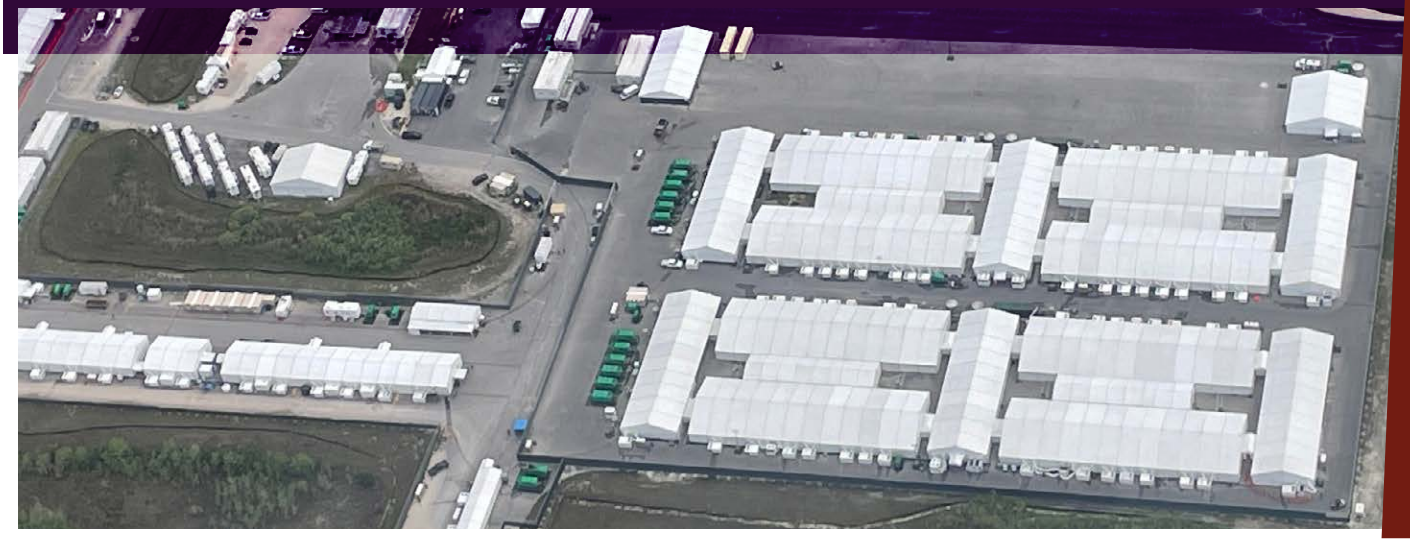
INSIDE THE CAGES:
Disability Rights Violations at Alligator Alcatraz



Disability Rights
FLORIDA
ADVOCACY. EQUALITY. DIGNITY.

Following the closing of Alligator Alcatraz,

Disability Rights Florida is releasing this summary of findings on the treatment of detainees with disabilities held there based on site visits, client interviews, medical record reviews, and advocacy efforts. **Our investigation revealed persistent concerns regarding medical care, and unsafe and unsanitary conditions.**



Background

Alligator Alcatraz, officially known as Florida Soft-Sided Facility South, was an immigration detention camp made up of tents and trailers in the Florida Everglades. The Florida Division of Emergency Management opened the facility in July 2025. Federal and State authorities made contradictory public statements regarding which government entity had ultimate authority over the facility and whether its operation was subject to state or federal laws and regulations. Day-to-day operations were largely carried out by private contractors, including Critical Response Strategies, CFM Solutions, IRG Global, GardaWorld Federal, CDR Health, and NHT Ambulance. In June 2026, all remaining detainees were transferred to other facilities across the country and contractors began to dismantle the facility. Although exact numbers cannot be verified, government officials stated that over 21,000 detainees were processed through the facility during its 12 months of operation. Alligator Alcatraz is reported to have cost the State of Florida $1 million per day to run.

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Methodology

While investigating the treatment of individuals with disabilities held at Alligator Alcatraz, Disability Rights Florida (DRF) sought records from the Florida Department of Emergency Management (FDEM), CDR Health (contractor providing health care on site), NHT Ambulance (contractor providing emergency transport), and HCA Florida Kendall Hospital in Miami (receiving hospital for detainees requiring emergency care) through public records requests. DRF only received a limited response from FDEM, including several facility policies and the ICE National Detainee Handbook. DRF also requested and obtained individual client medical records, conducted on-site client interviews, and reviewed the 2025 ICE National Detention Standards, along with publicly available court records and reporting. Consequently, the findings described below are based on the records and information available to DRF and have been corroborated where possible through interviews, medical documentation, and direct observation.

Key Findings

- **Dangerous Living Conditions**:
  - Unsafe construction, including sharp metal cages and ligature risks.
  - Unsanitary conditions, including overflowing toilets and mold.
  - Inconsistent access to clean drinking water.
- **Abuse of Power**:
  - Excessive use of force and shackling.
  - Inhumane punitive isolation practices.
- **Medical Neglect**:
  - Delays and interruptions in medical treatment.
  - Failure to provide necessary follow-up care.
  - Limited access to mental health treatment.
- **Denial of Accommodations for Detainees with Disabilities**:
  - Restricted access to mobility and communication devices and other necessary accommodations.
- **Inadequate Food**:
  - Significant weight loss among detainees.
  - Lack of medically appropriate diets.
- **Limited Communication with Outside**:
  - No non-legal visitors.
  - Limited access to important legal and medical documents.
  - No access to unmonitored legal calls.
  - No access to mail, inconsistent ability to receive or send legal mail.

Dangerous Living Conditions

Unlike a traditional brick-and-mortar facility, our discussion with detainees revealed that Alligator Alcatraz consisted of large cages inside tents. Each cage held 32 detainees, with multiple cages inside a single tent. Detainees spent most of their time inside these cages, exiting only for meals, 15 minutes of daily recreational time in another section of the tent, sick calls, legal visits, to meet with administrative staff regarding their status, or to be processed out of the facility.

The cages were constructed with metal panels containing diamond-shaped cutouts that left sharp exposed edges, like a cheese grater. The detainees reported that simply brushing up against the cage caused cuts and lacerations by the exposed edges. Four individuals DRF spoke with showed scars on their hands or arms from times they were cut by the edges of the cage, with one client named Nicolas[1] stating, "the cages cut like knife." Another client named Gabriel reported watching a guard slam another detainee's head onto the cage and rubbing his face into it, causing him to bleed across his forehead, resulting in that individual being sent to the hospital.

> *"...Gabriel reported watching a guard slam another detainee's head onto the cage and rubbing his face into it, causing him to bleed across his forehead, resulting in that individual being sent to the hospital."*

The cage design created potential ligature points that could be used for self-harm. Gabriel reported witnessing a suicide attempt by another detainee. Gabriel reported that, in late January or early February 2026, one detainee stood on a top bunk and tied his sheets to a metal beam running across the top of the cage. The individual tied the sheet around his neck and jumped. Gabriel saw the individual hanging and watched him be carried out by guards. Gabriel described the individual as unresponsive and did not know if he survived the incident or not. DRF was unable to verify whether the individual was deceased. Another client, Andres, reported hearing about the same event the day it occurred.

There were three toilets in each cage, each sitting on wooden platforms with no privacy and security cameras above. Detainees reported the toilets consistently overflowing, with feces regularly on the ground and over the wooden platforms that were never cleaned. The toilets were placed only a few feet away from the two telephones in the cell and some of the bunks. Detainees reported that bedding was not always cleaned regularly, with Andres reporting that for his first five weeks at the facility he used the same sheets.

> *"Detainees reported the toilets consistently overflowing, with feces regularly on the ground and over the wooden platforms that were never cleaned. The toilets were placed only a few feet away from the two telephones in the cell and some of the bunks."*

Detainees also reported mold throughout the facility, including near air vents and in sinks. In addition, every individual interviewed by DRF reported concerns regarding drinking water quality. DRF observed residue of a chalky substance inside the detainees' facility-issued drinking cups. Detainees stated that the water tasted dirty and sometimes contained sand. One client, Juan, called DRF in June to report that the water in his cage had made several individuals sick and was removed by guards.

> *"The cages were constructed with metal panels containing diamond-shaped cutouts that left sharp exposed edges, like a cheese grater. The detainees reported that simply brushing up against the cage caused cuts and lacerations by the exposed edges."*

[1] All client names have been anonymized.

Abuse of Power

DRF received concerning reports about a confinement room with torturous conditions. Juan provided a detailed account of a segregated housing unit that detainees referred to as "the freezer." The unit was kept at extremely low temperatures, and detainees were only provided with paper gowns to wear. Juan stated that he was there for three days and was not given access to phones or other people and only received cold water for showers. Two other individuals DRF interviewed described the unit similarly, though they had only heard about it from other detainees.

> *"...he was placed in a cage measuring approximately 3 feet long by 3 feet wide by 7 feet high for more than 12 hours. Gabriel reported that he was left exposed to the elements and sustained numerous mosquito and spider bites, which DRF observed."*

Gabriel also reported being placed in a different kind of confinement with alarming conditions. Gabriel detailed that, after an argument with a guard regarding needing additional time to eat, he was placed in a cage measuring approximately 3 feet long by 3 feet wide by 7 feet high for more than 12 hours. Gabriel reported that he was left exposed to the elements and sustained numerous mosquito and spider bites, which DRF observed.

Multiple detainees described being subjected to physical force by guards, including the use of tasers, pepper spray, punching, shoving, and painful shackling practices. Nicolas reported guards using pepper spray on all the units in his tent to quiet the detainees shouting over the poor conditions. Nicolas reported feeling the pepper spray in his lungs, eyes, and nose, and resorted to using water from the sink to wash out his face, even though he usually avoided the sink water because it was too dirty.

Gabriel reported that once, while being temporarily transferred from the facility, he was speaking with a nurse to get medical clearance and was standing up to be heard over the other detainees. A guard came by and told him to sit down. Gabriel and the nurse asked the guard to wait. Gabriel reported that the guard then picked him up and slammed him down on a bench, picked him up again, and slammed him down backwards on the bench. A second guard pulled the shackles connecting Gabriel's hands and feet through his legs and attached them to a hook on the floor two feet behind him. The tension on the shackles forced Gabriel to slide off the bench and onto his knees. Gabriel had to use his head to push against the tarp in front of him and his fingers to hold onto the bench behind him in order to not fall forward. Gabriel was held in that position for over 45 minutes. Once released, his ankles were bleeding from being cut by the handcuffs and his knees and neck were in pain.

During all video and in-person interviews, all clients were observed to be shackled at their hands and feet, including while in a wheelchair. Detainees observed outside the legal interview tent and medical tent were also shackled at their hands and feet. Clients reported that shackles remained on whenever detainees were transported to sick calls, legal visits, meetings with facility administrators, while being processed into or out of the facility, or during transport.

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Medical Neglect

Medical records reviewed by DRF and client interviews document repeated delays and interruptions in necessary medical care, including medication access and follow-up treatment after serious injuries.

Andres sustained a head injury after being struck by another detainee at the facility, resulting in loss of vision in one eye and partial loss of vision in the other. Hospital records indicate that providers identified significant vision loss and an eye contusion and referred Andres to urgent ophthalmology follow-up. The hospital also told Andres he should obtain an MRI if symptoms persisted and to seek emergency care if the issues worsened. Andres repeatedly sought medical care for vision loss, severe headaches, dizziness, nausea, and sensitivity to light. According to records, Andres never received the recommended follow-up care with specialists or an MRI. Andres only received Tylenol or ibuprofen as a response while at the facility.

Nicolas, who has diabetes, experienced repeated disruptions in insulin access and diabetes care during his detention. Prior to his detention, Nicolas had been prescribed insulin three times a day. While detained, Nicolas was only authorized to receive it once a day, and even this reduced dose was routinely delayed or missed. Nicolas reported getting his medication at inconsistent hours and being woken up late at night or very early in the morning to receive his nighttime medication. Medical records document a period where, due to Nicolas not receiving insulin for over 24 hours, Nicolas had extremely elevated blood sugar levels consistent with severe hyperglycemia. In another incident, Nicolas was unresponsive when checked by nurses due to dangerously low levels. Nicolas reported that he was refused a special diabetic diet, which is essential for helping regulate blood sugar levels and preventing long-term complications. During his detention, Nicolas also experienced a transient ischemic attack, which left a lasting impact on his speech and movement.

Juan sustained serious injuries after an assault by another detainee and was diagnosed at a hospital with a concussion, facial fractures and an MCL tear. Hospital records indicate that he was referred to follow-up treatment with multiple specialists, including an orthopedic surgeon, plastic surgeon, and neurologist within one to two weeks. The medical records indicate that Juan never received this recommended follow-up care.

"Andres repeatedly sought medical care for vision loss, severe headaches, dizziness, nausea, and sensitivity to light. According to records, Andres never received the recommended follow-up care with specialists or an MRI. Andres only received Tylenol or ibuprofen as a response while at the facility."

Juan was also on vital medications for both his physical and mental health during his time at Alligator Alcatraz. Medical records document that Juan had severe lapses in medication, sometimes for many days in a row, while on a few occasions records indicate he may have had duplicate doses of the same medication. Documentation shows Juan consistently making "sick call" requests to inform the facility's medical staff when he did not receive his medication. Despite his efforts, he often still did not receive it.

All clients reported frequently missed medication doses and lack of medical care. For example, records show that during a month, one client was prescribed an inhaler four times a day for 30 days, but he only received nine of 120 doses. During a month when one client was prescribed a muscle relaxant for a serious injury, he only received seven of 60 doses. During a month when another client was supposed to have their blood sugar level monitored once a day for five days, no measurements were recorded.

Clients also reported seeing other detainees with mental illness who were unable to communicate with others, understand the circumstances of their detention, or who expressed suicidal ideation. In describing one man who stood in the corner of the cage at night talking to himself, Andres stated, "This guy needs help. His body is here but his mind is somewhere else." Clients reported that these detainees appeared to remain untreated or unassisted while held at the facility.

Denial of Accommodations for Detainees with Disabilities

Our investigation revealed that no detainees were provided with mobility devices while inside the cages. After Juan's injuries, for example, he required mobility assistance through a wheelchair or other equipment such as a walker or crutches. Juan reported that he was only provided with a wheelchair during transport to medical or legal services and was not allowed one in his cage. As a result of his limited access to a mobility device inside the cage, Juan reported falling in an incident that further injured his wrist and ankle.

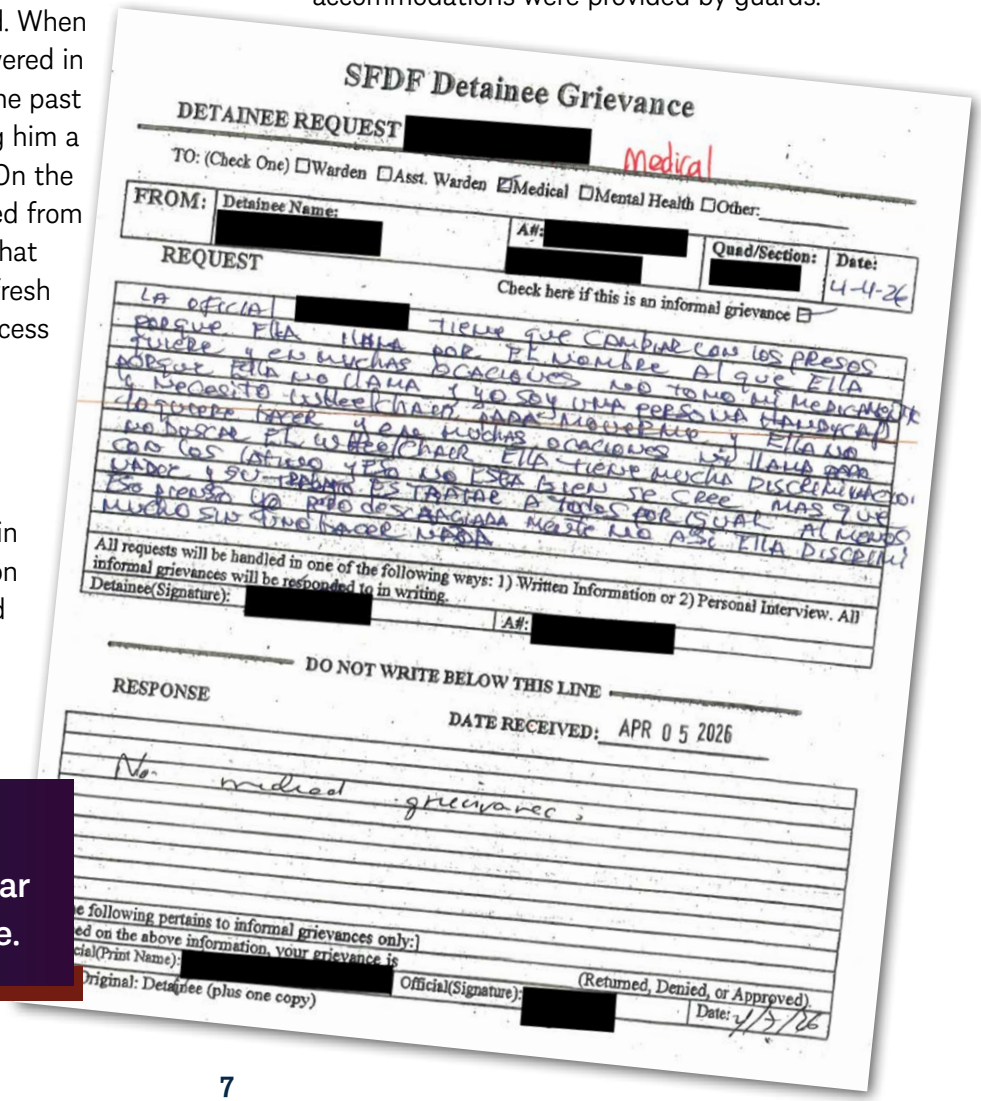
Juan also reported that access to a wheelchair for travel outside the cage was inconsistent. On one occasion, Juan had to hobble a significant distance from the housing tent to the air strip while being temporarily transferred from the facility, resulting in pain and prolonged injury to his torn MCL. Juan also reported routinely missing showers and meals because the facility failed to provide him with mobility assistance and would not always bring food to the cage when he was left behind. When DRF first spoke to Juan, he had not showered in four days and had missed two meals in the past two days because guards would not bring him a wheelchair to shower, and at mealtimes. On the day that contaminated water was removed from the cage, Juan contacted DRF to report that no one had brought him a wheelchair or fresh water to the cage, and he had not had access to clean drinking water for 10 hours.

Juan repeatedly requested access to a wheelchair, including through the facility grievance process. These requests were ignored, and Juan reported being placed in a segregated housing unit on one occasion after arguing with a guard about his need for a wheelchair.

Below is an example of a grievance stating that a specific guard consistently failed to provide Juan with a wheelchair and regular medication doses. The denial states, "No medical grievance."

Additionally, even with his injuries and requests, Juan did not have access to a bottom bunk for over two months. This is a necessary accommodation to ensure that people with mobility impairments can safely transfer into their bunks without climbing and falling. Other clients also reported difficulties in getting access to lower bunks and seeing other detainees with disabilities be denied access to lower bunks.

Andres described another detainee in his cage who was Deaf, communicated through writing and sign language, and had very limited mobility. This detainee was required to rely on other detainees to speak to his family members by phone and help him move around the cage because no accommodations were provided by guards.



SFDF Detainee Grievance

DETAINEE REQUEST [redacted] Medical

TO: (Check One) ☐Warden ☐Asst. Warden ☑Medical ☐Mental Health ☐Other:

FROM: Detainee Name: [redacted] A#: [redacted] Quad/Section: [redacted] Date: 4-4-26

REQUEST

Check here if this is an informal grievance ☐

LA OFICIAL [redacted] TIENE QUE CAMBIAR CON LOS PRESOS PORQUE ELLA HABLA POR EL NOMBRE AL QUE ELLA QUIERE, Y EN MUCHAS OCACIONES NO TOMO MI MEDICINA PORQUE ELLA NO LLAMA Y YO SOY UNA PERSONA HANDICAP Y NECESITO WHEELCHAIR PARA MOVERME Y ELLA NO QUIERE HACER Y ESO MUCHAS OCACIONES NO ME LLAMA PARA NO BUSCAR EL WHEELCHAIR. ELLA TIENE MUCHA DISCRIMINACION CON LOS LATINOS Y NO ESTA BIEN SE CREE MAS QUE TODOS Y SU JEFE NO ESTA BIEN TRATAR A TODOS POR IGUAL ALMENOS BO PIENSO YO PUEDO DESANGLADA MENTE NO ASI ELLA DISCRIMINA MUCHO SIN HACER NADA

All requests will be handled in one of the following ways: 1) Written Information or 2) Personal Interview. All informal grievances will be responded to in writing.

Detainee(Signature): [redacted] A#: [redacted]

DO NOT WRITE BELOW THIS LINE

RESPONSE

DATE RECEIVED: APR 05 2026

No medical grievance.

e following pertains to informal grievances only:]
ed on the above information, your grievance is
cial(Print Name): [redacted] Official(Signature): [redacted] (Returned, Denied, or Approved)
Original: Detainee (plus one copy) Date: 4/5/26

Grievance for failing to provide wheelchair and regular medication to caged detainee.

Inadequate Food

All clients reported concerns regarding both the quality and quantity of food provided at the facility and reported significant weight loss in their time at the facility, which averaged six months. Nicolas reported losing 54 pounds during his detention, dropping from 186 to 132 pounds, while other individuals reported losses ranging from 20 to 50 pounds. In two cases, DRF was provided with photos before their stay in detention and they were noticeably thinner and gaunt when DRF visited them.

Individuals with medical conditions requiring dietary accommodations, including diabetes, reported not receiving medically appropriate diets. Clients also reported having very little time to eat their meals. Gabriel, who had lost 13 teeth in prior tooth extractions, stated that he was not provided with additional time to eat his meals. On one occasion, when Gabriel requested additional time from staff, he reported being disciplined.

> *"Nicolas reported losing 54 pounds during his detention, dropping from 186 to 132 pounds, while other individuals reported losses ranging from 20 to 50 pounds."*

Limited Communication with Outside

> *"Multiple detainees also reported to DRF that DRF's main number appeared to be blocked from the phones inside the cages."*

While being held at Alligator Alcatraz, no detainees were permitted to see non-legal visitors. In late 2025, DRF attempted to hold legal video calls with detainees but on multiple occasions these calls were canceled at the last minute because the detainee had been moved to another facility. Before April of 2026, there was no publicly available information on how to conduct legal visits in person.

Clients reported that they had limited access to important legal and medical documents during their detention. Andres reported that his discharge orders from the emergency room were confiscated and never returned. Gabriel reported that some of his legal documents were taken and reviewed by facility guards outside of his presence. Clients also described challenges regarding receiving and sending mail. Juan reported long delays in being able to send out a habeas corpus petition for filing. At no time during DRF's investigation did detainees have access to unmonitored legal calls, despite multiple requests to guards. Multiple detainees also reported to DRF that DRF's main number appeared to be blocked from the phones inside the cages.

> *"This guy needs help. His body is here but his mind is somewhere else."*

CONCLUSION

While the transfer of detainees out of Alligator Alcatraz and its closure is an important step, closure alone does not address the harm experienced by individuals detained there, including detainees with disabilities. The concerns identified by DRF were not isolated incidents, but rather reflected recurring patterns documented through interviews, medical records, and advocacy efforts.

As Florida's designated Protection and Advocacy system for people with disabilities, DRF will continue to seek transparency regarding conditions at Alligator Alcatraz and other detention facilities in the state and advocate for individuals with disabilities who experienced harm while detained there. These findings underscore the need for independent oversight, meaningful accountability, and safeguards to ensure similar conditions do not occur in other detention settings.

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