (OCMO), a whistleblower who raised concerns about CBP's provision of medical care, including unfit medical providers, severe understaffing, privacy breaches, and failure to report sexual harassment in a CBP medical facility.[123]
- Other protected whistleblowers who are current or former employees of CBP and LSGS, including those whose names are unknown.
- CBP and other government officials involved in overseeing the contract with LSGS, including those whose names are unknown.
- Anyone involved in the detention and custody of Anadith between May 9–17, 2023.
- Anyone involved in providing care or medical treatment to Anadith between May 9–17, 2023.

Other than the individuals listed above, the names of witnesses are unknown to Claimants. The addresses of all witnesses are likewise unknown to Claimants.

12a. Property Damage:

None to Claimants.

12b. Nature and Extent of Personal Injury:

Wrongful Death, Personal Injury, Emotional Distress

12c. Wrongful Death: $15,000,000

12d. Total: $15,000,000

[122] Feb. Whistleblower Disclosure, *supra* note 23, at 2.
[123] Nov. Whistleblower Disclosure, *supra* note 10.