

U.S. Department of Homeland Security
500 12th St., SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

November 6, 2020

Austin Evers
American Oversight
1030 15th Street, NW
Suite B255
Washington, DC 20005

**RE: American Oversight v. DHS et al., (1:20-cv-02018-BAH)
ICE FOIA Case Number 2020-ICLI-00057
First Interim Production**

Dear Mr. Evers:

This letter is the first interim response to your Freedom of Information Act (FOIA) requests to U.S. Immigration and Customs Enforcement (ICE), dated March 20, 2020, seeking copies of the “Healthcare and Security Compliance Analysis” reports—or equivalent internal procedural compliance analysis—completed by or for ICE Office of Professional Responsibility as part of the detainee death reviews for each of the following individuals who died in custody.

ICE has considered your request under the FOIA, 5 U.S.C. § 552.

A total of 146 pages of records were reviewed for this interim production. The 146 pages of records were located pursuant to a search of the ICE, Enforcement and Removal Operations (ERO). The attached 146 pages of records have been marked 2020-ICLI-00057-1 through 2020-ICLI-00057-146. Upon review, ICE has determined that portions of the 146 pages will be withheld pursuant to FOIA Exemptions, (b)(5), (b)(6), (b)(7)(C) and (b)(7)(E) of the FOIA as described below:

FOIA Exemption 5 protects inter-agency or intra-agency memorandums or letters which not be available by law to a party other than an agency in litigation with the agency. The deliberative process privilege protects the integrity of the deliberative or decision-making processes within the agency by exempting from mandatory disclosure opinions, conclusions, and recommendations included within inter-agency or intra-agency memoranda or letters. The release of this internal information would discourage the expression of candid opinions and inhibit the free and frank exchange of information among agency personnel. The attorney work-product privilege protects documents and other memoranda prepared by an attorney in contemplation of litigation. The attorney-client privilege protects confidential communications between an attorney and his client relating to a legal matter for which the client has sought professional advice. It applies to facts divulged by a client to his attorney, and encompasses any opinions given by an attorney to his client based upon, and thus reflecting, those facts, as well as communications between attorneys

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that reflect client-supplied information. The attorney-client privilege is not limited to the context of litigation.

ICE has applied FOIA Exemptions 6 and 7(C) to protect from disclosure the names, e-mail addresses, and phone numbers of DHS employees contained within the documents.

FOIA Exemption 6 exempts from disclosure personnel or medical files and similar files the release of which would cause a clearly unwarranted invasion of personal privacy. This requires a balancing of the public's right to disclosure against the individual's right to privacy. The privacy interests of the individuals in the records you have requested outweigh any minimal public interest in disclosure of the information. Any private interest you may have in that information does not factor into the aforementioned balancing test.

FOIA Exemption 7(C) protects records or information compiled for law enforcement purposes that could reasonably be expected to constitute an unwarranted invasion of personal privacy. This exemption takes particular note of the strong interests of individuals, whether they are suspects, witnesses, or investigators, in not being unwarrantably associated with alleged criminal activity. That interest extends to persons who are not only the subjects of the investigation, but those who may have their privacy invaded by having their identities and information about them revealed in connection with an investigation. Based upon the traditional recognition of strong privacy interest in law enforcement records, categorical withholding of information that identifies third parties in law enforcement records is ordinarily appropriate. As such, I have determined that the privacy interest in the identities of individuals in the records you have requested clearly outweigh any minimal public interest in disclosure of the information. Please note that any private interest you may have in that information does not factor into this determination.

ICE has applied FOIA Exemption 7(E) to protect from disclosure internal agency case numbers contained within the document.

FOIA Exemption 7(E) protects records compiled for law enforcement purposes, the release of which would disclose techniques and/or procedures for law enforcement investigations or prosecutions or would disclose guidelines for law enforcement investigations or prosecutions if such disclosure could reasonably be expected to risk circumvention of the law. I have determined that disclosure of certain law enforcement sensitive information contained within the responsive records could reasonably be expected to risk circumvention of the law. Additionally, the techniques and procedures at issue are not well known to the public.

If you have any questions about this letter, please contact Assistant United States Attorney Michael A. Tilghman II at (202) 252-7113 or michael.tilghman@usdoj.gov

Sincerely,

Fernando Pineiro Jr.
(A)FOIA Officer

Enclosure(s): 146 page(s)

cc:

Michael A. Tilghman II
Assistant United States Attorney
Civil Division
United States Attorney's Office
for the District of Columbia
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Office of Enforcement and Removal Operations
ICE Health Service Corps

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Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

December 18, 2018

MEMORANDUM FOR:

Stewart D. Smith, DHSc, MPH
Assistant Director
ICE Health Service Corps

STEWART D
SMITH

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STEWART D SMITH
Date: 2019.01.09
12:18:54 -05'00'

THROUGH:

(b)(6); (b)(7)(C)

MD

(b)(6); (b)(7)(C)

Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

Armstrong, MS

(b)(6); (b)(7)(C)

Chief of Staff

ICE Health Service Corps

(b)(6); (b)(7)(C)

Date: 2018.12.26
11:44:56 -05'00'

FROM:

(b)(6); (b)(7)(C)

, MD

Regional Clinical Director - Western
ICE Health Service Corps

(b)(6); (b)(7)(C)

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(b)(6); (b)(7)(C)
Date: 2018.12.19
09:08:41 -08'00'

CDR (b)(6); (b)(7)(C), RN

Regional Nurse Consultant - Eastern
ICE Health Service Corps

(b)(6); (b)(7)(C)

Digitally signed (b)(6);
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Date: 2018.12.23 09:03:49
-05'00'

CDR (b)(6); (b)(7)(C) RN
Investigator
ICE Health Service Corps

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(b)(6); (b)(7)(C)
Date: 2018.12.18
20:27:50 -06'00'

CDR (b)(6); (b)(7)(C) PA-C
Regional Advanced Practice Provider - Western
ICE Health Service Corps

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(b)(6); (b)(7)(C)
Date: 2018.12.19
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SUBJECT:

Mortality Review – Gourgen MIRIMANIAN, A070 963 630

Executive Summary:

Mr. Gourgen MIRIMANIAN, a 54-year-old Armenian male, was in U.S. Immigration and

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Customs Enforcement (ICE) custody from February 6 to April 10, 2018. During his detention period, ICE housed Mr. MIRIMANIAN at Prairieland Detention Center (PDC), in Alvarado, Texas (TX), where he was treated for hypertension (elevated blood pressure) and hyperlipidemia (elevated lipid levels). On March 7, 2018, Mr. MIRIMANIAN presented to the PDC medical clinic with a report of intermittent, burning, and squeezing chest pain, lasting 30 to 40 seconds, for the previous ten days. An advanced practice provider (APP) evaluated Mr. MIRIMANIAN, diagnosed atypical (unusual) chest pain, and ordered a cardiology referral. Mr. MIRIMANIAN's initial cardiology appointment was scheduled to occur on April 13, 2018. On April 10, 2018, Mr. MIRIMANIAN was found in his bunk, unresponsive, not breathing, and pulseless. PDC staff initiated cardio-pulmonary resuscitation (CPR) and notified emergency medical services (EMS). After approximately 15 minutes, EMS arrived, continued CPR, and advanced cardiac life support measures and medications. EMS departed with Mr. MIRIMANIAN, to a local emergency department (ED), at approximately 8:44 a.m. At approximately 9:12 a.m., an ED physician pronounced Mr. MIRIMANIAN dead.

Mortality Finding:

A mortality review committee (MRC) determined that Mr. MIRIMANIAN's medical care at PDC was provided within the safe limits of practice and did not directly or indirectly contribute to his death.

Collateral findings identified during this review are included in the mortality review detailed report of findings below.

Mortality Review Detailed Report:

On April 10, 2018, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Gourgen MIRIMANIAN, A070 963 630. Mr. MIRIMANIAN, a 54-year-old Armenian male, was in ICE custody from February 6 to April 10, 2018, and assigned to PDC on the date of his death. Mr. MIRIMANIAN passed away at Huguley Memorial Hospital in Burleson, TX, on April 10, 2018.

The IHSC Assistant Director requested a mortality review to learn from Mr. MIRIMANIAN's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

(b)(5)

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(b)(5)

CDR

(b)(6); (b)(7)(C)

(b)(5)

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016). The MRC identified the following healthcare delivery/program strengths, weaknesses, and recommendations during this review:

Strengths

During this review, it was clear that the PDC staff are earnest and dedicated professionals. Strengths identified during this investigation were staff's:

(b)(5)

(b)(5)

Weaknesses

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.G. *Pharmaceutical Management*; Statement 11.
- PBNDS 2011: 4.3, Medical Care; section V.B. *Designation of Authority*.
- Texas Administrative Code, Title 26: *Health and Human Services*, Part 1: Health and Human Services Commission, Chapter 557: Medication Aides – Program Requirements, Rule 557.101: *Introduction*: Statements (a)(3) and (c)(6).

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.S. *Sick Call*.

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- PBNDS 2011: 4.3, Medical Care; section V.B. *Designation of Authority*.
- Texas Administrative Code, Title 22: *Examining Boards*, Part 11: Texas Board of Nursing, Chapter 217: Licensure, Peer Assistance, and Practice, Rule 217.11: *Standards of Nursing Practice*.
- PDC Local Operating Procedure (LOP) HC 1.12: *Sick Call*.
- PDC Sick Call Protocol.

3. Continuity of Care.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes (5)*.
- PBNDS 2011, 4.3., Medical Care; section II. *Expected Outcomes (23)*.
- PBNDS 2011, 4.3., Medical Care; section II. *Expected Outcomes (24)*.
- PDC LOP H-D-02; *Medication Services*.
- PDC LOP HC 1.3: *Medical Care – Continuity of Care*.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes (21)*.

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes (21)*.
- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes (22)*.

Recommendations

• (b)(5)

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End of report.

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

December 6, 2018

MEMORANDUM FOR:

Stewart D. Smith, DHSc, MPH
Assistant Director
ICE Health Service Corps

STEWART D
SMITH

Digitally signed by STEWART
D SMITH
Date: 2018.12.17 12:38:16
-05'00'

THROUGH:

A (b)(6); (b)(7)(C) MD (b)(6); (b)(7)(C)
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C), MS
Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Date: 2018.12.13 13:29:03
-05'00'

FROM:

C (b)(6); (b)(7)(C), MD
Deputy Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

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CDR (b)(6); (b)(7)(C) A-C
Risk Manager
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CDR (b)(6); (b)(7)(C) PA-C
Regional Advanced Practice Provider
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Date: 2018.12.13
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SUBJECT: Mortality Review - Ronal Francisco ROMERO, A078 963 293
(a.k.a. Ronald CRUZ)

Executive Summary:

Mr. Ronal Francisco ROMERO, a 39-year-old Honduran male, was in U.S. Immigration and Customs Enforcement (ICE) custody from May 14 to 16, 2018. During pre-screening and intake screening at Port Isabel Detention Center (PIDC) in Los Fresnos, Texas (TX), Mr. ROMERO denied a history of any medical/mental health conditions and voiced no complaints. Mr. ROMERO's vital signs (VS) were within normal limits (wnl). Within 30 hours of his arrival, an advanced practice provider (APP) evaluated Mr. ROMERO for fever, influenza like symptoms, dehydration, and clinical strep throat. The APP initiated treatment and admitted Mr. ROMERO to the medical housing unit (MHU) for observation. Within five hours, a registered nurse (RN) observed a change in Mr. ROMERO's health status, i.e., altered mental status and elevated blood pressure. The RN consulted with an APP and notified emergency medical services (EMS). EMS responded within 26 minutes to PIDC, assumed care of Mr. ROMERO, and transferred him to a local emergency department (ED). Within twelve hours after arrival, Mr. ROMERO went into cardiac arrest and was transferred to the intensive care unit (ICU), where he required ventilatory support and medication to maintain his blood pressure. Over the next 12 hours, Mr. ROMERO's status deteriorated, resulting in several cardiac arrests, and the physician pronounced Mr. ROMERO dead at 6:49 p.m. Autopsy results revealed Mr. ROMERO's manner of death was "natural" due to complications of sepsis (infection) with meningitis and other significant conditions listed as diabetes mellitus (an unknown or unreported condition).

Mortality Finding:

A mortality review committee (MRC) determined that Mr. ROMERO's medical care at PIDC was provided within the safe limits of practice and did not directly or indirectly contribute to his death.

Of note, during this review, it was found that Mr. ROMERO was in U.S. Customs and Border Protection (CBP) custody prior to his transfer to ICE custody, from May 9 to 14, 2018, where he received antibiotics for a left ear and throat infection. Mr. ROMERO was scheduled to complete a five-day course of antibiotics (otically and orally) on May 13, 2018, prior to his transfer to PIDC. A post-mortality search of his property revealed three pills remained and the medications were not shared with PIDC medical staff, nor did Mr. ROMERO report the treatment during his intake. It is unknown if this information would have affected Mr. ROMERO's care, course of treatment, and the outcome. Due to Mr. ROMERO's progressively deteriorating status and short time period within ICE custody, it is highly unlikely that the information would have changed the outcome.

Collateral findings identified during the course of this review are included in the mortality review detailed report of findings below.

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Mortality Review Detailed Report:

On May 16, 2018, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Ronal Francisco ROMERO, A078 963 293. Mr. ROMERO, a 39-year-old Honduran male, was in ICE custody from May 14 to May 16, 2018, and assigned to PIDC on the date of his death. Mr. ROMERO passed away at Valley Baptist Medical Center (VBMC) on May 16, 2018.

The IHSC Assistant Director requested a mortality review to learn from Mr. ROMERO's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The findings and recommendations of the MRC, which convened on September 11, 2018, are based on the review of the following information: (b)(5)

(b)(5); (b)(6); (b)(7)(C)

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016). The MRC identified the following health care delivery/program strengths, weaknesses, and recommendations during this review:

Strengths

During this review, it was readily apparent that PIDC are earnest and dedicated professionals. Strengths identified during this investigation were staff's (b)(5)

(b)(5)

Weaknesses

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-E-02, *Receiving Screening*.
- NCCHC standard, J-A-09, *Privacy of Care*.
- ACA standard, 1-HC-1A-19, *Health Screens*.
- PBNDS 2011: 4.3, Medical Care; section V.J. *Medical and Mental Health Screening of New Arrivals*.
- IHSC Directive 03-08, *Pre-Screening*, March 21, 2016.
- IHSC Directive 03-10, *Intake Screening and Intake Reviews*, March 28, 2016.
- PIDC LOP 8.1.1., *Medical Intake Screening*, 3.3-3, January 2018.

(b)(5)

Applicable standards of care for this finding:

- ACA standard, 1-HC-1A-04, *Continuity of Care*.
- Texas Nurse Practice Act, July 2012, V43, No. 3: *Professional Communication on Interdisciplinary Teams and a Nurse's Duty*.

(b)(5)

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Applicable standards of care for this finding:

- IHSC LVN/LPN Competencies, page 4.
- Texas Nurse Practice Act, V43, No. 3, *Professional Communication on Interdisciplinary Teams and a Nurse's Duty*.
- Nurse Practice Act (NPA), "Texas Board of Nursing Board Position Statements." Rule 217.11, 15.3, https://www.bon.texas.gov/practice_scope_of_practice_rn.asp.
- Texas NPA, "The Licensed Vocational Nurse Scope of Practice", https://www.bon.texas.gov/practice_bon_position_statements_content.asp#15.27.

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-C-07, *Staffing*.
- ACA standard, 1-HC-4A-05, *Staffing*.
- PBNDS 2011: 4.3, Medical Care; section V.B. *Designation of Authority*.
- IHSC Directive 17-002, Clinic Scheduling Guidelines; 4-1.5; 4-1.6, *Schedule Administration*, October 10, 2017.
- IHSC Guide 03-02-G-01, Sick Call; II. A. *Sick Call Process*, March 25, 2016.

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-D-02, *Medication Services*.
- ACA standard, 1-HC-1A-35, *Pharmaceuticals*.
- PBNDS 2011: 4.3, Medical Care; section V.G. *Pharmaceutical Management*.
- PBNDS 2011: 4.3, Medical Care; section V.U. *Delivery of Medication*.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.B. *Designation of Authority*.
- Nursing Process, “*Five step process (assessment, diagnosing, planning, implementing, and evaluation) to enhance the quality of patient care.*” Nursingprocess.org.

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard: J-E-12, *Continuity and Coordination of Care During Incarceration*.

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- Texas Administrative Code, Title 22: Examining Boards, Part 9: Texas Medical Board, Chapter 185: Physician Assistants, Rule 185.10: *Physician Assistant Scope of Practice*.

(b)(5)

PIDC.

Applicable standards of care for this finding:

- PBNDS 2011, 4.3., *Medical Care*., section II. *Expected Outcomes* (23).
- American Nurses Association (ANA) Nursing: Scope and Standards of Practice, *Standard I. Assessment*, states that an RN is expected to document relevant data in a retrievable format.

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard: J-G-03, *Infirmity Care*.
- ACA standards: 1-HC-1A-09, *Infirmity Care*.
- PBNDS 2011: 4.3, *Medical Care*; section V.F.3, *Medical Housing*.
- IHSC Directive 03-17, *Medical Housing Unit*, March 25, 2016.

Recommendations

(b)(5)

End of report.

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

February 7, 2019

MEMORANDUM FOR: Stewart D. Smith, DHSc, MPH
Assistant Director
ICE Health Service Corps

STEWART D
SMITH

Digitally signed by
STEWART D SMITH
Date: 2019.02.26
11:28:13 -05'00'

THROUGH:

(b)(6); (b)(7)(C)

MD

Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

MS

Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C)

FROM:

CAPT (b)(6); (b)(7)(C) MD
Clinical Director - Krome
ICE Health Service Corps

(b)(6); (b)(7)(C)

CAPT (b)(6); (b)(7)(C) RN
Regional Health Services Administrator - Western
ICE Health Service Corps

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CAPT (b)(6); (b)(7)(C) RN
Senior Investigator
ICE Health Service Corps

(b)(6); (b)(7)(C)

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Investigator
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LCDR (b)(6); (b)(7)(C) NP-C
Risk Manager
ICE Health Service Corps

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CDR (b)(6); (b)(7)(C) PA-C
Chief, Advanced Practice Provider
ICE Health Service Corps

(b)(6); (b)(7)(C)

CDR (b)(6); (b)(7)(C) NP-C
Deputy Assistant Director of Health Care Compliance
ICE Health Service Corps

(b)(6); (b)(7)(C)

SUBJECT: Mortality Review
Huy Chi TRAN, A037 949 945

Executive Summary:

Mr. Huy Chi TRAN, a 47-year-old Vietnamese male, was in U.S. Immigration and Customs Enforcement (ICE) custody from May 25 to June 12, 2018. On May 25, 2018, during Mr. TRAN's pre-screening at Florence Service Processing Center (FSPC), in Florence, Arizona (AZ), he denied a history of acute/chronic medical or mental health conditions, but stated he was taking medications [haloperidol 5 mg, one tablet orally, daily, to treat schizophrenia, and fluoxetine 20 mg, one capsule orally, daily, to treat major depressive disorder]. During the intake screening, Mr. TRAN added that he had a 20-year history of depression. The registered nurse (RN) completed the abnormal involuntary movement scale [AIMS; a system used to assess abnormal involuntary movements, such as hand tremors or rhythmic movements of the tongue and jaw, that may result from the long-term administration of psychotropic drugs] assessment on Mr. TRAN and documented a score of zero. The RN consulted with an advanced practice provider (APP) and was given an order from the APP to continue Mr. TRAN's medications and scheduled him for a next day physical examination and behavioral health (BH) evaluation. On the same day, a licensed clinical social worker (LCSW) completed Mr. TRAN's BH evaluation describing him as poorly groomed, bizarre, poor eye contact, shallow, flat affect, and lethargic. The LCSW assessed him with schizophrenia and scheduled him for a follow-up appointment on June 2, 2018, and encouraged Mr. TRAN to continue to take his prescribed medications. [Investigator's note: IHSC operates both EDC and FSPC medical departments, where they share access to the same electronic medical record, eClinical Works.]

On May 28, 2018, ICE transferred Mr. TRAN to Eloy Detention Center (EDC) in Eloy, AZ. Mr. TRAN arrived with a transfer summary documenting his BH history (schizophrenia and major depressive disorder) and current medications (haloperidol and fluoxetine). The RN labeled Mr. TRAN's prescreening as top priority, "PRI-1." Two hours later, the same RN completed Mr. TRAN's intake screening, documented it as "abnormal," and referred Mr. TRAN to an APP and BH provider (BHP) for further evaluation. On the same day, an APP completed a comprehensive medical evaluation for Mr. TRAN, noting his BH history and prescription medications. The APP noted that a call was made to the on-call tele-psychiatrist and Mr. TRAN's medication was prescribed. [Investigator's note: the on-call tele-psychiatrist did not co-sign or completed an encounter regarding this consultation.] The APP electronically routed the medical evaluation

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note and a different psychiatrist co-signed the APP's note on May 31, 2018. The psychiatrist scheduled Mr. TRAN for a follow-up appointment on June 4, 2018.

On June 4, 2018, a psychiatrist evaluated Mr. TRAN and noted an AIMS score of three [An AIMS score of two or higher, is evidence of tardive dyskinesia (TD). TD is a disorder that results in involuntary, repetitive body movement from psychotropic medications]. The psychiatrist also noted that Mr. TRAN was exhibiting extra pyramidal symptoms (EPS), a drug-induced movement disorder that includes acute and TD symptoms and ordered a trial of benztropine (used for management of certain movement problems associated with medications). The psychiatrist documented that Mr. TRAN's was able to cope in general population as this was the least restrictive housing environment for Mr. TRAN.

On June 5, 2018, a psychologist evaluated Mr. TRAN and admitted him to the special housing unit (SHU) for increased monitoring with every 15-minute custody checks, because Mr. TRAN's BH was deteriorating and he displayed EPS. Approximately four hours later, a custody officer (CO) found Mr. TRAN unresponsive and started basic life support. Emergency medical services (EMS) were called and arrived within ten minutes, assumed care of Mr. TRAN, and transported him to Banner Casa Grande Medical Center (BCGMC).

During Mr. TRAN's eight-day hospitalization, he remained unresponsive with no reflexes, including gag and pupils (eye movement); mechanical ventilation (breathing machine); hypothermia therapy (maintain body temperature); and medication management [suxamethonium chloride (skeletal muscle relaxant), propofol (used to induce or maintain anesthesia), norepinephrine (vasoconstrictor), and piperacillin/tazabactam (antibiotic).]

On June 12, 2018, a BCGMC physician performed an electroencephalography [EEG; a tool used to measure electrical activity of the brain] that showed no brain activity. These findings were confirmed with apneic testing (mandatory examination for determining brain death; it provides an essential sign of definitive loss of brainstem function), resulting in Mr. TRAN pronounced brain dead at 9:20 a.m.

Mortality Finding:

A mortality review committee (MRC) determined that Mr. TRAN's BH care at EDC was provided within safe limits of practice; however, a review of Mr. TRAN's EDC medical records revealed it is unclear whether health services directly or indirectly contributed to his death.

Collateral findings identified during this review are included in the mortality review detailed report of findings below.

Mortality Review Detailed Report:

On June 5, 2018, ICE Health Service Corps (IHSC) received notification of the death of ICE

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detainee Huy Chi TRAN, A037 949 945. Mr. TRAN, a 47-year-old Vietnamese male, was in ICE custody from May 25 to June 5, 2018, and assigned to EDC on the date of his death. Mr. TRAN passed away at BCGMC on June 5, 2018.

The IHSC Assistant Director requested a mortality review to learn from Mr. TRAN's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The following report is based on the findings and recommendations of the MRC, which convened on November 6, 2018. The review was based on the following information: (b)(5); (b)(6) TRAN's FSPC and EDC medical records, EMS, and community hospital records; 2) incident

(b)(5); (b)(7)(C)

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016). The MRC identified the following health care delivery/program strengths, weaknesses, and recommendations during the review:

Strengths

During the review, it was readily apparent that EDC personnel are earnest and dedicated professionals. Strengths identified during this review were staff's (b)(5)

(b)(5)

Weaknesses

(b)(5)

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Applicable standards of care for this finding:

- NCCHC standard, J-E-02, *Receiving Screening*.
- PBNDS 2011: 4.3, Medical Care, section V. J., *Medical and Mental Health Screening of New Arrivals*.
- IHSC Directive 03-08, *Pre-Screening*.
- IHSC Directive 03-10, *Intake Screening and Intake Reviews*.

(b)(5)

Applicable standards of care for this finding:

- ACA standard, 1-HC-1A-04, *Continuity of Care*.
- NCCHC standard, J-A-08, *Communication on Patients' Health Needs*.
- NCCHC standard, J-E-12, *Continuity and Coordination of Care During Incarceration*.
- PBNDS 2011: 4.3, Medical Care, section V. Z., *Continuity of Care*.
- Texas Nurse Practice Act, July 2012, V43, No. 3: *Professional Communication on Interdisciplinary Teams and a Nurse's Duty*.
- Tarsy, Daniel, Deik, Andres. UpToDate: "*Tardive Dyskinesia: etiology, risk factors, clinical features, and diagnosis*." Topic last updated: June 19, 2018.
https://www.uptodate.com/contents/tardive-dyskinesia-etiology-risk-factors-clinical-features-and-diagnosis?search=extrapyramidal%20side%20effects&source=search_result&selectedTitle=5~150&usage_type=default&display_rank=5.

3. Patient safety.

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-B-02, *Patient Safety*.
- EDC LOP 8.10.2, Urgent Care, *Nursing Responsibility*.

4. Medication services.

- On May 28, 2018, prior to Mr. TRAN's transfer to EDC, he did not receive his scheduled medications.
- Mr. TRAN did not receive three doses of his prescribed medication.
- Mr. TRAN did not sign a consent for psychotropic medications until June 4, 2018 (seven days after his arrival to EDC).
- EDC nursing staff completed the morning pill line on night shift (4:00 a.m. - 7:00 a.m.); therefore, when new prescription orders were received in the pharmacy after 7:00 a.m., the medication was not started until the next day.
- The EDC psychiatrist changed Mr. TRAN's scheduled time for medications (haloperidol and fluoxetine). The old medication administration record (MAR) was removed when the new MAR was provided, resulting in Mr. TRAN receiving a second dose of fluoxetine.
- The EDC psychiatrist documented that he would start Mr. TRAN on benztropine to treat his TD symptoms; however, the psychiatrist did not enter an e-script medication order.
- Since the psychiatrist did not order new medications (only changed the administration times), the pharmacist did not review the plan of care for other changes to the treatment plan. (e.g. recommendation to start benztropine).
- The EDC pill line nurse's documentation did not include changes in behavior when Mr. TRAN reported to pill line twice a day.

Applicable standards of care for this finding:

- NCCHC standard, J-D-02, *Medication Services*.
- ACA standard, 1-HC-1A-35, *Pharmaceuticals*.
- PBNDS 2011: 4.3, Medical Care, section V. G., *Pharmaceutical Management*.
- PBNDS 2011: 4.3, Medical Care, section V. U., *Delivery of Medication*.
- IHSC eCW V10C User Guide: *Ordering Medication*.

5. Knowledge deficit.

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(b)(5)

Applicable standards of care for this finding:

- Tarsy, Daniel, Deik, Andres. UpToDate: “*Tardive Dyskinesia: etiology, risk factors, clinical features, and diagnosis.*” Topic last updated: June 19, 2018.
https://www.uptodate.com/contents/tardive-dyskinesia-etiology-risk-factors-clinical-features-and-diagnosis?search=extrapyramidal%20side%20effects&source=search_result&selectedTitle=5~150&usage_type=default&display_rank=5.

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard: J-G-03, *Infirmity Care*.
- PBNDS 2011: 2.4, Facility Security and Control, section V. A., *Detainee Supervision and Monitoring*.
- PBNDS 2011: 4.3, Medical Care, section V.F. 3, *Medical Housing*.
- PBNDS 2011: 4.6, Significant Self-harm and Suicide Prevention and Intervention, section V. F., *Housing and Monitoring*.
- Core Civic EDC post orders: EDC PO-110, Bravo 600; section III. N., *Security Checks*.
- Core Civic EDC post orders: EDC PO-110, Bravo 600; section III. W., *Medical Observation Procedures*.

(b)(5)

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- (b)(5)
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Applicable standards of care for this finding:

- ACA standard, 1-HC-1A-03, *Clinical Services*.
- PBNDS 2011: 4.3, Medical Care, section V. S, *Sick Call*.
- PBNDS 2011: 4.3, Medical Care, section V. T, *Emergency Medical Services and First Aid*.
- PBNDS 2011: 4.3, Medical Care, section V. F. 3., *Medical Housing*.
- IHSC Directive 03-02, Access to Care; *Sick Call*.
- EDC LOP 8.10.2, Urgent Care, *Nursing Responsibility*.
- EDC LOP 822, Emergency Medical Response; section 1. A., *Medical Emergencies*.
- Core Civic policy 9-16: Emergency Response Team (ERT); D., *Entering the area*.
- Cardiopulmonary Resuscitation and Emergency Cardiovascular Care (ECC) Guidelines (2015), Part 5: Adult Basic Life Support and Cardiopulmonary Resuscitation Quality. Accessed on September 6, 2018 at <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/part-5-adult-basic-life-support-and-cardiopulmonary-resuscitation-quality/>.

Recommendations

- (b)(5)

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(b)(5)

End of

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

January 2, 2019

MEMORANDUM FOR: Stewart D. Smith, DHSc, MPH
Assistant Director
ICE Health Service Corps

STEWART D. SMITH
Digitally signed by
STEWART D. SMITH
Date: 2019.01.07
13:03:17 -05'00'

THROUGH:

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

MS

Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C)

FROM:

CAPT (b)(6); (b)(7)(C) MD
Regional Clinical Director - Eastern
ICE Health Service Corps

(b)(6); (b)(7)(C)

CAPT (b)(6); (b)(7)(C) RN
Chief, Investigations Unit
ICE Health Service Corps

(b)(6); (b)(7)(C)

CAPT (b)(6); (b)(7)(C) RN
Investigator
ICE Health Service Corps

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CDI (b)(6); (b)(7)(C) NP
Deputy Assistant Director of Health Care Compliance
ICE Health Service Corps

(b)(6); (b)(7)(C)

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RN

Risk Manager
ICE Health Service Corps

(b)(6); (b)(7)(C)

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CDR (b)(6); (b)(7)(C) PA-C
Chief, Advanced Practice Provider
ICE Health Service Corps

(b)(6); (b)(7)(C)

CDR (b)(6); (b)(7)(C) RN
Regional Nurse Consultant - Western
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) MD
Cardiology Consultant
ICE Health Service Corps

(b)(6); (b)(7)(C)

SUBJECT: Mortality Review
Agustina RAMIREZ Arreola, A206 266 687

Executive Summary:

Ms. Agustina RAMIREZ Arreola, a 62-year-old Mexican female, was in U.S. Immigration and Customs Enforcement (ICE) custody from June 3 to July 25, 2018, at Otay Mesa Detention Center (OMDC) in San Diego, California (CA). During the pre-screening and intake screening, Ms. RAMIREZ reported feeling “good,” but that she was ill with a cough and sore throat for the past three days. Ms. RAMIREZ’s chest x-ray results were “positive screening for active tuberculosis (TB),” and an advanced practice provider (APP) ordered her placement in a negative pressure isolation cell; however, OMDC’s negative pressure isolation cells were full, requiring a referral to a community hospital, Alvarado Hospital (AH). Ms. RAMIREZ spent 28 days in AH for TB management.

During Ms. RAMIREZ’ hospitalization, an AH physician (MD) discovered Ms. RAMIREZ had a heart murmur (heart sounds produced when blood flows across one of the heart valves that is loud enough to be heard with a stethoscope) and bicuspid aortic valve stenosis [BAVS: a congenital heart defect that causes an obstruction of blood flow across the aortic valve] while performing a diagnostic echocardiogram (uses electrodes to check your heart rhythm and ultrasound technology to see how blood moves through your heart). After stabilizing Ms. RAMIREZ’ TB medications, the MD discharged Ms. RAMIREZ back to OMDC with recommendations for a surgical cardiac consult to repair her BAVS. On July 24, 2018, the cardiac surgeon admitted Ms. RAMIREZ to AH for an elective BAVS surgical repair. On July 25, 2018, post-operation, the cardiac surgeon admitted Ms. RAMIREZ to the intensive care unit (ICU) in critical condition. Ms. RAMIREZ came out of surgery on extracorporeal membrane oxygenation [ECMO; a machine that pumps and oxygenates blood outside the body allowing the patient’s heart and lungs to rest] due to left ventricle heart failure. Over the next few hours, Ms. RAMIREZ’ condition deteriorated, and she developed cardiogenic shock (life threatening medical condition resulting from an inadequate circulation of blood due to malfunctioning of the heart ventricles) requiring life saving measures. At 10:00 p.m., Ms. RAMIREZ was returned to

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surgery; however, Ms. RAMIREZ suffered a cardiac arrhythmia (irregular heart beat) and never recovered. Ms. RAMIREZ was pronounced dead at 10:45 p.m.

Mortality Finding:

A mortality review committee (MRC) determined that Ms. RAMIREZ's medical care at OMDC was provided within the safe limits of practice and did not directly or indirectly contribute to her death.

Collateral findings identified during this review are included in the mortality review detailed report of findings below.

Mortality Review Detailed Report:

On July 26, 2018, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Agustina RAMIREZ Arreola, A206 266 687. Ms. RAMIREZ, a 62-year-old Mexican female, was in ICE custody from June 3 to July 25, 2018, and assigned to OMDC on the date of her death. Ms. RAMIREZ died at AH on July 25, 2018.

The IHSC Assistant Director requested a mortality review to learn from Ms. RAMIREZ's death by reviewing the care provided and the circumstances leading up to her death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The findings and recommendations of the MRC, which convened on October 23, 2018, are based on the review of the following information: (b)(5)

(b)(5); (b)(6); (b)(7)(C)

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016). The MRC identified the following healthcare delivery/program strengths, weaknesses, and recommendations during the review:

Strengths

During the review, it was clear that OMDC staff are earnest and dedicated professionals.

Strengths identified during this review were staff's: (b)(5)

(b)(5)

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Weaknesses

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-E-02, *Receiving Screening*.
- ACA standard, 1-HC-1A-19, *Health Screens*.
- IHSC Directive 03-08, *Pre-Screening*, March 21, 2016.

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-A-08, *Communication on Patients' Health Needs*.
- ACA standard, 1-HC-1A-04, *Continuity of Care*.
- Texas Nurse Practice Act, July 2012, V43, No. 3: *Professional Communication on Interdisciplinary Teams and a Nurse's Duty*.

(b)(5)

Applicable standards of care for this finding:

- NCCHC standard, J-C-07, *Staffing*.
- ACA standard, 1-HC-1A-05, *Staffing*.
- PBNDS 2011: 4.3, *Medical Care*; section V. B, *Designation of Authority*.
- IHSC Directive 17-002, *Clinic Scheduling Guidelines*, October 10, 2017.

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Recommendations

(b)(5)

End of report.

Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

April 3, 2019

MEMORANDUM FOR:

Stewart D. Smith, DHSc, MPH
Assistant Director
ICE Health Service Corps

STEWART D SMITH

Digitally signed by STEWART D
SMITH
Date: 2019.05.02 12:56:50 -04'00'

THROUGH:

(b)(6); (b)(7)(C)

MD

(b)(6); (b)(7)(C)

Digitally signed by
Date: 2019.05.02 12:35:09 -04'00'

(b)(6);

(b)(7)(C)

Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

MS

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Date: 2019.04.23 16:25:05 -04'00'

Chief of Staff

ICE Health Service Corps

FROM:

CAPT A

(b)(6); (b)(7)(C)

MD

(b)(6); (b)(7)(C)

Eastern Regional Clinical Director
ICE Health Service Corps

CAPT (b)(6); (b)(7)(C)

RN

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Senior Investigator
ICE Health Service Corps

Date: 2019.04.24 12:35:57
-04'00'

CAPT (b)(6); (b)(7)(C)

RN

Chief, Medical Case Management Unit
ICE Health Service Corps

(b)(6); (b)(7)(C)

CDR (b)(6); (b)(7)(C)

PA-C

Chief, Advanced Practice Provider
ICE Health Service Corps

(b)(6); (b)(7)(C)

CDI (b)(6); (b)(7)(C)

Central Regional Nurse Consultant
ICE Health Service Corps

(b)(6); (b)(7)(C)

SUBJECT:

Mortality Review – Report of Findings
Wilfredo PADRON, A022 776 291

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Executive Summary:

Mr. Wilfredo PADRON, a 58-year-old Cuban male, was in U.S. Immigration and Customs Enforcement (ICE) custody from August 15 to November 1, 2018. On August 17, 2018, ICE transferred Mr. PADRON from the Krome Processing Center in Miami, Florida (FL), to Monroe County Detention Center (MCDC) in Key West, FL. A transfer summary accompanied him and outlined the following conditions: essential hypertension [(HTN); high blood pressure], chronic pancreatitis, unspecified pain and hyperlipidemia (high blood lipids). Mr. PADRON's MCDC intake screening revealed the above conditions and a prior left leg fracture due to a 1998 motor vehicle accident (MVA). Mr. PADRON's medications were: lisinopril, hydrochlorothiazide (HCTZ) and amlodipine (all medications for HTN), diclofenac (for pain), and gemfibrozil (for hyperlipidemia). Mr. PADRON denied any other medical or mental health history. On observation, Mr. PADRON had an unsteady gait, requiring use of a cane. His vital signs (VS) were stable, except for a slightly elevated blood pressure (BP) of 134/81 (normal: 125-130/<80 mm Hg). A registered nurse (RN) cleared Mr. PADRON for general population (GP), and provided him with a wheelchair for mobility (to keep his cane on person was considered a security risk).

On August 20, 2018, during a sick call encounter, Mr. PADRON complained of a runny nose, coughing, and reported a history of two cerebral vascular accidents [(CVA), i.e., strokes] in 2014 and 2018, with his last hospitalization in Arizona (AZ) from January 24 to 31, 2018. The RN treated Mr. PADRON with cetirizine (for allergies) 10 mg, orally, daily for seven days.

On August 23, 2018, a medical doctor (MD) completed Mr. PADRON's initial "multiple medical problems" visit, reaffirming Mr. PADRON's chronic conditions of HTN, pancreatitis, chronic pain, hyperlipidemia, and "appearance of left leg shorter than right," related to his 1998 MVA. *[Investigator's note: The MD did not document a physical examination during this visit.]* The MD documented that Mr. PADRON had a good degree of control for his chronic conditions and was clinically stable. The treatment plan included to: continue with medications, initiate a heart-healthy diet and lower bunk assignment, and obtain the following laboratory tests: complete blood count (CBC), chemistry panel, lipid panel, and to follow up in three months. *[Investigator's note: All laboratory tests results were essentially normal.]*

On August 29, 2018, an RN completed Mr. PADRON's health assessment. Mr. PADRON reported a history of six CVAs and taking a baby aspirin (ASA) daily. The RN's assessment findings were: *mouth*: wears a bridge for missing teeth; *heart*: cardiomegaly (enlarged heart), HTN; *liver*: spot on the liver (self-reported from diagnosis at Jackson Memorial Hospital in Miami – years ago) and he took fiber for constipation. His VS were stable, except for an elevated BP of 152/88. The RN documented, "will check with advanced practice provider (APP) regarding ASA and follow her orders." On August 30, 2018, the MD reviewed and signed the health assessment.

On September 10, 2018, an RN evaluated Mr. PADRON during sick call for a complaint of foot fungus and a request "to have ASA restarted since he has a clogged artery in his head." The RN

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documented the request and forwarded for a provider's review. The RN treated Mr. PADRON with fluconazole (antifungal) 150 mg, orally, weekly for three weeks. On September 14, 2018, an APP ordered ASA 81 mg, orally, daily.

On September 25, 2018, an RN evaluated Mr. PADRON during an urgent encounter. Mr. PADRON complained of feeling "extremely sick" and reported throat pain with swelling to the left side of his throat, congestion, sneezing, and watery eyes. VS was stable. The RN issued a seven-day supply of acetaminophen (APAP) 325 mg, two tablets, orally, twice daily as needed, and a 30-day supply of cetirizine (antihistamine) 10 mg, one tablet, orally, daily as needed.

On October 10, 2018, an RN evaluated Mr. PADRON during sick call for complaints of constipation, neck pain, morning cough, and a sore spot in his mouth. An APP and dental provider assessed Mr. PADRON. The APP ordered ranitidine (antacid) 150 mg, orally, two times, daily, and docusate sodium (stool softener) 100 mg, orally, two times, daily. The dental provider recommended that Mr. PADRON remove his dentures and rest his mouth, since the dentures caused the irritation.

On October 26, 2018, during an urgent sick call encounter, Mr. PADRON complained of chest pain described as sharp, radiating to the left arm and back. VS were normal, except for an elevated BP of 196/98. The electrocardiogram (EKG) results showed normal sinus rhythm with depressed ST segment. The provider ordered Mr. PADRON's transfer to Lower Keys Medical Center (LKMC) in Key West, FL, via emergency medical services (EMS) transport.

On this same date, Mr. PADRON returned to the facility with the following emergency department (ED) findings: chest x-ray revealed no active disease, and an abdominal x-ray revealed gas scattered throughout the bowel in non-specific pattern; deformity in the left hip; sclerotic and cystic changes with severe degenerative changes, and old post traumatic deformity of the left superior and inferior pubic rami (pelvic bones). The EKG showed normal sinus rhythm with non-specific ST abnormality. Mr. PADRON's discharge diagnosis was constipation and he was prescribed lactulose 30 cubic centimeter (cc) oral solution, daily for this condition. Upon Mr. PADRON's return to MCDC, the APP completed his evaluation. During this encounter, Mr. PADRON complained of left scapula and arm pain with palpitations and voiced his concern regarding his elevated BP of 175/107. Mr. PADRON reported that he did not take his morning dose of HTN medications. The APP ordered the following: one-time dose of ketorolac 30 mg injection (for pain); 90-day supply of fiberlax 625 mg, one tablet, orally, daily; an extra mattress, encouraged hydration; and scheduled a chronic care follow-up in November 2018.

On October 28, 2018, during a walk-in encounter, an RN examined Mr. PADRON for a complaint of left arm pain. According to the RN, Mr. PADRON "only moaned when he was left alone, but was quiet when his BP was taken." His VS were essentially normal. The RN gave Mr. PADRON ibuprofen 400 mg, orally, for pain.

On October 29, 2018, due to Mr. PADRON's chest pain complaints a licensed practical nurse (LPN) monitored his BP and pulse (P) over a twenty-minute time frame, and the results were: BP 196/99, P 87; BP 180/100, P 88; and BP 157/97, P 88. After consulting with the APP, Mr.

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PADRON was placed in the medical housing unit (MHU) for observation, and fasting laboratory tests were ordered [*Investigator's note: specific laboratory tests were not documented*] and a seven-day supply of APAP 325 mg, two tablets, orally, twice daily, as needed.

On October 31, 2018, an RN noted “while passing medications in Unit Delta, patient [Mr. PADRON] refused to take his medications, because he stated the medications were making his BP worse and he is having chest pains, headache, and feels like he is having a stroke as he did in the past.” Custody staff escorted Mr. PADRON to the medical department. VS were P 104, respirations (R) 18, and BP 160/98. Mr. PADRON voiced his concern of not taking the same medications for HTN as when he arrived at the facility. The RN confirmed and explained his medications were the same. Mr. PADRON returned to the dorm and the RN advised him to alert staff of any additional chest pain. The RN scheduled a provider visit [*Investigator's note: A review of the medical record found no documented provider appointments scheduled.*]

On November 1, 2018, at approximately 6:45 a.m., Mr. PADRON's roommate attempted to wake him for breakfast, but Mr. PADRON was unresponsive. The dorm security officer called a code blue (medical emergency) over the radio. An RN and an APP arrived at the scene and found Mr. PADRON lying on the floor. Custody staff initiated cardio-pulmonary resuscitation (CPR), and Mr. PADRON was unresponsive and without a pulse. The nursing staff applied the automated external defibrillator (AED) to Mr. PADRON's chest, no rhythm was detected, and CPR continued until EMS arrived and assumed care. EMS transported Mr. PADRON to LKMC while CPR continued, with use of an automated chest compression device.

- At 7:17 a.m., hospital personnel pronounced Mr. PADRON was dead.

According to the assigned ICE Supervisory Detention Deportation Officer, after multiple requests, the responding EMS agency would not release the response/transport report without a subpoena.

Mortality Finding:

A mortality review committee (MRC) determined that Mr. PADRON's overall medical care at MCDC was not provided within the safe limits of practice, and it is unknown if these findings conclusively contributed to his death. According to the autopsy report, Mr. PADRON's cause of death was thrombosis (blood clot) of the right coronary artery due to atherosclerotic cardiovascular disease.

[*Investigator's note: According to UpToDate (2018), epidemiological data indicates uncontrolled HTN and history of CVA are well established major risk factors for adverse cardiovascular outcomes.*]

Collateral findings identified during this review are included in the mortality review detailed report of findings below.

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Mortality Review Detailed Report:

On November 1, 2018, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee, Wilfredo PADRON, A022 776 291. Mr. PADRON, a 58-year-old Cuban male, was in ICE custody from August 15 to November 1, 2018, and assigned to MCDC on the date of his death.

The IHSC Assistant Director requested a mortality review to learn from Mr. PADRON's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The following findings and recommendations of the MRC, which convened on February 6, 2019, were based on the following information: (b)(5)

(b)(5); (b)(6); (b)(7)(C)

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS) 2008 and National Commission on Correctional Health Care (NCCHC) 2018. Below is a summary of health care delivery/program strengths, weaknesses, and recommendations found during this review.

Strengths

During this review, it was clear that MCDC medical care staff are earnest and dedicated professionals. Strengths identified during this investigation were: (b)(5)

(b)(5)

Weaknesses

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section II., *Expected Outcomes*.
- Umbdenstock, Rick., *Improving Patient Safety Systems for Patients with Limited English Proficiency*, AHRQ, publication 12-0041 (2012). Accessed January 30, 2018 at <https://www.ahrq.gov/professionals/systems/hospital/lepguide/index.html>.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section V.J., *Health Appraisal*.
- NCCHC 2018 standard, J-E-04, *Initial Health Assessment*.

(b)(5)

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Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section II.15., *Expected Outcomes*.
- NCCHC 2018 standard, J-F-01, *Patients with Chronic Disease and Other Special Needs*.
- NCCHC 2018 standard, J-E-09, *Continuity, Coordination, and Quality of Care During Incarceration*.
- MCDC Correct Care Solutions (CCS) Guidelines, *Minimum standards for Care of Chronic Disease*, March 2016.
- (b)(6); (b)(7)(C) FE, et al. (2019). *Goal blood pressure in adults with HTN. In patients with established atherosclerotic cardiovascular disease (prior history of coronary, cerebrovascular, or peripheral arterial disease), it is recommended a goal blood pressure of 125 to 130/<80 mm Hg (using standard routine clinician office measurements)*. UpToDate. https://www.uptodate.com/contents/goal-blood-pressure-in-adults-with-hypertension?search=established%20atherosclerotic%20cardiovascular%20disease%20goal%20blood%20pressure&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1#H2941330581.
- (b)(6); (b)(7)(C) VF. (2018). *Overview of established risk factors for cardiovascular disease*. UpToDate. https://www.uptodate.com/contents/overview-of-established-risk-factors-for-cardiovascular-disease?search=correlation%20between%20hypertension%20and%20coronary%20artery%20disease&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1.

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(b)(5)

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section V.S., *Continuity of Care*.
- NCCHC 2018 standard, J-E-09, *Continuity, Coordination, and Quality of Care During Incarceration*.
- ACA standard, 1-HC-1A-04, *Continuity of Care*.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section V.N., *Sick Call*.
- NCCHC 2018 standard, J-E-07, *Non-emergency health care requests and services*.
- Nursing Process, “*Five step process (assessment, diagnosing, planning, implementing, and evaluation) to enhance the quality of patient care.*” Accessed January 10, 2019 at <https://www.nursingprocess.org/Nursing-Process-Steps.html>.

(b)(5)

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upon a written or verbal order from a practitioner licensed to practice in the state.” There was no provider order documented for the fluconazole.

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section V.N., *Sick Call*.
- NCCHC standard, J-E-07, *Non-emergency Health Care Requests and Services*.
- MCDC CCS Policy, OPS-100-E-11, *Clinical Pathways*, March 2016.
- American Nurses Association (ANA) Nursing: Scope and Standards of Practice, *Standard I. Assessment*, states that an RN is expected to document relevant data in a retrievable format. Accessed January 20, 2019 at <https://westafricaneducatednursesdotorg.files.wordpress.com/2016/01/ana-standards-of-nursing-practice-table.pdf>.

(b)(5)

Applicable standards of care for this finding:

- NCCHC 2018 standard, J-E-08, *Nursing Assessment Protocols and Procedures*.
- MCDC CCS Policy, OPS-100-E-11, *Clinical Pathways*, March 2016.
- MCDC CCS Nursing Pathway, *Hypertension*.
- MCDC CCS Nursing Pathway, *Cold/Allergy*.

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- American Nurses Association (ANA) Nursing: Scope and Standards of Practice, *Standard 1. Assessment*, states that an RN is expected to document relevant data in a retrievable format. Accessed January 20, 2019 at <https://westafricaneducatednursesdotorg.files.wordpress.com/2016/01/ana-standards-of-nursing-practice-table.pdf>.
- (b)(6); (b)(7)(C) 017). *NSAIDS and acetaminophen: Effects on blood pressure and HTN. All NSAIDS in doses adequate to reduce inflammation and pain can increase blood pressure in both normotensive and hypertensive individuals.* UpToDate. https://www.uptodate.com/contents/nsaids-and-acetaminophen-effects-on-blood-pressure-and-hypertension?search=effects%20of%20NSAIDS%20on%20%20blood%20pressure&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section V.S., *Continuity of Care*.
- NCCHC 2018 standard, J-B-07, *Communication on Patient's Health Needs*.
- NCCHC 2018 standard, J-E-09, *Continuity, Coordination, and Quality of Care During Incarceration*.

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(b)(5)

Applicable standards of care for this finding:

- NCCHC, J-A-05, *Policies and Procedures*.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2008: Part IV. Care., section V.O., *Emergency Medical Services and First Aid*.
- NCCHC standard, J-D-07, *Emergency Services and Response Plan*.
- Cardiopulmonary Resuscitation and Emergency Cardiovascular Care (ECC) Guidelines (2015), Part 5: *Adult Basic Life Support and Cardiopulmonary Resuscitation Quality*. Accessed February 5, 2019 at <https://eccguidelines.heart.org/index.php/circulation/cpr-ecc-guidelines-2/part-5-adult-basic-life-support-and-cardiopulmonary-resuscitation-quality/>.

(b)(5)

End of report.

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

September 4, 2019

MEMORANDUM FOR:

Stewart D. Smith, DHSc, MPH
Assistant Director
ICE Health Service Corps

STEWART D
SMITH

Digitally signed by STEWART D
SMITH
Date: 2019.09.17 08:48:49
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THROUGH:

(b)(6); (b)(7)(C) MD (b)(6); (b)(7)(C)
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

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Chief of Staff
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FROM:

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ICE Health Service Corps

SUBJECT: Mortality Review – Findings
Guerman VOLKOV, A209 879 518

Executive Summary:

Mr. Guerman VOLKOV, a 56-year-old Russian male, was in U.S. Immigration and Customs Enforcement (ICE) custody from June 26, 2017 to November 30, 2018, at Baker County Detention Center (BCDC) in MacClenny, Florida (FL). During Mr. VOLKOV's custody at BCDC, he presented with multiple comorbid conditions to include mental illness, periods of suicidality, seizure disorder, cardiovascular disease, repeated episodes of poor or non-compliance, and limited English proficiency (LEP).

Between October 23, 2017 and February 13, 2018, Mr. VOLKOV presented with several episodes of hypotension (low blood pressure), and reportedly fell (unwitnessed) and suffered an abrasion to his left forehead. A registered nurse (RN) evaluated Mr. VOLKOV and consulted with the medical doctor (MD) regarding treatment. On February 15, 2018, two days after Mr. VOLKOV's injury, the MD completed a face-to-face encounter; however, there was no documentary evidence of the MD's evaluation of his head injury or low blood pressure readings. On February 18, 2019, the MD gave telephone orders to perform serial blood pressure (BP) checks for five days and discontinue one of the anti-hypertensive medications. There were no subsequent MD evaluations or monitoring. Mr. VOLKOV's BP was not documented again until November 26, 2018; the date he was found unresponsive.

On November 26, 2018, prior to the BCDF staff's call for emergency medical services (EMS), Mr. VOLKOV presented with unresponsiveness, hyperglycemic (elevated blood sugar), and hypotensive. EMS arrived and transferred Mr. VOLKOV to Ed Fraser Memorial Hospital (EFMH) in MacClenny, FL, where Mr. VOLKOV was diagnosed with profound anemia and required a blood transfusion. The EFMH staff determined that Mr. VOLKOV required a higher level of care and ordered an air ambulance transfer to another hospital. However, due to severe weather, Mr. VOLKOV was transferred by ground ambulance to Memorial Hospital of Jacksonville (MH-J) in Jacksonville, FL. The small bowel obstruction (SBO) was diagnosed at MH-J approximately 48 hours prior to Mr. VOLKOV's demise. The documentation at MH-J indicates that Mr. VOLKOV refused care and removed his nasogastric tube (NGT; catheter inserted through the nose, through the throat and down into the stomach for nutritional support, medication administration, and decompression). This behavior was considered refusal of care and Mr. VOLKOV was released from MH-J against medical advice (AMA). Mr. VOLKOV was released to BCDC and his follow up care was not consistent with applicable standards of care.

On November 30, 2018, Mr. VOLKOV presented with visible distress, difficulty with breathing, abdominal distention, absent bowel sounds, tachycardia, hypotension, hyperglycemia, and

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hypoxia (low oxygen saturation). He was transferred by ground ambulance to MH-J ED. Within one hour of arrival at MH-J, Mr. VOLKOV was pronounced deceased. The cause of death was ruled as SBO and gastrointestinal hemorrhage and deemed ‘natural’ by a limited post-mortem evaluation.

Mortality Finding:

A mortality review committee (MRC) determined that several aspects of Mr. VOLKOV’s medical care at BCDC was directly and/or indirectly associated with his death and was not provided within the safe limits of practice. Specifically, the MRC found that Mr. VOLKOV’s care was not appropriately or timely managed. The BCDC’s MD failed to order proper monitoring after his hospital discharge, including basic care and interventions for the untreated SBO. In addition, the MRC agreed that the documentation and care at MH-J was inadequate and that Mr. VOLKOV’s refusal of care should have prompted a psychiatric evaluation. As documentation showed, Mr. VOLKOV’s condition, at the time of his MH-J release, was life-threatening.

Mortality Review Detailed Report:

On November 30, 2018, IHSC received notification of the death of ICE detainee Guerman VOLKOV, A209 879 518. Mr. VOLKOV, a 56-year-old Russian male, was in ICE custody from June 26, 2017 to November 30, 2018, and assigned to BCDC in MacClenny, FL, on the date of his death.

The IHSC Assistant Director requested a mortality review to learn from Mr. VOLKOV’s death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures or practices are warranted; and identify issues that require further study.

The findings and recommendations of the IHSC MRC, which convened on April 18 and May 8, 2019, are based on the review of the following information:

(b)(5); (b)(6); (b)(7)(C)

ICE detention standards used for this review: ICE National Detention Standards (NDS), 2000. The following is a summary of events and an outline of health care delivery/program strengths, weaknesses, and recommendations found during this review.

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Summary of Events

On June 27, 2017, Mr. VOLKOV arrived at BCDC with transfer summaries from Pinellas County Sheriff's Office, in Largo, FL, and Pasco County Jail, in Land O' Lakes, FL, which noted Mr. VOLKOV's medical history of hypertension [(HTN); high blood pressure], and conversion disorder with seizures (a mental condition in which a person has blindness, paralysis, or other neurologic symptoms that cannot be explained by medical evaluation). The listed medications were: levetiracetam (anti-seizure medication) 500 mg, one tablet, two times daily; carbamazepine (anti-seizure medications) 200 mg, one tablet, two times, daily; lisinopril (anti-hypertensive medication) 20 mg, one tablet, daily; and metoprolol (anti-hypertensive medication) 25 mg, one tablet, daily. During Mr. VOLKOV's intake screening, he reported a history of seizure disorder (last seizure - two months ago), HTN, a heart condition, broken/missing teeth, and denied a history of mental health conditions or drug use. His vital signs (VS) were within normal limits (wnl), except for a mildly elevated blood pressure (BP) of 136/90 (normal: 115-120/75-80 mmHg). The BCDC MD ordered to continue Mr. VOLKOV's medications, referred him to the chronic care clinic (CCC), and cleared him for general population (GP).

On June 29, 2017, the MD completed Mr. VOLKOV's CCC evaluation. During his evaluation, Mr. VOLKOV did not report additional symptoms and the MD documented unremarkable findings, except for an elevated BP of 155/102. The MD ordered the following: clonidine (anti-hypertensive medication) 0.3 mg, now, and recheck BP (one hour later, BP was 105/75), aspirin (ASA) 81 mg, one tablet, daily; electrocardiogram (EKG) now [*results: slow sinus rhythm with possible septal infarct*], and the following laboratory studies for July 3, 2017: complete blood count (CBC) with differential, comprehensive metabolic panel (CMP), lipid profile, carbamazepine level, and a urinalysis (UA). The abnormal results were: red blood cells (RBC) 4.07 (4.70-6.10 M/uL), hemoglobin (Hgb) 13.0 (14-18 13.0 g/dL), hematocrit (Hct) 39.0 percent (42-52%), high density lipoprotein (HDL) 28.0 (40-60 mg/dL), low density lipoprotein (LDL) calculated 109.0 (0.00 – 39.0) and very low density lipoprotein (VLDL) 46.0 (8.00-39.00).

On September 12, 2017, BCDC's custody sergeant advised the licensed mental health counselor (LMHC) that Mr. VOLKOV stated, "If I can't go home, then I just want to kill myself." The LMHC ordered Mr. VOLKOV to be placed on suicide watch (SW) in segregation cell A-7.

On September 13, 2017, the LMHC completed Mr. VOLKOV's initial mental health evaluation. The LMHC documented, due to a language barrier and Mr. VOLKOV showing officers the sign of a cross (medical red cross sign), he was placed on SW. Mr. VOLKOV stated he pointed out the cross sign, because he needed medical attention. Mr. VOLKOV reported a history of HTN, seizures, two heart attacks requiring one month in the hospital, head injury, and status-post a motor vehicle accident (MVA) - two years ago. Mr. VOLKOV denied having any suicidal/homicidal ideations (S/HI) and was released from SW.

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On September 26, 2017, the LMHC completed mental health rounds and documented “refusal of mental health care;” however, the LMHC completed a mental status exam [(MSE); structured way of observing and describing a patient’s current state of mind, under the domains of appearance, attitude, behavior, mood and affect, speech, thought process, thought content, perception, cognition, insight and judgement] and documented, “refused mental health treatment without providing adequate reasoning.” The LMHC further documented, “no reports of suicidal ideation behavior and/or psychotic outbursts and patient’s [Mr. VOLKOV] care will be referred to improve consistency of care.”

On September 29, 2017, a licensed practical nurse (LPN) assessed Mr. VOLKOV after a use-of-force incident in the booking area for his refusal to stop hitting the cell door with his fist. Custody staff officers placed Mr. VOLKOV in a restraint chair, with handcuffs, and applied a spit mask. The examination was unremarkable. An LPN cleared Mr. VOLKOV for confinement/restraint. *[Investigator’s note: Mr. VOLKOV was placed in restraints prior to medical clearance.]* After one and a half hours in confinement, custody staff released Mr. VOLKOV to protective custody (PC).

On October 10, 2017, a custody sergeant notified medical that Mr. VOLKOV verbalized “he couldn’t take it anymore.” An RN stated, Mr. VOLKOV appeared agitated, spoke in German, Muslim [*Arabic*], Russian, and Dutch, and stated, “I’m going to slit my wrist,” while making motions of “slitting his wrist.” An RN notified the LMHC and received an order to place Mr. VOLKOV on SW.

On October 11, 2017, the LMHC completed mental health rounds, and Mr. VOLKOV’s MSE was normal, except for irritable mood, and paranoid thought content. The LMHC documented “patient [Mr. VOLKOV] dysphoric [a state of unease or generalized dissatisfaction with life], refusing language line because he wanted to speak English. He is upset due to being ridiculed by officers and inmates because, he is Russian. He explained he speaks Russian, but he is not Russian; and, he also speaks Muslim [*sic*], but he is not a Muslim. Hard to understand his broken English.” Mr. VOLKOV denied having S/HI but expressed frustration. The LMHC released Mr. VOLKOV from SW to GP with follow-up in one to two weeks.

On October 15, 2017, an LPN placed Mr. VOLKOV on SW due to Mr. VOLKOV verbalizing, “I can’t handle it anymore,” and notified the LMHC. On the following day, the LMHC documented, patient placed back on SW for threatening to kill himself again per nursing. Patient refusing to speak to mental health. Remain on SW.”

On October 23, 2017, during nursing rounds, an RN documented Mr. VOLKOV remained on SW, VS normal, except for BP of 79/56 right arm (RA) and 82/62 left arm (LA). The RN gave Mr. VOLKOV Gatorade and encouraged fluid intake. An RN rechecked Mr. VOLKOV’s BP two and half hours later, showing a reading of 90/56. An RN discussed the BP readings with the MD, who gave verbal orders to push oral fluids and to continue to monitor Mr. VOLKOV.

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Mortality Review – Guerman VOLKOV, A209 879 518
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On October 27, 2017, while housed in the medical unit, an RN documented “patient [Mr. VOLKOV] continues on SW. A custody officer heard Mr. VOLKOV yelling in his cell and reported to the RN that Mr. VOLKOV banged his head on the door. An RN advised Mr. VOLKOV to have a seat and to stop hurting his head. He complied but continued to yell.” The LMHC requested an order of intramuscular (IM) lorazepam, and the psychiatrist gave a verbal order for lorazepam 2 mg, orally, every six hours, for anxiety and agitation as needed, and, if Mr. VOLKOV refused the oral administration, to give lorazepam 2 mg, IM, as needed, with a maximum of four doses within 24 hours.

On October 30, 2017, Mr. VOLKOV became agitated in his cell yelling “one case, one judge.” He [Mr. VOLKOV] requested lorazepam to help his head. An RN contacted the psychiatrist, who gave a verbal order to start and administer lorazepam (b)(5)

(b)(5) On this same date, the MD evaluated Mr. VOLKOV for complaint of left inguinal hernia. Mr. VOLKOV requested a surgical procedure to correct his hernia and appeared to be in mild discomfort. The examination findings revealed a bulging mass to the left inguinal area, without pain to palpation and reducible. The MD explained to Mr. VOLKOV the hernia did not require a surgical procedure [sic] and Mr. VOLKOV agreed.

On October 31, 2017, the LMHC completed mental health rounds. Mr. VOLKOV stated, “I am not sure if I will kill myself.” The LMHC noted Mr. VOLKOV as dysphoric, but calm, still conversing about court date and being transferred several times. Mr. VOLKOV refused to verbalize “keeping himself safe.” Mr. VOLKOV remained on SW. The LMHC documented “Patient responds better to men ...” (b)(5)

(b)(5)

On this same date, the psychiatrist evaluated Mr. VOLKOV due to agitation, banging his head on the door, screaming, and continued thoughts and reports to harm himself. “I have seizures, but two months ago, I was a different man. I am sitting here like an idiot.” MSE: agitated, overly dramatic behavior, depressed, and anxious mood. The abnormal involuntary movement scale [(AIMS); a 12-item clinician rating scale to assess the presence and severity of involuntary movements in patients taking neuroleptic medications] score was zero. Assessment: acute stress disorder. The psychiatrist ordered lorazepam 2 mg, one tablet, two times daily, and chlorpromazine 50 mg, one tablet, two times daily.

On November 2, 2017, during nursing rounds, an RN documented Mr. VOLKOV remained on SW and responds to questions in English but “switches between languages.” On this same date, the LMHC completed mental health rounds. “Mr. VOLKOV is ranting about one court, one prison.” He requested a regular uniform but refused to articulate how he intends to keep himself safe. The LMHC documented “I cannot comfortably release him off SW without a safety plan.” At the request of the psychiatrist, an RN contacted the MD for orders to increase his [Mr. VOLKOV] carbamazepine dosage to 400 mg, one tablet, two times daily.

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Mortality Review – Guerman VOLKOV, A209 879 518
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On November 3, 2017, the LMHC completed mental health rounds and documented, MSE: disheveled appearance and refusing to shower. Agitated behavior, dysphoric, and irritable mood. Mr. VOLKOV stated, “I have no reason for this life.” The LMHC observed Mr. VOLKOV as irritable and made comments about President Trump, “The zero [sic],” and “one court, one prison.” He refused to converse normally and refused to discuss safety plan. The LMHC ordered Mr. VOLKOV to remain on SW.

On November 6, 2017, during mental health rounds, the LMHC noticed Mr. VOLKOV’s gait was a little “wobbly” and unsteady. The LMHC notified an LPN that Mr. VOLKOV was not feeling well and to assess his VS, which were normal, except a BP of 75/58. The MD was notified and stated, “patient [Mr. VOLKOV] is not moving around enough. There is nothing we can do for him.” An LPN gave Mr. VOLKOV Gatorade and he remained on SW.

On November 7, 2017, the psychiatrist evaluated Mr. VOLKOV and noted Mr. VOLKOV was seen in his cell and was too sedated to engage in meaningful conversation. The psychiatrist assessed Mr. VOLKOV with acute stress disorder and reduced his lorazepam dosage to 1 mg, one tablet, two times daily, and ordered a one-week follow-up.

On November 9, 2017, the LMHC completed mental health rounds and documented, MSE: unremarkable. Mr. VOLKOV was smiling and walking around in his cell. He was animated and discussed returning to GP. He stated he could feel a positive outlook coming back to him again. Denies S/HI and requested to go to GP tomorrow. The LMHC released Mr. VOLKOV from SW and initiated mental health observation.

On this same date, the psychiatrist completed an evaluation with Mr. VOLKOV for unspecified psychosis. The psychiatrist documented Mr. VOLKOV as calmer, cooperative, sleepy; however, “his BP is running low.” MSE: unremarkable and AIMS score of zero. The psychiatrist documented, “will decrease lorazepam to 0.5 mg, one tablet, two times daily, and chlorpromazine to 25 mg, one tablet, two times daily. May continue lorazepam 1 mg, orally, two times daily until lorazepam 0.5 mg arrives from pharmacy and follow up in four weeks.”

(b)(5)

On November 10, 2017, the LMHC completed mental health rounds and documented, Mr. VOLKOV’s mood was mildly anxious, and he focused on being frustrated with not knowing when he goes to court; not for only ICE court, but also for criminal court. Although, he denied S/HI and verbalized reason for keeping safe, he was hesitant to return to GP. On this same date, the psychiatrist and an RN reviewed Mr. VOLKOV’s BP readings, and the psychiatrist asked the MD to consider decreasing the lisinopril. The MD gave a verbal order to decrease lisinopril to 10 mg, daily.

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On November 14, 2017, the LMHC completed mental health rounds and documented that Mr. VOLKOV had a disheveled appearance and needed a shower, had a dysphoric mood and tangential [diverging from a previous course or line; erratic] speech. Mr. VOLKOV then tried to direct the conversation to court and the FBI. LMHC noted, “I was firm and insisted we discuss his suicidal/homicidal thoughts, which he denied both and stated he would not harm himself here at BCDC but was still concerned about court and deportation.” The custody officer asked Mr. VOLKOV if he would consider being in GP with another Russian detainee. Mr. VOLKOV stated, he “would like that.” The officer stated he would notify his supervisor and prepared to move him. The LMHC released Mr. VOLKOV from mental health observation to GP, with a follow-up the same week. The psychiatrist discontinued the oral dose of lorazepam.

On November 16, 2017, the psychiatrist evaluated Mr. VOLKOV because several detainees were complaining about his strange and bizarre behavior in the dorm. Mr. VOLKOV reported he was stressed, not sleeping, and responded “I don’t have a plan, but I don’t trust nobody,” when asked about harming himself. MSE: depressed mood and disorganized thought processes. The psychiatrist increased Mr. VOLKOV’s chlorpromazine to 50 mg, one tablet, two times daily, and added hydroxyzine 25 mg, one tablet, orally, two times daily, and submitted orders placing Mr. VOLKOV on psychiatric watch with close observation.

On November 17 and 20, 2017, the LMHC and psychiatrist, respectively, completed mental health rounds and documented, Mr. VOLKOV was placed on mental health observation “because the pod was too noisy, and it affected his nerves.” The psychiatrist documented, MSE: disheveled appearance, agitated behavior, passive aggressive attitude, labile/irritable mood, tangential speech and disorganized/loose associations thought processes. Denied S/HI. Assessment: acute stress disorder with anxiety and hallucinations. Mr. VOLKOV remained on mental health observation.

On November 25, 2017, an RN assessed Mr. VOLKOV in his cell after a use of force incident because Mr. VOLKOV refused to comply with custody staff’s verbal orders. Mr. VOLKOV was restrained with handcuffs. On examination, Mr. VOLKOV stated, “I am good.” The RN found no reportable injuries and cleared Mr. VOLKOV for confinement.

On December 4, 2017, the LMHC completed mental health rounds and documented, “Mr. VOLKOV states, I have no reason or desire to hurt myself anymore. Patient tried to avoid conversation but was persistent and explained I must be able to assess him to determine if he needed to remain on mental health observation. Patient denied S/HI and through frustration of having to talk to MHP, states he would keep himself safe and was not experiencing distress except for an adjustment to continued incarceration.” The psychiatrist ordered, “discontinue all suicide precautionary measures, house in GP without clothing or utensil restrictions.”

On February 13, 2018, a custody officer reported to medical staff that Mr. VOLKOV reportedly fell (unwitnessed) and hit his head causing a quarter-size abrasion to his left forehead. An RN

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evaluated Mr. VOLKOV, who denied having any accompanying symptoms. The RN documented a normal assessment, except for a BP of 85/65, performed first aid, notified the MD and received a verbal order to push fluids and keep Mr. VOLKOV in the medical unit, pending a provider's evaluation. On retake, his BP was 103/73.

On February 14, 2018, during nursing rounds, Mr. VOLKOV's BP was 70/52 and he refused Gatorade and his morning medications. The LPN notified the MD, who gave verbal orders to hold his BP medications, continue to offer Gatorade and monitor. On this same date, Mr. VOLKOV's BP on re-check was 103/73 and the MD ordered the following laboratory studies: CBC, CMP, carbamazepine and levetiracetam levels. The abnormal results were: sodium (NA+) 133 (normal 134-144 mmol/L), and chloride 92 (96-106 mmol/L). (b)(5)

(b)(5)

On February 18, 2018, Mr. VOLKOV's BP was 63/50 and pulse (P) of 111 (normal 60-100 beats per minute). An RN notified the MD, who ordered to hold metoprolol (anti-hypertensive medication), offer Gatorade every shift, continue BP checks every shift for five days, and encourage exercise as tolerated. Mr. VOLKOV's BP on re-check was 90/65 and a P of 77.

On February 20, 2018, Mr. VOLKOV's BP was 88/61 and he was "asymptomatic." Mr. VOLKOV was escorted via wheelchair to medical from the booking area. An RN notified the MD of Mr. VOLKOV's BP and orders were given to encourage fluids, exercise, and monitor. On re-check, Mr. VOLKOV's BP was 102/73. The MD ordered serial BP checks for five days and return to the booking area. (b)(5)

(b)(5)

On March 20, 2018, the LMHC completed mental health rounds. Mr. VOLKOV was on SW. The LMHC documented "patient speaks with strong Cerelic [sic] accent, mumbles, and is incoherent for the most part. He is guarded. Continue with suicide confinement." During March 26 to March 29, 2018, the LMHC completed daily mental health rounds for SW. The LMHC documented communication problems due to "heavy Russian accent and what appears to be paranoid delusions; continued SW recommended."

On March 30, 2018, the LMHC completed mental health rounds for mental health watch and documented, MSE: withdrawn behavior, guarded attitude, dysphoric mood, flat affect, speech with heavy accent, mumbles. Multiple areas of MSE was not assessed due to "he has a heavy accent. Very difficult to evaluate comprehensively." Maintained on mental health watch.

(b)(5)

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On April 9, 2018, the psychiatrist evaluated Mr. VOLKOV for psychosis, and he reported that the voices are down, he sleeps well and desire to continue with treatment. When asked about the voices, he replied, “It’s okay.” Assessment: unspecified psychosis with insomnia and hallucinations. The psychiatrist continued his medications and ordered an eight-week follow-up.

On May 23, 2018, [an *unknown provider type*] completed mental health rounds. Mr. VOLKOV reported, “I am on medicine for sleep, it feels nice.” (b)(5)

(b)(5) MSE: poor hygiene; speech incoherent at times. Patient denies need for MH services, happy with current medications. Mr. VOLKOV denied S/HI. Difficult to understand due to language barrier; presented as euthymic and no paranoia noted. The unknown provider type ordered a monthly MH follow-up, or as needed, and to continue with the psychiatrist for medication management.

On July 2, 2018, the psychiatrist evaluated Mr. VOLKOV and documented, MSE unremarkable. Assessment unspecified psychosis with anxiety, insomnia, and hallucinations. The psychiatrist ordered no changes to Mr. VOLKOV’s medications and a follow-up appointment on September 3, 2018.

On October 2, 2018, an LMHC completed mental health rounds for refusal of psychiatric care and mental health follow-up. The LMHC documented, MSE: unremarkable. “Prior to this entry, Mr. VOLKOV refused psychiatric treatment with expiring prescription. Medical and mental health staff met collaboratively to cajole [sic] and admonish Mr. VOLKOV’s inconsistency in terms of refusing his medications and mental health appointments.” Mr. VOLKOV agreed and was scheduled for a follow-up.

On November 26, 2018, an RN and LPN responded to an urgent call in the dorms to evaluate Mr. VOLKOV for unresponsiveness. Upon arrival, Mr. VOLKOV was lying supine on the floor, minimally responsive. After attempting to place Mr. VOLKOV in a wheelchair, he became unresponsive, was placed on the stretcher and escorted to the medical unit for further evaluation. Mr. VOLKOV’s VS were: P - 114, respirations (R) - 22 (normal 12-20), and an SpO2 level - 86 % (normal 96-100%) room air. His random blood sugar (RBS) level was 187 mg/dl (normal 90-130 mg/dl). According to the RN, Mr. VOLKOV appeared pale, diaphoretic (sweating), confused, with periods of apnea (cessation of breathing), difficult to arouse and sustained four abrasions to his skin, without bleeding. Nursing interventions included applying oxygen at 15 liters per non-rebreather mask, head and feet elevated 30 degrees, and encouraged Mr. VOLKOV to respond and remain awake. The MD ordered EMS transport to EFMH ED. Upon EMS arrival, Mr. VOLKOV remained unresponsive with a Glasgow coma scale [(GCS); objective method of evaluating a trauma patient’s neurological status, rating between three for deep unconsciousness to 15 for fully conscious] of three (3). The attending RN and LPN advised EMS that Mr. VOLKOV was found unresponsive and possibly had a seizure.

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The following are the EMS personnel's assessment findings: 12-lead EKG showed - normal sinus rhythm (NSR) without ectopy, RBS of 299 and a BP of 83/39. EMS had difficulty obtaining intravenous access but were able to initiate fluids through an intraosseous (infusion through the bone marrow) site. EMS then transported Mr. VOLKOV to EFMH. En route to the ED, although Mr. VOLKOV remained hypotensive, his mental status improved, and his GCS increased to eight (8). (b)(5)

(b)(5)

On this same date, BCDC's LPN received report from EFMH's staff stating, Mr. VOLKOV was in stable condition, his Hgb level was 3.2 g/dL (normal 14 – 17.5 g/dL) and he was given two units of blood. Mr. VOLKOV was transferred to MH-J for a higher level of care.

On November 28, 2018, a BCDC RN received report from MH-J nursing staff, noting Mr. VOLKOV was diagnosed with an SBO with abdominal distention, his Hgb was 8.4 g/dL, and nutritional support was initiated using an NGT. Mr. VOLKOV was reportedly non-compliant with all procedures, cursing and yelling at staff, removed his NGT and reported to the MH-J's staff, he "would rather die than get better and he wished to die in the U.S." According to the MH-J staff, the plan was to re-insert the NGT for possible bowel decompression, but no surgery was planned at the time. All plans were discontinued due to Mr. VOLKOV's continued refusal of treatment. The BCDC's director of nursing (DON) and the charge nurse were notified regarding Mr. VOLKOV's behavior. On this same date, Mr. VOLKOV was discharged from MH-J AMA and returned to BCDC.

The MH-J MD noted on the discharge summary "... with past medical history of seizure disorder. Brought in from Baker County Jail [BCDC] due to anemia and seizure. The patient was found with obstruction and SBO. Patient left AMA." Upon Mr. VOLKOV's return to the facility, he continued to refuse treatment and procedures, stating "I want to die." The MD was notified and gave orders to admit Mr. VOLKOV to medical housing for observation, initiate SW protocols, and refer to mental health services.

On November 29, 2018, the LMHC evaluated Mr. VOLKOV for suicidal ideations. Mr. VOLKOV reported, "I don't want to kill myself, not today, not tomorrow, not next month." Mr. VOLKOV was compliant with his VS and medications. Mr. VOLKOV was scheduled for a psychiatrist appointment for further evaluation and placed on close observation without clothing restrictions, but "will continue his suicide dietary status with no utensils." Later this date, the LMHC released Mr. VOLKOV from mental health observation and noted, "he is currently under medical care," and returned him [Mr. VOLKOV] to GP.

On this same date, the MD evaluated Mr. VOLKOV for unstable VS and altered mental status with a history of HTN, seizure disorder, and status post hospital discharge. Examination unremarkable, except VS with elevated P of 112, BP of 100/90, and an SpO2 of 92% on room air

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[Per MD note, when oxygen applied, SpO2 increases to 95%]. Assessment: HTN, seizure disorder. The following orders were given: initiate oxygen at two liters per nasal cannula if SpO2 is less than 92%, as needed; docusate sodium (stool softener) 100 mg, orally, two times daily, as needed; ferrous sulfate (iron) 325 mg, orally, two times daily; and laboratory studies to be drawn immediately: CBC, CMP. The abnormal results were: white blood cells 13.10 (4.50-11.00 K/uL), RBC 2.73, Hgb 8.1, Hct 24.3, glucose 130 (70-100 mg/dL), blood urea nitrogen (BUN) 29 (7-23 mg/dL), Na+ 134, calcium 8.1 (8.5-10.1 mg/dL), total protein 5.2 (3.4-5.1 g/dL), albumin 2.9 (3.4-5.1 g/dL), AST (liver enzyme) 14 (15-41 IU/L) and ALT (liver enzyme) 10 (17-63 IU/L). The MD ordered continued monitoring and Mr. VOLKOV was encouraged to continue drinking plenty of water and notify nursing staff of difficulty with breathing, weakness, or feeling faint.

(b)(5)

On this same date after the MD appointment, the psychiatrist evaluated Mr. VOLKOV for unspecified psychosis. During this encounter, the psychiatrist observed Mr. VOLKOV experiencing shortness of breath (SOB) while talking, anxiety, unable to say if his abdomen was hurting. The psychiatrist ordered “hold chlorpromazine and hydroxyzine for two weeks” due to “patient may have a small bowel obstruction” and advised the nurses to consult with the MD for a chest x-ray and possible aspiration pneumonia.

On November 30, 2018 at 2:45 a.m., during nursing rounds, an RN documented patient sitting on bed talking without distress. His VS were P 112, R 23, BP 143/94, and SpO2 96%. Examination: respirations even, unlabored, lung sounds clear in all quadrants. Patient educated on treatment compliance.

On this same date at 12:00 p.m., the MD evaluated Mr. VOLKOV and noted, although alert and oriented, he [Mr. VOLKOV] was visibly distressed, having trouble with breathing, distended abdomen, severe abdominal pain, negative bowel sounds, and pale colored skin. His VS were: P 120, RR 16, BP of 94/61, SpO2 at 76%. The MD initiated oxygen via non-rebreather mask and referred Mr. VOLKOV to the ED. Upon the arrival of EMS personnel, the following observations were noted: patient sitting upright in chair, oriented, lethargic, weak, slow to respond to verbal commands, obviously pale, SOB, rapid breathing, elevated pulse, abdominal tenderness, and distension, GCS of 15. EKG revealed sinus tachycardia and RBS level of 206. EMS personnel obtained IV access and initiated IV fluids. Based on Mr. VOLKOV’s previous history, EMS directly transported Mr. VOLKOV to MH-J ER. [Investigator’s note: MH-J is approximately 36 miles/25 minutes from BCDC] Soon after arrival to the ED, Mr. VOLKOV became hypoxic, hypotensive, experienced extreme abdominal pain and distention, and GCS was 7. Mr. VOLKOV was vomiting significantly large amounts of dark black vomitus. At 1:11 p.m., Mr. VOLKOV went into cardiac arrest and despite advanced cardiac life support (ACLS) measures, Mr. VOLKOV was pronounced dead at 1:59 p.m.

Strengths

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Strengths identified during this review were: (b)(5)

(b)(5)

Weaknesses

(b)(5)

Applicable standards of care for this finding:

- ICE NDS 2000: Medical Care., section III.A. *General*.
- ICE NDS 2000: Medical Care., section III.D. *Medical Screening (New Arrivals)*.
- BCDC Healthcare Policy, J-E-02.2, *Receiving Screening*.
- BCDC Healthcare Policy, J-E-05, *Mental Health Screening and Evaluation*.

(b)(5)

Applicable standards of care for this finding:

- ICE NDS 2000: Medical Care., section III.D. *Medical Screening (New Arrivals)*.
- BCDC Healthcare Policy, J-E-04, *Initial Health Assessment*.

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(b)(5)

Applicable standards of care for this finding:

- ICE NDS 2000: Medical Care., section III.D. *Medical Screening (New Arrivals)*.
- BCDC Healthcare Policy, J-A-01.2, *Patients with Limited English Proficiency*.
- Umbdenstock, Rich, “Improving Patient Safety Systems for Patients with Limited English Proficiency,” *Agency for Health Care Research and Quality (AHRQ)*, publication 12-0041 (2012). Accessed February 15, 2019.
<https://www.ahrq.gov/professionals/systems/hospital/lepguide/index.html>.

(b)(5)

Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-A-01, *Access to Care*.

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Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-E-11, *Nursing Assessment Protocols*.
- American Nurses Association (ANA), *Standards of Professional Nursing Practice*, (2010). Accessed February 15, 2019. <https://www.ferris.edu/health-professions/Nursing/standards-of-Professional-nursing-practice.htm>

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Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-G-01, *Chronic Disease Services*.

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Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-G-04, *Basic Mental Health Services*.
- BCDC Healthcare Policy, J-E-05, *Mental Health Screening and Evaluation*.
- BCDC Healthcare Policy, J-D-02.5, *Psychotropic Medication*.
- BCDC Healthcare Policy, J-D-02.6, *Monitoring Psychotropic Medications*.
- BCDC Healthcare Policy, J-G-05, *Suicide Prevention Program*.
- BCDC Healthcare Policy, J-I-02, *Emergency Psychotropic Medication*.

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Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-A-08, *Communication on Patients' Health Needs*.
- U.S. Department of Health and Human Services. "*Communication Between Clinicians*." Agency for Health Care Research and Quality (AHRQ), (update January 2019). Accessed February 15, 2019.
<https://psnet.ahrq.gov/primers/primer/26/communication-between-clinicians>

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Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-E-12, *Continuity and Coordination of Care During Incarceration*.
- Umbdenstock, Rich, “Improving Patient Safety Systems for Patients with Limited English Proficiency,” *Agency for Health Care Research and Quality (AHRQ)*, publication 12-0041 (2012). Accessed February 15, 2019.
- Bordeianou, Lilliana and Daniel Dante Yeh, “Management of small bowel obstruction in adults.” *UpToDate* (2019). Accessed August 22, 2019 at https://www.uptodate.com/contents/management-of-small-bowel-obstruction-in-adults?search=small%20bowel%20obstruction%20management&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

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detained at BCDC.

Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-E-12, *Continuity and Coordination of Care During Incarceration*.
- BCDC Healthcare Policy, J-A-04.2, *Health Services Reports-Jails*.
- BCDC Healthcare Policy, J-G-05, *Suicide Prevention Program*.

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(b)(5)

Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-A-02, *Responsible Health Authority*.
- BCDC Healthcare Policy, J-B-02, *Patient Safety*.

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- BCDC Healthcare Policy, J-H-01, *Health Record Format and Contents*.
- American Health Information Management (AHIMA), “*Clinical Documentation Improvement*” ...clinical documentation is at the core of every patient encounter. It must be accurate, timely and reflect the scope of services provided. Accessed on February 20, 2019. <http://www.ahima.org/topics/cdi>

13. Health records.

(b)(5)

Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-H-01, *Health Record Format and Contents*.

(b)(5)

Applicable standards of care for this finding:

- ICE NDS 2000: Medical Care., section III.H. *First Aid and Medical Emergencies*.
- BCDC Healthcare Policy, J-E-08, *Emergency Services*.

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(b)(5)

Applicable standards of care for this finding:

- ICE NDS 2000: Medical Care., section III.C. *Medical Personnel*.
- BCDC Healthcare Policy, J-C-01, *Credentialing Personnel/Qualifications*.

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(b)(5)

Applicable standards of care for this finding:

- ICE NDS 2000: Medical Care., section III.L. *Consents*.
- BCDC Healthcare Policy, J-D-02.5, *Psychotropic Medication*.
- BCDC Healthcare Policy, J-I-05, *Informed Consent and Right to Refuse*.

(b)(5)

Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-A-07, *Emergency Response Plan*.

(b)(5)

Applicable standards of care for this finding:

- BCDC Healthcare Policy, J-A-05, *Policies and Procedures*.

Recommendations

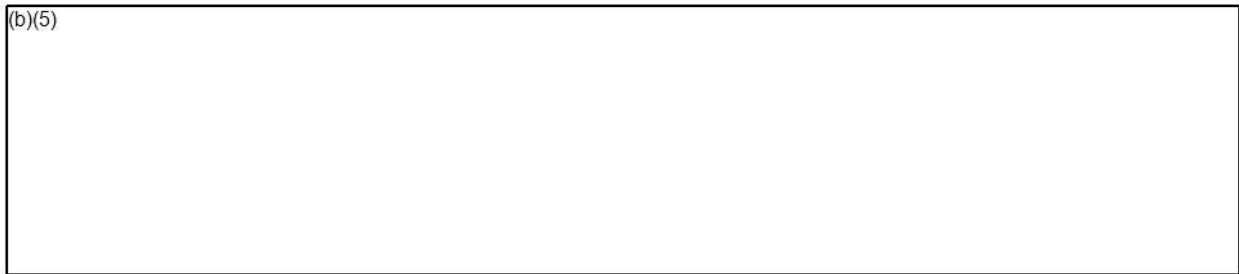
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End of report.

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U.S. Immigration
and Customs
Enforcement

July 21, 2020

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE
Assistant Director
ICE Health Service Corps

STEWART D
SMITH

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SMITH
Date: 2020.07.23 10:10:53 -04'00'

THROUGH:

(b)(6); (b)(7)(C)

MD

Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

MS

Chief of Staff
ICE Health Service Corps

CAPT (b)(6); (b)(7)(C)

RN

Chief, Investigations Unit
ICE Health Service Corps

FROM:

CDR (b)(6); (b)(7)(C)

Senior Investigator
ICE Health Service Corps

SUBJECT:

Mortality Review – Report of Findings
Abel REYES-Clemente, A215 881 614

Executive Summary:

On April 3, 2019, U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of ICE detainee Abel REYES-Clemente. Mr. REYES, a 54-year-old Mexican male, was in ICE custody from February 26, 2019, and assigned to Florence Service Processing Center (FSPC) in Florence, Arizona (AZ), on the date of his death. An autopsy ruled Mr. REYES' death a natural death resulting from complications of liver cirrhosis, diabetes mellitus, and hypertensive cardiovascular disease.

Prior to ICE custody, on January 14, 2019, Mr. REYES was encountered at the Lower Buckeye Jail in Maricopa County, AZ, where he was serving 80 days for a driving under the influence

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conviction. Mr. REYES stated he entered the U.S. near Nogales, AZ, and had been living in the U.S. for the past 19 years. On February 26, 2019, Lower Buckeye Jail, Phoenix, AZ, released Mr. REYES to ICE Enforcement and Removal Operations (ERO) Phoenix's custody. ERO Phoenix served him with a Notice to Appear, Form I-862, and transferred him to the Florence Staging Facility, Florence, AZ.

From February 27 to March 31, 2019, FSPC medical staff diagnosed and treated Mr. REYES for Type 2 diabetes mellitus [(T2DM); a metabolic disorder causing elevated blood sugar levels] and restless leg syndrome [(RLS); a condition causing someone to continuously move their legs, occurring mostly in the evening hours].

On April 1, 2019, an FSPC advanced practice provider (APP) diagnosed and treated Mr. REYES for influenza. The APP ordered to house Mr. REYES in medical segregation with daily nursing checks.

From April 1, 2019, at 5:23 p.m. to April 3, 2019, at 4:36 a.m., Mr. REYES' condition deteriorated without changes to his treatment plan.

- At 6:12 a.m., the segregation housing officer notified and requested medical to evaluate Mr. REYES, because he was having difficulty breathing. While medical staff were enroute, a medical emergency was announced, and security staff initiated cardiopulmonary resuscitation (CPR), and notified emergency medical services (EMS). A registered nurse (RN) noted Mr. REYES was unconscious, unresponsive to any stimuli, had a weak, thready pulse, and that the pulse oximeter could not detect a reading. Staff continued CPR and applied an automatic external defibrillator (AED) to Mr. REYES. The AED advised no shock, and CPR was continued.
- At 6:24 a.m., EMS personnel arrived, assumed care of Mr. REYES, and continued CPR. The emergency medical technician (EMT) noted Mr. REYES was pulseless, had no spontaneous respiration, the back of his right leg and the back of his chest were discolored and appeared to have lividity (the settling of blood into the lowest blood vessels, after death, resulting in the discoloration of skin). The electrocardiogram indicated Mr. REYES did not have a heartbeat. The EMT reported his findings to a medical doctor (MD) overseeing the EMS' actions.
- At 6:33 a.m., the MD pronounced Mr. REYES dead.

Mortality Finding:

As a result of Mr. REYES' death, the IHSC Assistant Director requested a mortality review to learn from his death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care;

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ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

A mortality review committee (MRC) unanimously determined that Mr. REYES' medical care at FSPC was not provided within the safe limits of practice. Specifically, the MRC determined that FSPC's lack of care could pose a significant future risk. Overall findings identified were: 1)

(b)(5)

The MRC convened on June 18, 2020, and consisted of the following members: (b)(6); (b)(7)(C), (b)(6); (b)(7)(C), Central Regional Medical Director, physician reviewer; CDR (b)(6); (b)(7)(C), PA-C, Eastern Regional APP, APP reviewer; CDR (b)(6); (b)(7)(C), RN, Eastern Regional Nurse Manager, nurse reviewer; and (b)(6); (b)(7)(C), Risk Manager, IHSC Medical Quality Management Unit Risk Management Program, risk management reviewer.

The following summary of events was based on (b)(5)

(b)(5)

Summary of Events

FSPC Medical Records

On February 27, 2019, at 12:15 a.m., an RN documented Mr. REYES' pre-screening, noting he spoke Spanish, and that a Spanish interpreter was not available for the pre-screening. The RN classified Mr. REYES as a priority for intake screening, because of the language barrier.

At 6:54 a.m., an RN completed Mr. REYES' intake screening, noting he spoke "English fluently." Mr. REYES reported a three-year history of T2DM, and taking metformin 500 milligrams (mg), by mouth (PO), twice daily (BID). The RN measured Mr. REYES' blood sugar at 144 mg/deciliter (dL) [normal range of 70 – 100 mg/dL]. The RN obtained a telephone order from an APP to initiate metformin 500 mg, PO, BID, obtain BID blood sugars, and to notify an APP if any blood sugar reading was over 400 mg/dL. A radiologist read Mr. REYES' chest x-ray as negative. The RN scheduled Mr. REYES' physical exam, and medically cleared him for custody.

On February 28, 2019, an APP completed Mr. REYES' physical exam, noting he spoke English

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fluently, had a history of T2DM, as well as a history of high blood pressure that was previously treated, but not recently. In addition, Mr. REYES reported a history of untreated RLS. The physical exam was normal, except for pterygium (a non-cancerous growth of the eye). The APP diagnosed T2DM, RLS, and tinea unguium (toenail fungal infection). In addition, the APP ordered baseline laboratory tests, prescribed metformin 500 mg, PO, BID, to keep on person (KOP), gabapentin 200 mg, PO, daily, KOP, to treat RLS, and noted treatment of the tinea unguium would be considered after reviewing the laboratory test results. The APP provided education to Mr. REYES, and scheduled him for a one-week follow-up.

On March 4, 2019, at 4:40 a.m., an RN collected the February 27, 2019 ordered laboratory tests.

- At 7:41 a.m., an RN used a Spanish interpreter to conduct a sick call evaluation of Mr. REYES for complaints of bilateral foot pain and dry, scaly skin on both feet for one to two days, with a pain rating of 8/10 (on a scale of one to ten). The RN provided Mr. REYES with bacitracin ointment to apply to his feet, and submitted a telephone encounter [(TE); a note within the electronic medical record] to an APP advising him of Mr. REYES' visit.

On March 7, 2019, at 7:50 a.m., an APP evaluated Mr. REYES, who voiced that the gabapentin was not relieving his RLS. The physical exam was normal. The results of the baseline laboratory tests were reviewed with the following abnormalities noted: creatinine was low at 0.59 mg/dL (normal range of 0.76 – 1.27 mg/dL), potassium was low at 3.4 millimoles (mmol)/L (normal range of 3.5 – 5.2 mmol/L), alkaline phosphatase was high at 153 international units (IU)/L (normal range of 39 – 117 IU/L), red blood cell count was low at 4.11 micrograms (mcg)/L (normal range of 4.14 – 5.80 mcg/L), hematocrit was low at 37.4% (normal range of 37.5 – 51.0 %), and hemoglobin A1c was high at 6.1% (normal range of 4.8 – 5.6%). The APP increased the gabapentin dosage to 400 mg, PO, daily, prescribed a daily aspirin, KOP, and scheduled Mr. REYES for a four-week follow-up.

- At 6:09 p.m., a licensed vocational nurse (LVN) delivered Mr. REYES' aspirin prescription, and provided him education.

On March 19, 2019, an RN prepared Mr. REYES' transfer summary. The transfer summary included all recent diagnostic results, but did not include his diagnoses of RLS or tinea unguium.

LPCC Medical Records

On March 20, 2019, an RN completed Mr. REYES' intake screening. All findings were consistent with those noted at FSPC. The RN measured his blood sugar at 153 mg/dL. All medications were continued as prescribed at FSPC. The RN cleared Mr. REYES to work in food services, made a routine referral to mental health and dental services, and an urgent referral to an APP.

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On March 21, 2019, at 10:57 a.m., an APP completed Mr. REYES' physical exam. All medications were ordered. Per Mr. REYES' request, and his hemoglobin A1c of 6.1%, the APP discontinued his blood sugar checks. The APP noted the physical exam as normal, except Mr. REYES' left great toenail had been cut too short, resulting in a scant amount of drainage. The APP provided him antibiotic ointment, bandages, and scheduled him for a three-month follow-up.

- At 12:04 p.m., a dentist performed a visual exam of Mr. REYES' mouth and teeth, noting poor oral hygiene. The dentist provided education, and planned to see Mr. REYES as needed.

FSPC Medical Records

On March 21, 2019, at 11:46 p.m., an RN completed Mr. REYES' pre-screening, noting he spoke Spanish and that a Spanish interpreter was not available for the pre-screening. The RN classified Mr. REYES as a priority for intake screening, because of the language barrier. The RN also noted his current diagnoses and medications.

On March 22, 2019, at 3:35 a.m., an RN completed Mr. REYES' intake screening, noting he spoke English fluently, his current diagnoses and medications, and measured his blood sugar at 160 mg/dL. The RN submitted a TE to an APP regarding Mr. REYES' medications, scheduled him for a same day APP appointment, and continued his medications and treatments.

On March 25, 2019, an APP completed Mr. REYES' physical exam visit. The APP did not use an interpreter, noting he was fluent in Mr. REYES' native language. His temperature was 100.5 degrees (°) Fahrenheit (F) [normal range of 97.8 - 99.1°F], his heartrate was 105 beats per minute (bpm) [normal range of 60 – 100 bpm], and his blood sugar was 306 mg/dL. The APP did not perform a physical exam, noting one was completed within the last 90 days. All medications and treatments were continued, and annual follow-up appointments were scheduled. No other treatment was provided.

On March 26, 2019, an LVN triaged Mr. REYES for an RN sick call visit. Mr. REYES' temperature was 99.1°F, and his heart rate was 89 bpm. The LVN noted Mr. REYES denied requesting sick call and did not have any complaints. The LVN released him to return to the housing unit.

On March 28, 2019, an RN used a Spanish interpreter and evaluated Mr. REYES for sick call complaints of bilateral foot pain, which he rated as 8/10. His temperature and heart rate were normal. The RN consulted an APP and received instructions for Mr. REYES to continue taking his medications as prescribed and for the RN to schedule an APP appointment for April 4, 2019.

On March 29, 2019, the order to measure Mr. REYES' blood sugar BID expired and was not renewed.

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On March 30, 2019, a housing unit officer escorted Mr. REYES to the medical department, because he was in possession of an expired metformin prescription. The officer was concerned Mr. REYES was not compliant with his medication as prescribed. He was also in possession of a current metformin prescription. An RN interviewed Mr. REYES and determined he was taking his medication, as instructed. The RN did not measure Mr. REYES' blood sugar, but did submit a TE to an APP advising him of the encounter.

On April 1, 2019, at 10:30 a.m., an APP evaluated Mr. REYES for complaints of fever, chills, sore throat, and mild cough, that began two nights ago. The APP noted a temperature of 100.1° F, a heartrate of 114 bpm, and a pulse oximetry reading (level of oxygen in arterial blood) of 96 percent [(%); normal range of 95 – 100%]. The APP noted Mr. REYES was ill-appearing and had the symptoms described. The remainder of the physical exam was normal. The APP diagnosed influenza (flu), and prescribed oseltamivir (antiviral) 75 mg, PO, BID, for the flu, and acetaminophen 650 mg, PO, four times daily, as needed for pain and fever. The APP provided education and planned to see Mr. REYES again for his scheduled appointment on April 4, 2019.

- At 5:23 p.m., the APP ordered for Mr. REYES to be housed in medical segregation with daily nursing checks.

On April 2, 2019, at 5:30 a.m., an RN noted Mr. REYES needed assistance to sit up in bed, took his medicines as prescribed, and that he was encouraged to hydrate and eat throughout the day. His temperature was 100.0°F. A physical exam was not documented.

- At 6:00 a.m., the RN submitted a TE to an APP advising him of the above encounter.
- At 12:15 p.m., an RN completed nursing rounds on Mr. REYES, noting a normal physical exam, except a heartrate of 103 bpm, and a pulse oximetry reading of 83%. A security officer informed the RN that Mr. REYES had been lying in bed all day. The RN encouraged Mr. REYES to be more active and educated him on hydration.
- At 2:56 p.m., the RN submitted a TE to an APP advising him that Mr. REYES' pulse oximetry readings ranged from 79 – 83%, and his heartrate ranged from 103 – 110 bpm. The RN noted Mr. REYES was ambulatory in his cell and had no complaints, except knee pain after ambulating. The RN documented concern that Mr. REYES was non-compliant with taking his medications as prescribed, because he was in possession of expired prescriptions for metformin and aspirin.

On April 3, 2019, at 4:36 a.m., an RN completed nursing rounds on Mr. REYES, noting he sat up for the assessment, his heart rate was 100 bpm, temperature was 98.6° F, and pulse oximetry reading was 94%. The RN also noted he refused to take his morning medications.

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- At 6:12 a.m., the segregation housing officer called the medical department for someone to respond, because Mr. REYES was having difficulty breathing. While medical staff were enroute, a medical emergency was announced, and security staff initiated CPR on Mr. REYES, while he laid in bed. When medical staff arrived, Mr. REYES was transferred from his bed to the floor. EMS was called. An RN noted Mr. REYES was unconscious, unresponsive to any stimuli, had a weak, thready pulse, and that the pulse oximeter could not detect a reading. CPR continued. AED electrodes were applied to Mr. REYES. The AED advised no shock. Staff again resumed CPR. Additional medical personnel and equipment arrived. An RN used suction equipment to remove secretions from Mr. REYES' oral airway.
- At 6:23 a.m., fire department personnel arrived.

Florence Fire Department Patient Care Record

- At 6:24 a.m., EMS personnel arrived, assumed care of Mr. REYES, and continued CPR. The EMT noted Mr. REYES was pulseless, had no spontaneous respiration, the back of his right leg and the back of his chest were discolored and appeared to have lividity. The electrocardiogram indicated Mr. REYES did not have a heartbeat. The EMT reported his findings to the MD overseeing EMS' actions.
- At 6:33 a.m., the MD pronounced Mr. REYES dead.

The final autopsy report revealed Mr. REYES' cause of death was due to complications of liver cirrhosis, diabetes mellitus, and hypertensive cardiovascular disease. The coroner determined the manner of death as natural.

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016). The following are identified program strengths, weaknesses, and recommendations found during this review.

Strengths

(b)(5)

Weaknesses

(b)(5)

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Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, II.3. The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English proficiency (LEP).
- IHSC Directive (Dir.) 03-07: *Health Assessment*, 4-10. Facilities will provide appropriate interpretation and language services for LEP detainees for all clinical encounters. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services.

(b)(5)

Applicable standards of care for this finding:

- IHSC Dir. 09-02: *Pharmaceutical Services and Medication Management*, 4-10, Verbal orders. Providers should only use verbal orders for medications when they are off-site, or during after-hours, or emergency situations, or where a delay of giving the medication is expected to cause significant suffering, injury, or death to the detainee.

(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, II.21. Health care services shall be provided by a sufficient number of appropriately trained and qualified personnel.

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Applicable standards of care for this finding:

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- IHSC Public Health Actions for the Management of Influenza: *Risk Factors for Flu-Related Complications*; Some people will develop complications as a result of the flu, some of which can be life-threatening and result in death, and *Vaccination*; Influenza vaccine is prioritized for administering to detainees/residents, who are at high risk for complications and to control institutional outbreaks.

(b)(5)

Applicable standards of care for this finding:

- IHSC Interim RN Guidelines 2008: *Wound Care*, 3. Apply a thin layer of triple antibiotic ointment to prevent crusting.
- IHSC Operations Memorandum (OM) 16-027: *Clinical Nursing Guidelines*, 4-1.2. If any other medication (OTC or prescription) is provided to treat the condition and is not named in the guideline, it must have a telephone/verbal order signed by the prescriber.
- IHSC Sick Call Process: II. *Sick Call Process*, B.2.a. Nurses are required to strictly adhere to the *IHSC Clinical Nursing Guidelines*.

(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 7. *Administration and Management*, 7.4, Detainee Transfers, V.C.2.a.3. The medical transfer summary shall include current mental, dental, and physical health status, including all significant health issues.

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Applicable standards of care for this finding:

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- IHSC Dir. 03-07: *Health Assessment*, 4-6.b.2. If there have been changes, or there is uncertainty about the detainee's/resident's health status, a new health assessment will be completed.

(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, V.AA.9. Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee's medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatment.
- IHSC Dir. 02-08: *Refusal of Treatment*, 4-1. The IHSC health care provider must provide the detainee with sufficient information to make an informed decision to accept or refuse the proposed treatment, as well as a reasonable explanation of viable alternatives.
 - 4-2. The nurse, medical provider, behavioral health professional (BHP), or dentist must ensure the IHSC Refusal Form (IHSC Form 820) is completed in its entirety each time the detainee refuses treatment.

(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, V.S.4. In an urgent situation, the housing unit officer shall notify medical personnel immediately.
- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, II.1. Detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis, and treatment.
- IHSC Sick Call Process: I. *Sick Call*, C. Sick call is not meant to take the place of urgent/emergent access to care. All medical emergencies are immediately addressed consistent with IHSC 03-02 and ICE Standards.

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(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, II.1. Detainees shall have access to a continuum of health care services, including screening, prevention, health education, diagnosis, and treatment.
- ICE PBNDS 2011 (revised December 2016): 2.12, *Special Management Units*, V.P. Detainees must be evaluated by a medical professional prior to placement in an SMU.
- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, II.8. A detainee who requires close, chronic or convalescent medical supervision shall be treated in accordance with a written treatment plan conforming to accepted medical practices for the condition in question, approved by a licensed physician, dentist, or mental health practitioner.
- IHSC Directive 03-17: *Medical Housing Units*, 5-3.c. RN/LPN/LVN Admission Notes: Appropriate nursing staff members document information on all patients admitted to the MHU in the detainee health record. The information documented includes: c. Complete nursing assessment and care plan completed by an RN.
- IHSC Directive 03-07: *Health Assessment*, 4-2.m. An appropriate plan of care to address any medical or mental health condition identified during the examination.
- IHSC Directive 03-17: *Medical Housing Units*, 4-11. Use of Special Management Units: A detainee may be housed in the SMU to undergo medical/mental health observation or treatment, if an MHU is unavailable. The admission and discharge processes that apply to the MHU are utilized when use of SMU is required for medical reasons.
- IHSC Directive 03-17: *Medical Housing Units*, 5-4, MHU Monitoring: A medical provider makes daily rounds in the MHU based on the detainee's condition, unless otherwise required by the detainee's condition, ordered by the CD, or written in the designated approved treatment plan.

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- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, V.N. Where a detainee requires close medical care, medical staff shall complete a Medical/Psychiatric Alert Form (IHSC-834).
- IHSC Dir. 03-12: *Medical-Psychiatric Alert*, 5-1. A health care professional shall immediately complete the Med/Psych Alert Form (IHSC-834) in relation to: c.(3) Other currently communicable diseases, and e. Medical housing unit care.
- IHSC Directive 03-17: *Medical Housing Units*, 5-1. The local ERO designated office receives notifications as defined by forms IHSC-834 and IHSC-819, as appropriate.

(b)(5)

Applicable standards of care for this finding:

- IHSC OM 16-027: *Clinical Nursing Guidelines*, 4-1.6. When in doubt, confer with or refer to the appropriate provider or on-call provider.
 - 5.3.b. RNs must exercise good judgement and seek consultation if uncertainty exists.

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, V.D. Consent forms and refusals shall be documented and placed in the detainee's medical file.
- ICE PBNDS 2011 (revised December 2016): 4.3, *Medical Care*, V.BB.1.b. The HSA shall maintain a complete health record on each detainee that is available to all practitioners and used by them for health care documentation.
- IHSC Public Health Actions for the Management of Influenza: *Vaccination*; Influenza vaccine is prioritized for administering to detainees/residents, who are at high risk for complications and to control institutional outbreaks.
- IHSC Dir. 02-08: *Refusal of Treatment*, 4-2. IHSC Refusal Form. The nurse, medical provider, BHP, or dentist must ensure the IHSC Refusal Form (IHSC 820) is completed in its entirety each time the detainee refuses treatment.

(b)(5)

Applicable standards of care for this finding:

- FSPC Local Operating Procedure (LOP) 822: *Emergency Medical Response*, I.A. Those identified for a medical response will respond within four minutes with the emergency bag, radio, and the AED.

(b)(5)

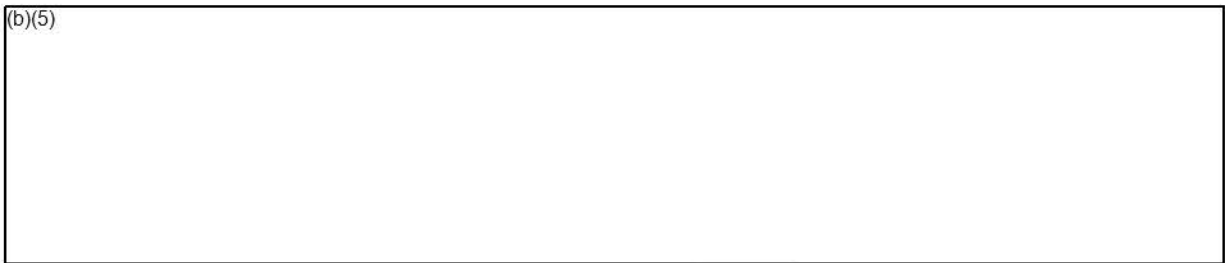
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Recommendations

(b)(5)



End of report.

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

October 22, 2019

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE STEWART D SMITH Digitally signed by STEWART D SMITH
Assistant Director Date: 2019.10.30 08:42:05
ICE Health Service Corps -04'00'

THROUGH: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C) MS (b)(6); (b)(7)(C)
Chief of Staff
ICE Health Service Corps

FROM: (b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C)
Senior Investigator
ICE Health Service Corps

(b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C)
Investigator
ICE Health Service Corps

SUBJECT: Mortality Review – Report of Findings
Yimi Alexis BALDERRAMOS-Torres, A206 179 679
(a.k.a. Yimi BALDERAMO-Torres)

Executive Summary

Mr. Yimi BALDERRAMOS-Torres, a 30-year-old Honduran male, was in U.S. Immigration and Customs Enforcement (ICE) custody from June 6 to 30, 2019. During his detention period, ICE housed Mr. BALDERRAMOS-Torres at Montgomery Processing Center (MPC) in Conroe, Texas (TX) from June 7 to 18, 2019, and Houston Contract Detention Facility (HCDF), in Houston, TX, from June 18 to 30, 2019, the date of his death.

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www.ice.gov

While in ICE custody, Mr. BALDERRAMOS-Torres' denied a history of any medical or mental health conditions, other than a rash. During MPC intake processes, Mr. BALDERRAMOS-Torres reported having a rash to his arms and abdomen, secondary to "mosquito bites he acquired during travel." Mr. BALDERRAMOS-Torres' vital signs (VS) were within normal limits (wnl). During his health assessment at MPC, an advanced practice provider (APP) treated Mr. BALDERRAMOS-Torres for a scattered rash on his trunk, bilateral upper and lower extremities, without signs of infection.

On June 18, 2019, ICE transferred Mr. BALDERRAMOS-Torres to HCDF. During HCDF's intake processes, Mr. BALDERRAMOS-Torres admitted to previous treatment for a rash, but denied any medical or mental health history. His VS were wnl. During his health assessment at HCDF, Mr. BALDERRAMOS-Torres again denied any history of medical or mental health conditions, and the registered nurse (RN) documented his assessment as unremarkable.

On June 30, 2019, while housed at HCDF, two RNs responded to a medical emergency in dorm B10 and found Mr. BALDERRAMOS-Torres lying in bed, pulseless, without spontaneous respirations, and cyanotic (bluish coloration to the skin). HCDF staff initiated basic life support, pending emergency medical services (EMS) arrival. Approximately fourteen minutes after CPR began, EMS personnel arrived on scene, and continued CPR with advanced cardiac life support measures (intubation, medications, intravenous (IV) access). EMS personnel then transported Mr. BALDERRAMOS-Torres to Memorial Hermann Northeast Hospital (MHNH) in Humble, TX. En route to MHNH, Mr. BALDERRAMOS-Torres remained in asystole, except for one rhythm check that showed fine ventricular fibrillation (v-fib; rapid and inadequate heartbeat). EMS personnel administered five doses of epinephrine and one defibrillation (administration of a controlled electrical shock to allow restoration of a normal heart rhythm), and continued CPR until arriving at MHNH emergency department (ED). Despite lifesaving interventions and resuscitative efforts, an MHNH physician pronounced Mr. BALDERRAMOS-Torres dead at 6:45 a.m.

Based on the autopsy report, the Institute of Forensic Sciences' medical examiner in Harris County, TX, determined the cause of death was sudden cardiac death, associated with biventricular cardiac dilation (both heart ventricles become enlarged and leads to heart failure), arteriolosclerosis (thickening, hardening, and loss of elasticity of the walls of the arteries) and glomerulosclerosis (hardening and scarring of the kidney's tiny blood vessels).

Mortality Review Finding(s)

A mortality review committee (MRC) unanimously concurred that Mr. BALDERRAMOS-Torres' medical care at MPC and HCDF was provided within the safe limits of practice and did not directly or indirectly contribute to his death.

Collateral findings identified during the course of this review are included in the mortality review detailed report of findings below.

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Mortality Review Detailed Report

Mr. BALDERRAMOS-Torres entered the U.S. in El Paso, TX, on May 19, 2019. On this same date, the U.S. Border Patrol (USBP) arrested Mr. BALDERRAMOS-Torres and issued a Notice to Appear. During processing, Mr. BALDERRAMOS-Torres claimed fear of persecution if he returned to Honduras. The USBP returned Mr. BALDERRAMOS-Torres to Mexico under the Migration Protection Protocol to await hearing before an immigration judge that was scheduled for September 30, 2019. On or about May 27, 2019, Mr. BALDERRAMOS-Torres illegally entered the U.S. near Hidalgo, TX. On June 6, 2019, the Montgomery County Sheriff Office in Conroe, TX, conducted a traffic stop and reported Mr. BALDERRAMOS-Torres to Homeland Security Investigations (HSI) for suspected smuggling activities. HSI responded and arrested Mr. BALDERRAMOS-Torres. On June 7, 2019, HSI transferred Mr. BALDERRAMOS-Torres to Enforcement and Removal Operations (ERO) Houston at MPC for booking. Based on the review of this information, it is highly unlikely that this information would have changed the outcome.

On June 30, 2019, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Yimi Alexis BALDERRAMOS-Torres, A206 179 679. Mr. BALDERRAMOS-Torres, a 30-year-old Honduran male, was in ICE custody from June 6 to 30, 2019, and assigned to HCDF on the date of his death. Mr. BALDERRAMOS-Torres was pronounced dead at MHNH in Houston, TX on June 30, 2019.

The IHSC Assistant Director requested a mortality review to learn from Mr. BALDERRAMOS-Torres' death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The following are findings and recommendations of the MRC, which convened on October 3, 2019. The MRC consisted of the following member: (b)(6); (b)(7)(C) MD, IHSC Eastern Regional Clinical Director, physician reviewer; Commander (CDR) (b)(6); (b)(7)(C) Physician Assistant-certified (PA-C), APP reviewer; CDR (b)(6); (b)(7)(C) PA-C, IHSC Eastern Regional Health Services Administrator, administration and APP reviewer; Captain (CAPT) (b)(6); (b)(7)(C) IHSC Regional Compliance Specialist, risk management reviewer; and CAPT (b)(6); (b)(7)(C) RN, IHSC Chief Nurse, nurse reviewer.

The review was based on the following information: (b)(5)
(b)(5); (b)(6); (b)(7)(C)

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The detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016), and the National Commission on Correctional Healthcare (NCCHC), 2018. The following is a summary of health care delivery/program strengths, weaknesses, and recommendations found during this review:

Summary of Events

On June 18, 2019, at HCDF, a licensed vocational nurse (LVN) completed Mr. BALDERRAMOS-Torres' intake screening and reviewed his transfer summary. The transfer summary outlined that Mr. BALDERRAMOS-Torres was using hydrocortisone 1% cream and ammonium lactate 12% cream. Mr. BALDERRAMOS-Torres denied any medical or mental health history. The LVN documented normal VS and medically cleared him for general population. *[Investigator's note: The transfer summary did not note any medical conditions.]*

On June 29, 2019, an RN completed Mr. BALDERRAMOS-Torres' health appraisal using language services and reviewed his intake screening. Mr. BALDERRAMOS-Torres again denied a medical history and his health appraisal was unremarkable.

On June 30, 2019

- At 1:03 a.m., per video footage, Mr. BALDERRAMOS-Torres was sitting on the side of his bed reading a book.
- At 1:28 a.m., per video footage, Mr. BALDERRAMOS-Torres laid down in bed and covered himself with the bed linen.
- Between 1:35 a.m. and 4:41 a.m., per video footage, Mr. BALDERRAMOS-Torres appeared to be shifting/repositioning in bed, under the covers.
- At 4:41 a.m., per video footage, Mr. BALDERRAMOS-Torres appeared to be lying halfway off the bed in prone position (half of upper torso leaning off bed, waist and legs were on the bed). Mr. BALDERRAMOS-Torres did not contact the floor.
- At 4:42 a.m., per video footage, the detainee in the bed adjacent to Mr. BALDERRAMOS-Torres' bed appeared to be talking to Mr. BALDERRAMOS-Torres, but it appeared Mr. BALDERRAMOS-Torres did not respond.
- At 4:43 a.m., per video footage, the detainee in the bunk adjacent to Mr. BALDERRAMOS-Torres' bunk got out of bed and physically assisted Mr. BALDERRAMOS-Torres, returning him completely onto the bed. There was no visible movement from Mr. BALDERRAMOS-Torres after being placed back into bed. The detainee assisting Mr. BALDERRAMOS-Torres returned to his bed.

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- At 5:28 a.m., per video footage, lights were turned on and detainees awoke and prepared for breakfast.
- Between 5:30 a.m. and 5:36 a.m., per video footage, two detainees attempted to wake Mr. BALDERRAMOS-Torres and informed the dorm officer.
- At 5:39 a.m., the dorm officer called a medical emergency via radio. *[Investigator's note: Two RNs were outside of dorm B10's door when the emergency was called. The RNs were preparing for morning sick call rounds.]*
- At 5:40 a.m., two RNs entered dorm B10 and found Mr. BALDERRAMOS-Torres lying in bed, pulseless, without spontaneous respirations, cyanotic and his mouth slightly open without drainage. The RN noted there were no visible bruises or bleeding.
- At 5:41 a.m., the RNs transferred Mr. BALDERRAMOS-Torres to the floor and initiated compression-only CPR and instructed Core Civic to call EMS.
- At 5:42 a.m., Core Civic called EMS.
- At 5:43 a.m., the HCDF medical staff arrived with the emergency medical equipment. The AED was placed on Mr. BALDERRAMOS-Torres' chest, but a shockable rhythm was never indicated. While medical staff continued CPR, the RN noted bloody drainage from the side of Mr. BALDERRAMOS-Torres' mouth and nose; however, there was no pooling of blood to the back of his mouth. Medical staff cleared his airway, repositioned his head, and continued CPR.
- At 5:55 a.m., EMS personnel arrived on scene, applied their medical equipment, continued CPR, and advanced cardiac life support measures. EMS personnel assessed Mr. BALDERRAMOS-Torres' blood sugar level at 36 milligram/deciliter (mg/dl) [normal range 70-130 mg/dl], administered IV fluids with fifty percent dextrose solution and two doses of epinephrine.
- At 6:10 a.m., EMS personnel reassessed Mr. BALDERRAMOS-Torres' blood sugar, which increased to 78 mg/dl.
- At 6:15 a.m., EMS personnel departed the facility while continuing CPR and transported Mr. BALDERRAMOS-Torres to MHNH, where he remained unresponsive. En route to MHNH, Mr. BALDERRAMOS-Torres was in asystole for most of the arrest period, except for one rhythm check that showed fine v-fib. EMS personnel administered a total of five doses of epinephrine and one defibrillation at 360 joules, and continued CPR until arrival at MHNH ED.
- At 6:45 a.m., an MHNH physician pronounced Mr. BALDERRAMOS-Torres dead.

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Strengths

Strengths identified during this review were:

(b)(5)

(b)(5)

Weaknesses

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011 (with 2016 revisions): 4.3, Medical Care, section II. *Expected Outcomes* (30).
- IHSC Directive: 03-05 (effective March 11, 2016), *All Hazards Emergency Preparedness and Response*.

(b)(5)

Applicable standards of care for this finding:

- NCCHC Standards, 2018: J-A-05, *Policies and Procedures*.
- IHSC Directive: 01-03 (effective December 1, 2015), *Staff Responsibilities related to Current Official Guidance in their Area of Responsibility*.

Recommendations

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(b)(5)

End of report.

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U.S. Immigration
and Customs
Enforcement

December 3, 2019

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE
Assistant Director
ICE Health Service Corps

THROUGH: (b)(6); (b)(7)(C) MD
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C) MS
Chief of Staff
ICE Health Service Corps

CAPT (b)(6); (b)(7)(C) RN
Chief, Investigations Unit
ICE Health Service Corps

FROM: CAPT (b)(6); (b)(7)(C)
Senior Investigator
ICE Health Service Corps

SUBJECT: Mortality Review - Report of Findings
Pedro ARRIAGO-Santoya, A216 428 457

Executive Summary

Mr. Pedro ARRIAGO-Santoya, a 44-year-old Mexican male, was in U.S. Immigration and Customs Enforcement (ICE) custody from April 24 to July 24, 2019. ICE housed Mr. ARRIAGO-Santoya at Folkston ICE Processing Center (FIPC) in Folkston, Georgia (GA), from April 24, 2019, until his transfer on July 10, 2019, to Stewart Detention Center (SDC) in Lumpkin, GA.

During intake screening at FIPC and SDC, Mr. ARRIAGO-Santoya reported a history of right chronic knee pain, latex allergy, and admitted to drinking three beers per day (last use - two weeks ago). He denied a history of medical or mental health conditions, surgeries or hospitalizations, or

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457

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chronic medications. The health appraisal completed at FIPC and SDC revealed normal findings, except abnormal heart sounds, which were discovered during his exam at SDC. The advanced practice provider (APP) ordered an electrocardiogram (EKG) and laboratory tests.

On July 20, 2019, at SDC, an APP evaluated Mr. ARRIAGO-Santoya for complaints of intermittent right lower quadrant (RLQ) pain for approximately one and a half months. Mr. ARRIAGO-Santoya denied worsening pain but reported a loss of appetite and unable to eat due to experiencing nausea and pain. His vital signs (VS) and exam findings were normal, except increased RLQ tenderness. The APP referred Mr. ARRIAGO-Santoya to Southwest Georgia Regional Medical Center [(SWGRMC); a 25-bed critical access hospital] emergency department (ED) in Cuthbert, GA, via emergency medical services (EMS) for further evaluation. SWGRMC admitted Mr. ARRIAGO-Santoya with a diagnosis of RLQ abdominal pain, nausea and vomiting, cholecystitis (inflammation of the gallbladder), cardiomegaly (a condition in which the heart is enlarged), hepatomegaly (a condition in which the liver is enlarged), colitis (inflammation of the inner lining of the colon), and elevated liver enzymes (this may indicate inflammation or damage to the cells of the liver). The medical doctor (MD) ordered intravenous (IV) fluids, antibiotics, and referred Mr. ARRIAGO-Santoya to Piedmont Columbus Midtown Medical Hospital [(PCMMH); a level two trauma center] in Columbus, GA for suspected gall bladder disease and an advanced level of care. At PCMMC, an MD diagnosed Mr. ARRIAGO-Santoya with acute cholecystitis, systemic inflammatory response syndrome (inflammatory state affecting the entire body), respiratory distress, and hyponatremia (low sodium levels in the blood).

On July 22, 2019, Mr. ARRIAGO-Santoya experienced cardiac arrest. The PCMMH medical staff initiated advanced lifesaving measures and regained a normal sinus rhythm (cardiac rhythm when electrical impulses are properly transmitted). However, Mr. ARRIAGO-Santoya remained unresponsive.

On July 24, 2019, Mr. ARRIAGO-Santoya was diagnosed with disseminated intravascular coagulation [(DIC); a condition in which blood clots are excessively formed in the body's blood vessels] with multi-organ system failure, dilated cardiomyopathy, and endocarditis (infection of the heart valve). The MD consulted with a vascular surgeon, infectious disease specialist, and a cardiologist; however, Mr. ARRIAGO-Santoya's prognosis remained grave, and he was not expected to survive.

On this same date, Mr. ARRIAGO-Santoya experienced cardiac arrest, and despite the initiation of advanced lifesaving measures, a PCMMH MD pronounced Mr. ARRIAGO-Santoya dead at 3:10 p.m.

The preliminary cause of death is cardio-pulmonary arrest secondary to multi-organ system failure, endocarditis, dilated cardiomyopathy, and respiratory failure. The final autopsy report is pending.

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457
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Mortality Finding

A mortality review committee (MRC) concurred that Mr. ARRIAGO-Santoya's medical care at FIPC and SDC was provided within the safe limits of practice.

Mortality Review Detailed Report

On July 24, 2019, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Pedro ARRIAGO-Santoya, A216 428 457, a 44-year-old Mexican male, who was in ICE custody from April 24 to July 24, 2019, and assigned to SDC on the date of his death.

The IHSC Assistant Director requested a mortality review to learn from Mr. ARRIAGO-Santoya's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures or practices are warranted; and identify issues that require further study.

The following report is based on the findings of the MRC, which convened on October 29, 2019. The MRC consisted of the following members: Captain (CAPT) (b)(6); (b)(7)(C) MD, physician reviewer; Lieutenant Commander (LCDR) (b)(6); (b)(7)(C) nurse practitioner - board certified, APP reviewer; Commander (CDR) (b)(6); (b)(7)(C) physician assistant - certified, IHSC Eastern Regional APP, APP reviewer; and CDR (b)(6); (b)(7)(C) RN, IHSC Western Regional Nurse Manager, nurse reviewer.

The review was based on the following information (b)(5)

(b)(5); (b)(6); (b)(7)(C)

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS) 2011 (revised December 2016) and the National Commission on Correctional Health Care (NCCHC) Standards, 2018. The following is a summary of events and an outline of health care delivery/program strengths, weaknesses, and recommendations found during this review.

Summary of Events

On April 24, 2019, Mr. ARRIGAO-Santoya arrived at FIPC.

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457
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On April 25, 2019, a licensed practical nurse (LPN) completed Mr. ARRIAGO-Santoya's intake screening using language services (Spanish). Mr. ARRIAGO-Santoya reported a history of right chronic knee pain, latex allergy, and admitted to drinking three beers per day (last use - two weeks ago). He denied a history of medical or mental health conditions, surgeries or hospitalizations, or current medications. His VS were within normal limits and his chest x-ray was negative. Mr. ARRIAGO-Santoya was cleared for general population (GP) without restrictions and scheduled for a routine health assessment.

On May 7, 2019, an APP completed Mr. ARRIAGO-Santoya's health assessment. Mr. ARRIAGO-Santoya again denied a history of medical or mental health conditions, surgeries or hospitalizations, or current complaints. His VS and exam findings were within normal limits.

On July 1 and 5, 2019, Mr. ARRIAGO-Santoya presented to sick call with a complaint of sharp, dull pain behind his right knee and difficulty walking for five days. His VS were within normal limits. An LPN assessed Mr. ARRIAGO-Santoya during both encounters and prescribed him acetaminophen 325 mg, two tablets, orally, two times daily, as needed for three days. *[Investigator's note: Mr. ARRIAGO-Santoya did not present to medical with any additional complaints during his detention at FIPC.]*

On July 10, 2019, Mr. ARRIAGO-Santoya was transferred to SDC. A registered nurse (RN) reviewed Mr. ARRIAGO-Santoya's transfer summary, which noted a history of chronic right knee pain and over-the-counter medications for pain (acetaminophen and ibuprofen), as needed, and completed his intake screening using language services (Spanish). Mr. ARRIAGO-Santoya reported latex allergies and current right knee pain, rated 5/10 (pain scale 0 out of 10); however, he denied a history of medical or mental health conditions, surgeries or hospitalizations. His VS were within normal limits. The RN referred Mr. ARRIAGO-Santoya to the APP as a routine follow up, and he was cleared for GP.

On July 16, 2019, an APP completed Mr. ARRIAGO-Santoya's health assessment. Again, he denied a history of medical or mental health conditions, surgeries, hospitalizations, or current complaints. His VS and exam findings were unremarkable, except for abnormal heart sounds. The APP ordered an EKG (no results documented), laboratory tests [complete blood count (CBC), comprehensive metabolic panel (CMP), and thyroid stimulating hormone (TSH)]. The abnormal laboratory results were: white blood cells (WBC) - 10.56 (3500-10,500 mcL), hematocrit (HCT) - 28.1 (38-50 %), hemoglobin (Hgb) - 8.6 (14.0-17.5 g/dL), red blood cells (RBC) - 3.16 (4.7-6.1 m/mcL), serum sodium - 131 (135 - 145 mEq/L), and liver enzymes [AST 122 (13-39 IU/L), ALT 91 (7-52 IU/L)]. The APP scheduled a follow-up visit on July 31, 2019.

On July 20, 2019, at 12:57 p.m., an APP evaluated Mr. ARRIAGO-Santoya for complaints of intermittent RLQ pain, and episodic nausea, vomiting, and loss of appetite for approximately one and a half months. Mr. ARRIAGO-Santoya denied worsening pain but reported pain increased with the consumption of food. He was unable to eat breakfast due to experiencing current loss of appetite, nausea, and pain. His VS were stable and exam findings were normal, except increased RLQ

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457

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tenderness with gentle palpation, and Mr. ARRIAGO-Santoya was observed guarding his abdomen. The APP referred Mr. ARRIAGO-Santoya to SWGRMC's ED via EMS, for further evaluation.

- At 2:05 p.m., EMS arrived at SDC and transported Mr. ARRIAGO-Santoya to SWGRMC in stable condition.
- At 2:33 p.m., Mr. ARRIAGO-Santoya arrived and was admitted to SWGRMC with a diagnosis of RLQ abdominal pain, nausea and vomiting, cholecystitis, cardiomegaly, hepatomegaly, colitis, and elevated liver enzymes. His VS were within normal limits. The following laboratory results were abnormal: liver enzymes [AST 833, ALT 778 IU/L], WBC - 12.8 mcL, Hgb - 9.2 g/dL, HCT - 27.6%, and bilirubin - 1.7 (0.3-1.0 mg/dL). The attending MD ordered IV fluids, antibiotics, and consulted with PCMMH's critical care services to consider a referral for higher level of care and suspected gallbladder disease.

On July 21, 2019 at 5:15 a.m., Mr. ARRIAGO-Santoya's laboratory results were: AST: 2185, ALT: 1458, WBC: 18.8, Hgb: 9.0, and HCT of 28.2.

- At approximately 1:30 p.m., SWGRMC transferred Mr. ARRIAGO-Santoya to PCMMH via EMS. At approximately 6:00 p.m., a PCMMH MD evaluated Mr. ARRIAGO-Santoya. He [Mr. ARRIAGO-Santoya] complained of progressively worsening right sided abdominal pain, rated 10/10, that sometimes radiated to his back, but improved when in the squatting position. His VS were: temperature (T) - 95.8 (98.6 – 100.3), pulse (P) - 104 (60-100 beats per minute), respirations (R) - 32 (12-20 breaths per minute), and blood pressure (BP) - 132/80 (<120/80 mmHg). The MD diagnosed Mr. ARRIAGO-Santoya with acute cholecystitis, systemic inflammatory response syndrome, respiratory distress, and hyponatremia. Mr. ARRIAGO-Santoya was admitted as an in-patient and the following orders were given: liver function test (LFT), CBC, CMP, computer tomography (CT) scan, general surgery and gastroenterology (GI) consultations, IV antibiotics, anti-emetics (for nausea), and morphine 4 mg, as needed for pain (b)(5); (b)(7)(C)

(b)(5)

- At approximately 9:30 p.m., the general surgeon evaluated Mr. ARRIAGO-Santoya for treatment of cholecystitis. The surgeon ordered a hepatobiliary iminodiacetic acid scan [(HIDA); imaging of the liver, gallbladder, and bile ducts] to rule out cystic duct obstruction.

(b)(5)

On July 22, 2019, at approximately 3:57 a.m., Mr. ARRIAGO-Santoya experienced cardiac arrest. The PCMMH medical staff initiated advanced cardiac life support and regained a normal sinus rhythm. Mr. ARRIAGO-Santoya was intubated (tube inserted into the trachea for ventilation), placed on a ventilator, and admitted to the intensive care unit with the diagnosis of multi-organ system

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457

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failure and severe dilated cardiomyopathy (condition in which the heart cannot pump blood effectively). He remained unresponsive.

On July 24, 2019, at approximately 2:28 p.m., the PCMMH attending MD diagnosed Mr. ARRIAGO-Santoya with DIC with multi-organ system failure, dilated cardiomyopathy, and endocarditis. The MD consulted with a vascular surgeon, infectious disease specialist, and cardiologist; however, Mr. ARRIAGO-Santoya's prognosis remained grave, and he was not expected to survive.

- At 2:40 p.m., Mr. ARRIAGO-Santoya experienced cardiac arrest; however, lifesaving measures were unsuccessful and the PCMMH MD pronounced him dead at 3:10 p.m.

Strengths

Strengths identified during this review were (b)(5)

(b)(5)

Weaknesses

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V. J. *Medical and Mental Health Screening of New Arrivals*.
- NCCHC Standards, 2018: J-E-02, *Receiving Screening*.
- Core Civic policy 13-50, *Initial Intake Screening*.

(b)(5)

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457

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(b)(5)

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V. M. *Comprehensive Health Assessment*.
- NCCHC Standards, 2018: J-E-04, *Initial Health Assessment*.
- Core Civic policy 13-40, *Health Appraisals*; December 8, 2010.
- The Free Dictionary by Farlex, accessed November 19, 2019 at <https://acronyms.thefreedictionary.com/Left+Intercostal+Space>.

(b)(5)

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457

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(b)(5)

Applicable standards of care for this finding:

- Guthelil, Thomas G., Fundamentals of Medical Record Documentation, *Psychiatry MMC*, November 2004; 1(3):26-28. Accessed November 19, 2019 at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010959/>.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V. BB. *Medical Records*.
- NCCHC Standards, J-H-01, *Health Record Format and Content*.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V. S, *Sick Call*.
- NCCHC Standards, 2018: J-E-07, *Non-emergency Health Care Requests and Services*.

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Mortality Review – Pedro ARRIAGO-Santoya, A216 428 457
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- Georgia Board of Nursing. Rules and Regulations of the State of Georgia-Rule 410-10.02 Standards of Practice for Licensed Practical Nurses. Accessed November 19, 2019 at <http://rules.sos.ga.gov/GAC/410-10-.02>.

Recommendations

(b)(5)

End of report.

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U.S. Immigration
and Customs
Enforcement

January 15, 2020

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE
Assistant Director
ICE Health Service Corps

STEWART D
SMITH

Digitally signed by
STEWART D SMITH
Date: 2020.01.15 11:21:51
-05'00'

THROUGH: (b)(6); (b)(7)(C) MD (b)(6); (b)(7)(C)
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C) MS
Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C)

CAPT (b)(6); (b)(7)(C) RN
Chief, Investigations Unit
ICE Health Service Corps

(b)(6); (b)(7)(C)

FROM: CDI (b)(6); (b)(7)(C), RN
Investigator
ICE Health Service Corps

(b)(6); (b)(7)(C)

SUBJECT: Mortality Review – Report of Findings
Roberto RODRIGUEZ-Espinoza, A215 809 440
(a.k.a. Candido RODRIGUEZ)

Executive Summary:

Mr. Roberto RODRIGUEZ-Espinoza, a 37-year-old Mexican male, was in U.S. Immigration and Customs Enforcement (ICE) custody from September 3 to 10, 2019. During his detention period, ICE housed Mr. RODRIGUEZ-Espinoza at McHenry County Adult Correctional Facility (MCACF) in Woodstock, Illinois (IL).

On September 3, 2019, an MCACF custody officer (CO) completed Mr. RODRIGUEZ-Espinoza's intake screening. Mr. RODRIGUEZ-Espinoza denied a history of medical or mental health conditions, but reported a history of consuming a six pack of alcohol daily. The CO did

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Mortality Review – Roberto RODRIGUEZ-Espinoza, A215 809 440
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not inquire further about his alcohol usage, or observe any signs of alcohol withdrawal, and documented his appearance as “ok.” A licensed practical nurse (LPN) reviewed and initialed Mr. RODRIGUEZ-Espinoza’s intake screening form, but did not document any additional information regarding his alcohol usage, i.e., alcohol frequency, last day of consumption, and alcohol withdrawal history.

On September 7, 2019, at approximately 3:30 p.m., a CO observed Mr. RODRIGUEZ-Espinoza walking around his dorm confused and unfamiliar with his surroundings and notified the shift sergeant (Sgt.) and an LPN, who reported to the housing unit. During the LPN’s conversation with Mr. RODRIGUEZ-Espinoza, using interpreter services, he reported a history of consuming a six pack of beer and a quarter bottle of tequila, daily for 27 years. The LPN suspected alcohol withdrawal and completed a clinical institute withdrawal assessment for alcohol [(CIWA); a guide for evaluating the severity of alcohol withdrawal symptoms; scores range from absent to minimal (zero to nine) to severe (21 to 67)]. The LPN documented Mr. RODRIGUEZ-Espinoza’s CIWA score of 4, and his vital signs (VS) were: blood pressure (BP) - 130/84 (90/60 - 120/80), pulse (P) - 81 (60 to 100 beats per minute), temperature (T) - 97.8 (97.8 - 99.1), respirations (R) - 16 (12 to 20 breaths per minute), and oxygen saturation [(SpO₂); fraction of oxygen saturated hemoglobin in the blood] - 98 percent [(%) 95-100] while breathing room air.

The LPN notified the on-call medical doctor (MD), initiated MCACF’s alcohol detoxification protocol, administered chlordiazepoxide (a sedative used to treat alcohol abuse), and advised the officer to transfer Mr. RODRIGUEZ-Espinoza to the medical pod for ongoing medical observation. Later that evening, the shift Sgt. spoke to Mr. RODRIGUEZ-Espinoza, observed normal physical movement, clear speech, and persistent altered mental status.

- At approximately 9:45 p.m., the LPN contacted the on-call MD due to Mr. RODRIGUEZ-Espinoza’s altered mental status worsening. The LPN received a verbal order to transport him to the local hospital via custody transportation for a neurological evaluation and to rule out delirium tremens [(DTs); most severe form of alcohol withdrawal, which involves sudden and severe mental and/or nervous system changes].

On September 8, 2019, at approximately 10:45 p.m., MCAF transferred Mr. RODRIGUEZ-Espinoza to Northwestern Medicine Woodstock Hospital (NMWH) in Woodstock, IL, via custody transportation. Upon arrival to NMWH, an MD assessed Mr. RODRIGUEZ-Espinoza. He complained of a headache and nausea, and the MD ordered ondansetron (antiemetic medication), ketorolac (pain medication), and lorazepam (anti-anxiety medication). Mr. RODRIGUEZ-Espinoza’s VS were: BP 130/74, P 82, R 18, T 99, SpO₂ 100%, and a CIWA score of 25. The MD diagnosed Mr. RODRIGUEZ-Espinoza with acute alcoholic liver disease with fatty liver, alcohol withdrawal with DTs, irritability, agitation, and confusion, and transferred him to Northwestern Medicine Huntley Hospital (NMHH) in Huntley, IL, due to a severely altered mental status and for a higher level of care.

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Mortality Review – Roberto RODRIGUEZ-Espinoza, A215 809 440

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- At approximately 3:10 a.m., Mr. RODRIGUEZ-Espinoza arrived at NMHH. An MD evaluated him, continued intravenous fluids with vitamin supplements, initiated CIWA protocols, and transferred him to the intensive care unit (ICU), due to severe alcohol withdrawal symptoms and heavy sedation, as a result of receiving multiple doses of lorazepam while at NMWH. His VS were BP 144/77, P 113, T 99.9 and SpO2 of 99.9%. Shortly after arriving at NMHH, Mr. RODRIGUEZ-Espinoza fell asleep and never regained consciousness.
- At approximately 5:30 p.m., the NMHH MD ordered a computed tomography [(CT); radiological imaging] scan, which revealed a subdural hematoma [(SDH); a collection of blood outside of the brain]. Mr. RODRIGUEZ-Espinoza required intubation and a neurosurgery evaluation. The NMHH MD arranged for Mr. RODRIGUEZ-Espinoza's transfer to Northwestern Medicine Central DuPage Hospital (NMCDH) in Winfield, IL, for a higher level of care (i.e., neurology evaluation).
- At approximately 9:00 p.m., Mr. RODRIGUEZ-Espinoza arrived at NMCDH. His VS were P 75, R 22, and a Glasgow Coma Scale rating of 3 [(GCS); neurological scale that objectively evaluates a person's consciousness; a minimum score of 3, indicates deep coma or brain dead, and a maximum score of 15, indicates fully awake]. A neurologist evaluated Mr. RODRIGUEZ-Espinoza, observed fixed and dilated pupils, ordered an emergent CT scan, confirming an SDH, posterior ischemia (inadequate blood supply to the brain), and loss of brainstem reflexes. The neurosurgeon admitted Mr. RODRIGUEZ-Espinoza into the ICU, placed him on life support (use of specialized equipment to support life after the failure of one or more organs), and advised against surgery, due to irreversible loss of brain function and the poor chance of survival.

On September 9, 2019, Mr. RODRIGUEZ-Espinoza's repeat CT scan revealed extensive irreversible brain damage due to SDH, herniation (brain tissue, blood and cerebrospinal fluid shifts from their normal position inside the skull), multiple strokes, untreatable cerebral edema (brain swelling), and a poor chance of a meaningful recovery. The neurologist documented Mr. RODRIGUEZ-Espinoza's GCS of 4 and considered him a high risk for neurological deterioration, leading to imminent brain death.

On September 10, 2019, the NMCDH's MD disconnected Mr. RODRIGUEZ-Espinoza from life support and pronounced him dead at 9:35 p.m.

The final autopsy report revealed Mr. RODRIGUEZ-Espinoza's cause of death was complications of chronic alcoholism. The coroner noted Mr. RODRIGUEZ-Espinoza suffered from chronic alcoholism, cirrhosis of the liver, and an acute chronic SDH. Although each of these entities may cause death on its own, cirrhosis may contribute to SDH, as it is associated with increased risk of bleeding due to a decreased production of clotting factor.

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Mortality Review – Roberto RODRIGUEZ-Espinoza, A215 809 440
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Mortality Finding(s):

A mortality review committee (MRC) unanimously determined that Mr. RODRIGUEZ-Espinoza's medical care at MCACF was not provided within the safe limits of practice, and directly and indirectly contribute to his death. It was determined that a non-healthcare provider performed the initial assessment, but did not fully evaluate Mr. RODRIGUEZ-Espinoza's acknowledgment of drinking a six pack of beer daily, or refer him to a higher-level provider. Additionally, an LPN acknowledged awareness of Mr. RODRIGUEZ-Espinoza's alcohol consumption, but did not document a complete alcohol use assessment (i.e., drinking frequency, last alcoholic intake, history of alcohol withdrawal, CIWA score) or refer him to a higher-level provider.

Mortality Review Detailed Report:

On September 3, 2019, Homeland Security Investigations (HSI) encountered Mr. RODRIGUEZ-Espinoza in Chicago, IL, while conducting investigations for violations of the Immigration Nationality Act (INA). HSI arrested Mr. RODRIGUEZ-Espinoza for unknown legal status and transferred him to ERO Chicago at MCACF for overnight housing. On September 4, 2019, ERO transferred and processed Mr. RODRIGUEZ-Espinoza at the Broadview Service Staging Area (BSSA) in Broadview, IL. On the same date, ERO transferred Mr. RODRIGUEZ-Espinoza back to MCACF.

On September 11, 2019, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Roberto RODRIGUEZ-Espinoza. Mr. RODRIGUEZ-Espinoza, a 37-year-old Mexican male, was in ICE custody from September 3 to 10, 2019, and assigned to MCACF on the date of his death. Mr. RODRIGUEZ-Espinoza was pronounced dead at NMCDH in Winfield, IL, on September 10, 2019.

The IHSC Assistant Director requested a mortality review to learn from Mr. RODRIGUEZ-Espinoza's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and, identify issues that require further study.

The following report is based on the findings of the MRC, which convened on December 19, 2019. The MRC consisted of the following members: Captain (CAPT) (b)(6); (b)(7)(C) MD, IHSC Eastern Regional Clinical Director, physician reviewer; CAPT (b)(6); (b)(7)(C) Nurse Practitioner-certified, IHSC Deputy Assistant Director of Health Care Compliance (DAD of HCC), administration and advanced practice provider (APP) reviewer; Commander (CDR) (b)(6); (b)(7)(C), registered nurse, IHSC Western Regional Nurse Consultant, nurse reviewer; and Lieutenant Command (b)(6); (b)(7)(C) Physician Assistant-certified, APP reviewer.

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Mortality Review – Roberto RODRIGUEZ-Espinoza, A215 809 440
Page 5 of 6

The review was based on the following information (b)(5)

(b)(5)

Although, MCACF is managed under a U.S. Marshall's rider, the detention standards used for this review were: ICE National Detention Standards (NDS) 2000, American Correctional Association (ACA) Standards, 2004 and the National Commission on Correctional Health Care (NCCHC) Standards, 2018. The following is a summary of health care delivery/program strengths, weaknesses, and recommendations found during this review:

Weaknesses

(b)(5)

Applicable standards of care for this finding:

- NDS 2000: Medical Care; section D. *Medical Screening (New Arrival)*.
- ACA standard, 1-HC-1A-19, *Health Screens*.
- NCCHC standard, J-E-02, *Receiving Screening*.
- MCACF policy, HCD 100-E-02, *Receiving Screening*, May 2019.

(b)(5)

Applicable standards of care for this finding:

- MCACF policy, HCD 100-E-02, *Receiving Screening*, May 2019.

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Mortality Review – Roberto RODRIGUEZ-Espinoza, A215 809 440

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- MCACF policy, HCD 100-F-04, *Medically Supervised Withdrawal and Treatment*, May 2019.

(b)(5)

Applicable standards of care for this finding:

- MCACF policy, HCD 100-F-04, *Medically Supervised Withdrawal and Treatment*, May 2019.

(b)(5)

Applicable standards of care for this finding:

- Centers for Disease Control (CDC) and Prevention: Morbidity and Mortality Weekly Report: *Prevention and Control of Tuberculosis in Correctional and Detention Facilities: Recommendations*, July 2006.

Recommendations

(b)(5)

End of report.

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U.S. Immigration
and Customs
Enforcement

March 19, 2020

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE
Assistant Director
ICE Health Service Corps

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SMITH

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THROUGH:

(b)(6); (b)(7)(C)

MD

(b)(6); (b)(7)(C)

Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

, MS

Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

RN

Chief, Investigations Unit
ICE Health Service Corps

(b)(6); (b)(7)(C)

FROM:

CDR (b)(6); (b)(7)(C) RN
Investigator
ICE Health Service Corps

(b)(6); (b)(7)(C)

SUBJECT:

Mortality Review – Report of Findings
Anthony Oluseye AKINYEMI, A201 576 988

Executive Summary:

On December 22, 2019, U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of ICE detainee Anthony Oluseye AKINYEMI. Mr. AKINYEMI, a 56-year-old Nigerian male, was in ICE custody from December 20 - 21, 2019, and assigned to Worcester County Jail (WCJ) in Snow Hill, Maryland (MD), on the date of his death. An autopsy ruled Mr. AKINYEMI's death a suicide.

Prior to ICE custody, on December 13, 2019, Mr. AKINYEMI presented to U.S. Customs and Border Protection for admission into the U.S. at New York City, New York, as a B2 non-immigrant with authorization to remain in the U.S. for a temporary period not to exceed June 12,

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Mortality Review – Anthony Oluseye AKINYEMI, A201 576 988

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2018; however, he remained beyond that date. On July 23, 2019, Enforcement and Removal Operations (ERO) Baltimore, MD, served an immigration detainer on Mr. AKINYEMI after his arrest for sexual abuse of a minor. On December 19, 2019, Baltimore, MD, convicted and sentenced Mr. AKINYEMI to eight years' incarceration. On December 20, 2019, Baltimore City Jail in Baltimore, MD, released Mr. AKINYEMI to ERO Baltimore pursuant to the immigration detainer. ERO transferred and housed Mr. AKINYEMI at WCJ.

On December 20, 2019, during his intake screening, Mr. AKINYEMI reported a medical history of hypertension [(HTN) high blood pressure], controlled with medication, and admitted he assaulted his daughter, verbalized his inability to cope and manage stress, but denied suicidal ideations. Additionally, he appeared visibly agitated showing restlessness while sitting, intermittent standing, jumping during telephone conversations, expressive hand gestures, tapping on the desk, pacing, and rubbing his head. The intake nurse scheduled Mr. AKINYEMI for a mental health evaluation on December 23, 2019, and WCJ custody housed him on a maximum-security unit pending classification and tuberculosis clearance.

On December 21, 2019, at approximately 5:03 a.m. a custody officer (CO) found Mr. AKINYEMI unresponsive, hanging from a wall vent with a ligature, and radioed for medical assistance. At approximately, 5:04 a.m., a nurse, shift supervisor, and another CO arrived, removed Mr. AKINYEMI from the hanging position, checked for responsiveness, started chest compressions, and requested EMS activation and the automated external defibrillator (AED). At approximately 5:05 a.m., the Snow Hill, MD, voluntary fire department and advanced life support emergency medical services (EMS) personnel arrived, assumed care, and approximately 20 minutes later pronounced Mr. AKINYEMI deceased.

Mortality Finding:

As a result of Mr. AKINYEMI's death, the IHSC Assistant Director requested a mortality review to learn from his death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

A mortality review committee (MRC) unanimously determined that Mr. AKINYEMI's medical care at WCJ was not provided within the safe limits of practice. Specifically, the MRC determined WCJ's care or lack thereof, could pose a significant future risk. Overall findings

(b)(5)

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Mortality Review – Anthony Oluseye AKINYEMI, A201 576 988
Page 3 of 7

(b)(5); (b)(6); (b)(7)(C)

(b)(5); (b)(6); (b)(7)(C)

ICE Detention Standards.

Summary of Events

On December 20, 2019 at approximately 8:30 p.m., a WCJ CO completed Mr. AKINYEMI's booking and preliminary medical screening. Mr. AKINYEMI reported a medical history of HTN, controlled with medication. Mr. AKINYEMI did not exhibit any abnormal behavior during the preliminary screening process, but the CO described Mr. AKINYEMI's behavior as "agitated," during a telephone call with an unknown person. In review of the processing video footage, Mr. AKINYEMI was observed visibly agitated showing restlessness while sitting, intermittent standing and jumping during the telephone conversation, expressive hand gestures, and tapping on the desk. The CO verbally redirected Mr. AKINYEMI multiple times during his telephone conversation. After the telephone call, Mr. AKINYEMI began pacing, rubbing his head, and making expressive hand gestures. The CO did not report Mr. AKINYEMI's behavior to medical or custody leadership.

The detainees, who arrived and were held in the holding cell at WCJ with Mr. AKINYEMI, reported he appeared anxious, agitated, emotionally distressed, and would hit himself, while repeating, "why, why, why?" The detainees did not report Mr. AKINYEMI's behavior to medical or custody staff.

- At approximately 10:05 p.m., an LPN completed Mr. AKINYEMI's medical intake screening. Mr. AKINYEMI reported taking lisinopril and hydrochlorothiazide (anti-hypertensive medication) for his HTN. His vital signs were normal, except for a mildly elevated blood pressure (BP) – 140/90 mmHg (normal 90/60 – 120/80 mmHg). During the mental health and Prison Rape Elimination Act (PREA) screening, Mr. AKINYEMI denied a history of mental illness, suicidal, or homicidal ideations, but admitted to

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Mortality Review – Anthony Oluseye AKINYEMI, A201 576 988

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assaulting his daughter. Mr. AKINYEMI continued repeating, “He did something he should not have,” and verbalized concerns of losing his family, inability to cope emotionally, and managing his stress. The LPN recorded Mr. AKINYEMI’s mood and behavior as appropriate, scheduled a mental health evaluation for Mr. AKINYEMI on December 23, 2019, because he reported assaulting his daughter, and informed the registered nurse (RN) of Mr. AKINYEMI’s statements. However, the RN did not inform the on-call provider of Mr. AKINYEMI’s mental health status, when she called to request medication continuation. After the intake screening, WCJ custody housed Mr. AKINYEMI on a maximum-security unit pending classification and tuberculosis clearance.

On December 21, 2019, at approximately 12:03 a.m., 2:00 a.m., and 3:47 a.m., the night shift CO performed official counts, and Mr. AKINYEMI appeared asleep in his bed.

- At approximately 4:43 a.m., the CO conducted rounds in the maximum-security unit and Mr. AKINYEMI appeared asleep, covered with a blanket from head to toe.
- At approximately 5:03 a.m., the CO began to awaken detainees in preparation for medication administration and discovered Mr. AKINYEMI hanging from the wall vent with a ligature, consisting of five socks tied together. The CO radioed the shift sergeant (Sgt.), requested he report to his location with medical staff and the 911 tool (a sharp-like tool used to cut down detainee from a hanging position).
- At approximately 5:04 a.m., the Sgt., an LPN, and another CO responded with the 911 tool, cut the ligature from around Mr. AKINYEMI’s neck, placed him on his back, and checked for responsiveness. The LPN observed Mr. AKINYEMI as pulseless and not breathing. She then began chest compressions, requested EMS activation, and the AED. A CO retrieved the AED, placed it on Mr. AKINYEMI’s chest, but no shock was advised. *[Investigator’s note: The LPN was the only medical staff on duty and was in the process of administering medications when she received the medical emergency notification, and did not have access to emergency equipment; therefore, she only initiated chest compressions.]*
- At approximately 5:05 a.m., the Snow Hill, MD voluntary fire department and advanced life support EMS personnel arrived on scene and assumed care. EMS personnel observed Mr. AKINYEMI as unresponsive, not breathing, pulseless, and his skin was cold to touch. The EMS personnel transferred Mr. AKINYEMI to their cardiac monitor, which showed an asystole rhythm (also known as flatline, a condition of cardiac arrest where there is no discernible electrical activity in the heart).

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Mortality Review – Anthony Oluseye AKINYEMI, A201 576 988

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- At approximately 5:23 a.m., the EMS personnel contacted the on-call physician at Peninsula Regional Medical Center in Salisbury, MD, and requested orders to terminate cardiopulmonary resuscitation efforts and pronounced Mr. AKINYEMI deceased.
- At approximately 5:50 a.m., an LPN notified the on-call provider of Mr. AKINYEMI's death.

The final autopsy report revealed Mr. AKINYEMI's cause of death was hanging. The coroner noted Mr. AKINYEMI's injuries were consistent with a self-inflicted act. The physical markings observed on one side of the thyroid cartilage was also consistent with the ligature that accompanied Mr. AKINYEMI's body. The coroner determined the manner of death as suicide.

CAPT (b)(6); (b)(7)(C) Behavioral Health Unit Chief, performed Mr. AKINYEMI's psychological autopsy (procedure for analyzing the cause of death by reconstructing what the person thought, felt, and did before death, based on gathered information). The final psychological autopsy report is pending.

ICE detention standards used for this review: ICE National Detention Standards (NDS) 2000. The following are identified program strengths, weaknesses, and recommendations found during this review.

Strengths

Strengths identified during this investigation were: 1) custody and medical staff's response time was within one minute of notification; 2) the LPN completed Mr. AKINYEMI's intake screening within six hours of arrival; and, 3) although WCJ is not currently accredited by the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA), WCJ health care services have implemented local policies to coincide with these standards.

Weaknesses

1. Staffing.

- On December 21, 2019, WCJ health services administrator did not provide adequate staffing for the night shift. An LPN and a certified nursing assistant (CNA) were scheduled for the night shift; however, the CNA did not report to work, leaving the LPN to work alone with a total population of 243 detainees, which included 131 ICE detainees.
- WCJ staffing model was inadequate to address the medical needs of the assigned population.

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Mortality Review – Anthony Oluseye AKINYEMI, A201 576 988
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Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.C. *Medical Personnel*.

2. Patient safety.

- On December 21, 2019, during the medical emergency, the LPN failed to use cervical spine precautions to immobilize Mr. AKINYEMI's head and avoid further injury.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- Up to Date, *Evaluation and initial management of cervical spinal column injuries in adults* (2020). Accessed March 5, 2020. https://www.uptodate.com/contents/evaluation-and-initial-management-of-cervical-spinal-column-injuries-in-adults?source=history_widget.

3. Mental health screening.

- On December 20, 2019, during the medical intake screening, Mr. AKINYEMI verbalized concerns of losing his family, inability to cope emotionally, and managing stress; however, the RN did not timely refer Mr. AKINYEMI to a mental health provider, notify the on-call provider, or initiate mental health observation protocol.
- The WCJ booking officer did not report Mr. AKINYEMI's agitated behavior to medical or custody leadership.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.D. *Medical Screening*.
- WCJ, Standard 02, Inmate Safety Policy, *Emergency Medical Services*.
- Wellpath's Worcester County, MD Detention Center Policies and Procedures: HCD-100_F-03, *Mental Health Services*.

4. Training.

- Several WCJ staff reported, no participation in a man-down drill, scenario-based patient, or situational simulation exercises.
- Several WCJ staff reported suicide prevention and intervention training inconsistencies regarding frequency, content, and method.

Applicable standards of care for this finding:

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Mortality Review – Anthony Oluseye AKINYEMI, A201 576 988

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- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- WCJ, Standard 02, Inmate Safety Policy, *Emergency Medical Services*.
- Wellpath's Worcester County, MD Detention Center Policies and Procedures: HCD-100_F-03, *Mental Health Services*.

5. First aid and cardiopulmonary resuscitation.

- During the emergency response, the LPN did not have access to medical equipment; specifically, the bag valve mask and was unable to provide rescue breathing.
- Correctional staff were not familiar with the location of the AED.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- WCJ, Standard 02, Inmate Safety Policy, *Emergency Medical Services*.
- American Heart Association, Highlights of the 2015 American Heart Association Guidelines Update for CPR and ECC (Emergency Cardiovascular Care). Accessed March 5, 2020. <https://eccguidelines.heart.org/wp-content/uploads/2015/10/2015-AHA-Guidelines-Highlights-English.pdf>.

Recommendations

- Forward these findings to the IHSC Deputy Assistant Director of Health Care Compliance (DAD of HCC).
- The IHSC DAD of HCC will share these findings through appropriate communication channels to ICE, WCJ's administrator and health authority for review and any action(s) deemed appropriate.
- The respective IHSC HCC Unit and ICE will ensure the corrective action plan, if applicable, is implemented and sustained.

End of report.

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Office of Enforcement and Removal Operations
ICE Health Service Corps

U.S. Department of Homeland Security
500 12th Street, SW
Washington, D.C. 20536



U.S. Immigration
and Customs
Enforcement

December 6, 2018

MEMORANDUM FOR:

(b)(6); (b)(7)(C) DHSc, MPH
Assistant Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

Date: 2018.12.17 12:38:16
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MD

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Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

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(b)(6); (b)(7)(C)

Chief of Staff
ICE Health Service Corps

Date: 2018.12.13 13:29:03
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FROM:

(b)(6); (b)(7)(C)

MD

Deputy Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

RN

Regional Nurse Consultant
ICE Health Service Corps

(b)(6); (b)(7)(C)

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RN

Investigator
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

PA-C

Risk Manager
ICE Health Service Corps

(b)(6); (b)(7)(C)

(b)(6); (b)(7)(C)

PA-C

Regional Advanced Practice Provider
ICE Health Service Corps

(b)(6); (b)(7)(C)

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www.ice.gov

SUBJECT: Mortality Review - Ronal Francisco ROMERO, A078 963 293
(a.k.a. Ronald CRUZ)

Executive Summary:

Mr. Ronal Francisco ROMERO, a 39-year-old Honduran male, was in U.S. Immigration and Customs Enforcement (ICE) custody from May 14 to 16, 2018. During pre-screening and intake screening at Port Isabel Detention Center (PIDC) in Los Fresnos, Texas (TX), Mr. ROMERO denied a history of any medical/mental health conditions and voiced no complaints. Mr. ROMERO's vital signs (VS) were within normal limits (wnl). Within 30 hours of his arrival, an advanced practice provider (APP) evaluated Mr. ROMERO for fever, influenza like symptoms, dehydration, and clinical strep throat. The APP initiated treatment and admitted Mr. ROMERO to the medical housing unit (MHU) for observation. Within five hours, a registered nurse (RN) observed a change in Mr. ROMERO's health status, i.e., altered mental status and elevated blood pressure. The RN consulted with an APP and notified emergency medical services (EMS). EMS responded within 26 minutes to PIDC, assumed care of Mr. ROMERO, and transferred him to a local emergency department (ED). Within twelve hours after arrival, Mr. ROMERO went into cardiac arrest and was transferred to the intensive care unit (ICU), where he required ventilatory support and medication to maintain his blood pressure. Over the next 12 hours, Mr. ROMERO's status deteriorated, resulting in several cardiac arrests, and the physician pronounced Mr. ROMERO dead at 6:49 p.m. Autopsy results revealed Mr. ROMERO's manner of death was "natural" due to complications of sepsis (infection) with meningitis and other significant conditions listed as diabetes mellitus (an unknown or unreported condition).

Mortality Finding:

A mortality review committee (MRC) determined that Mr. ROMERO's medical care at PIDC was provided within the safe limits of practice and did not directly or indirectly contribute to his death.

Of note, during this review, it was found that Mr. ROMERO was in U.S. Customs and Border Protection (CBP) custody prior to his transfer to ICE custody, from May 9 to 14, 2018, where he received antibiotics for a left ear and throat infection. Mr. ROMERO was scheduled to complete a five-day course of antibiotics (otically and orally) on May 13, 2018, prior to his transfer to PIDC. A post-mortality search of his property revealed three pills remained and the medications were not shared with PIDC medical staff, nor did Mr. ROMERO report the treatment during his intake. It is unknown if this information would have affected Mr. ROMERO's care, course of treatment, and the outcome. Due to Mr. ROMERO's progressively deteriorating status and short time period within ICE custody, it is highly unlikely that the information would have changed the outcome.

Collateral findings identified during the course of this review are included in the mortality review detailed report of findings below.

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Mortality Review Detailed Report:

On May 16, 2018, ICE Health Service Corps (IHSC) received notification of the death of ICE detainee Ronal Francisco ROMERO, A078 963 293. Mr. ROMERO, a 39-year-old Honduran male, was in ICE custody from May 14 to May 16, 2018, and assigned to PIDC on the date of his death. Mr. ROMERO passed away at Valley Baptist Medical Center (VBMC) on May 16, 2018.

The IHSC Assistant Director requested a mortality review to learn from Mr. ROMERO's death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

The findings and recommendations of the MRC, which convened on September 11, 2018, are based on the review of the following information: 1) Mr. ROMERO's PIDC and CBP medical records, EMS, and community hospital records; 2) incident and notification reports; 3) ICE ENFORCE Alien Removal Module (EARM) and ICE ENFORCE Alien Detention Module (EADM) database records; 4) Mr. ROMERO's PIDC detention file; 5) Mr. ROMERO's autopsy report; 6) audio-visual recordings from May 14 to 16, 2018 EMS response; 7) an on-site review and staff interviews conducted by factfinder, CAPT (b)(6); (b)(7)(C) at PIDC on June 6-7, and 13, 2018; and 8) applicable IHSC directives and guides, PIDC policies and procedures, and ICE detention standards.

ICE detention standards used for this review: ICE Performance-Based National Detention Standards (PBNDS), 2011 (revised December 2016). The MRC identified the following health care delivery/program strengths, weaknesses, and recommendations during this review:

Strengths

During this review, it was readily apparent that PIDC are earnest and dedicated professionals. Strengths identified during this investigation were staff's: 1) prompt recognition of Mr. ROMERO's deteriorating status; 2) identifying the need for EMS; 3) and, most importantly, PIDC medical staff were receptive to this review process and looked forward to receiving constructive feedback.

Weaknesses

1. Pre-screening and intake screening.

- On May 14, 2018, an RN performed Mr. ROMERO's pre-screening inside the holding cell, in a group fashion, rather than individually.
- An RN conducted Mr. ROMERO's pre-screening and obtained responses; however, a licensed vocational nurse (LVN) documented the encounter and shredded the RN's

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documentation. When interviewed the RN stated, in her practice, when performing a group pre-screening, she uses the I-216 to record a positive response to anyone who responds or raises their hand if the detainee has a medical issue or recent hospitalization. According to the video footage, Mr. ROMERO raised his hand, pointed to his left ear, but the RN could not recall his specific response and the LVN did not record any responses in the pre-screening.

Applicable standards of care for this finding:

- NCCHC standard, J-E-02, *Receiving Screening*.
- NCCHC standard, J-A-09, *Privacy of Care*.
- ACA standard, 1-HC-1A-19, *Health Screens*.
- PBNDS 2011: 4.3, Medical Care; section V.J. *Medical and Mental Health Screening of New Arrivals*.
- IHSC Directive 03-08, *Pre-Screening*, March 21, 2016.
- IHSC Directive 03-10, *Intake Screening and Intake Reviews*, March 28, 2016.
- PIDC LOP 8.1.1., *Medical Intake Screening*, 3.3-3, January 2018.

2. Communication on patient's health needs.

- Custody officers checked Mr. ROMERO's medications into his personal property; however, this was not communicated to medical staff.
- The clinic coordinator (CC) did not provide the MHU RN with a verbal report.
- The clinic APP did not provide report to the receiving MHU APP.
- Off-going MHU RN did not provide a thorough report to the on-coming MHU RN.

Applicable standards of care for this finding:

- ACA standard, 1-HC-1A-04, *Continuity of Care*.
- Texas Nurse Practice Act, July 2012, V43, No. 3: *Professional Communication on Interdisciplinary Teams and a Nurse's Duty*.

3. Patient safety.

- An RN delegated an inappropriate scope of practice task to an LVN, who initiated an intravenous (IV) site and administered a fluid bolus. The TX LVN scope of practice states, "The LVN shall not engage in IV therapy...until successful completion of a validation course that instructs the LVN in the knowledge and skills applicable to the LVN's IV therapy practice." No course is provided within IHSC or locally.

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Applicable standards of care for this finding:

- IHSC LVN/LPN Competencies, page 4.
- Texas Nurse Practice Act, V43, No. 3, *Professional Communication on Interdisciplinary Teams and a Nurse's Duty*.
- Nurse Practice Act (NPA), "Texas Board of Nursing Board Position Statements." Rule 217.11, 15.3, https://www.bon.texas.gov/practice_scope_of_practice_mn.asp.
- Texas NPA, "The Licensed Vocational Nurse Scope of Practice", https://www.bon.texas.gov/practice_bon_position_statements_content.asp#15.27.

4. Staffing.

- According to the PIDC current staffing plan, there is a 40 percent RN vacancy rate (12 filled/20 positions).
- One RN (CC) was in the clinic responsible for responding to normal clinic activities and emergent events. At the time Mr. ROMERO arrived at the clinic, the CC was involved in a separate medical emergency.
- The second RN performed sick call out of the medical staging area, leaving the CC as the only RN in the clinic.
- IHSC Guide 03-02-G-01, *Sick Call Process*, suggests for facilities with greater than 1001 detainee population, there should be four to five RNs performing sick call; there were only two.

Applicable standards of care for this finding:

- NCCHC standard, J-C-07, *Staffing*.
- ACA standard, 1-HC-4A-05, *Staffing*.
- PBNDS 2011: 4.3, Medical Care; section V.B. *Designation of Authority*.
- IHSC Directive 17-002, Clinic Scheduling Guidelines; 4-1.5; 4-1.6, *Schedule Administration*, October 10, 2017.
- IHSC Guide 03-02-G-01, Sick Call; II. A. *Sick Call Process*, March 25, 2016.

5. Medication services.

- Medications were not delivered in a timely manner after an APP gave a verbal order to administer a stat medication.
- An MHU RN documented medication administered (antibiotic) at 8:00 a.m., two hours prior to Mr. ROMERO receiving medical care and the APP writing orders.

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- The MHU RN documented an IV bolus as given; however, an LVN administered therapy.
- Nursing documentation does not support the effectiveness of treatment after fever reducing medication was administered.
- Scheduled medication was not administered in a timely manner (i.e., 2:00 p.m. doses of ibuprofen and normal saline flush, and a 4:00 p.m. dose was not administered or signed off, as given).

Applicable standards of care for this finding:

- NCCHC standard, J-D-02, *Medication Services*.
- ACA standard, 1-HC-1A-35, *Pharmaceuticals*.
- PBNDS 2011: 4.3, Medical Care; section V.G. *Pharmaceutical Management*.
- PBNDS 2011: 4.3, Medical Care; section V.U. *Delivery of Medication*.

6. Nursing assessment.

- The CC, LVN, and MHU RN's documentation was incomplete regarding their assessment(s), treatment(s), and procedures.
- The MHU RN did not perform a comprehensive admission assessment and did not document Mr. ROMERO's generalized weakness, reliability on a wheelchair, and inability to care for self without assistance.

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.B. *Designation of Authority*.
- Nursing Process, "*Five step process (assessment, diagnosing, planning, implementing, and evaluation) to enhance the quality of patient care.*" Nursingprocess.org.

7. Diagnostics.

- On May 15, 2018, Mr. ROMERO had a blood sugar of 266 mg/dL. There were no additional orders or a recheck obtained addressing the abnormal finding.
- A repeat urinalysis was not obtained.

Applicable standards of care for this finding:

- NCCHC standard: J-E-12, *Continuity and Coordination of Care During Incarceration*.

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- Texas Administrative Code, Title 22: Examining Boards, Part 9: Texas Medical Board, Chapter 185: Physician Assistants, Rule 185.10: *Physician Assistant Scope of Practice*.

8. Documentation.

- Mr. ROMERO's medical record reflected incomplete documentation during his stay PIDC.

Applicable standards of care for this finding:

- PBNDS 2011, 4.3., *Medical Care*., section II. *Expected Outcomes* (23).
- American Nurses Association (ANA) Nursing: Scope and Standards of Practice, *Standard I. Assessment*, states that an RN is expected to document relevant data in a retrievable format.

9. MHU (infirmary) care.

- Upon admission to the MHU, an RN did not review the APP orders.
- At change of shift, the clinic APP went to the MHU to verify if the repeat urinalysis had been completed. This reminded the off-going nurse to tell the on-coming nurse that a repeat urinalysis was needed.

Applicable standards of care for this finding:

- NCCHC standard: J-G-03, *Infirmary Care*.
- ACA standards: 1-HC-1A-09, *Infirmary Care*.
- PBNDS 2011: 4.3, Medical Care; section V.F.3, *Medical Housing*.
- IHSC Directive 03-17, *Medical Housing Unit*, March 25, 2016.

Recommendations

- Forward these findings to the IHSC Deputy Assistant Director (DAD) of Health Care Compliance (HCC).
- The IHSC DAD of HCC will share these findings through appropriate communication channels to ICE, the PIDC administrator, and health authority for review and any action(s) deemed appropriate.

End of report.

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U.S. Immigration
and Customs
Enforcement

April 29, 2020

MEMORANDUM FOR: (b)(6); (b)(7)(C) DHS, FACHE (b)(6); (b)(7)(C)
Assistant Director
ICE Health Service Corps

THROUGH: (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C) MS (b)(6); (b)(7)(C)
Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C)
Chief, Investigations Unit
ICE Health Service Corps

FROM: (b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C)
Investigator
ICE Health Service Corps

SUBJECT: Mortality Review – Report of Findings
Ben James OWEN, A219 403 429

Executive Summary:

On January 26, 2020, U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of ICE detainee Ben James OWEN. Mr. OWEN, a 39-year-old male citizen of the United Kingdom, was in ICE custody from January 15 - 25, 2020, and assigned to Baker County Detention Center (BCDC) in Macclenny, Florida (FL), on the date of his death. An autopsy ruled Mr. OWEN's death a suicide.

Prior to ICE custody, on July 23, 2019, U.S. Customs and Border Protection admitted Mr. OWEN into the U.S. at the Miami Sea Port, FL, as an O2 non-immigrant with authorization to remain in the U.S. for a temporary period, not to exceed December 10, 2019; however, he

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Mortality Review - Ben James OWEN, A219 403 429

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remained beyond that date without authorization. On January 14, 2020, Enforcement and Removal Operations (ERO), Orlando Federal Criminal Alien Program, encountered Mr. OWEN while he was detained at the Volusia County Branch Jail (VCBJ) in Daytona Beach, FL, and issued him a Notice to Appear, form I-862. On January 15, 2020, VCBJ released Mr. OWEN to ERO Miami, pursuant to the immigration detainer. ERO transferred Mr. OWEN to BCDC for housing.

During Mr. OWEN's custody at BCDC, he denied having any medical, mental health conditions, past suicide attempts, or suicidal ideations. Additionally, on January 24, 2020, Mr. OWEN refused his physical assessment and did not submit any sick call requests. BCDC's medical staff did not complete any medical or mental health evaluations after his initial medical intake screening.

On January 25, 2020, at approximately 7:24 p.m., Mr. OWEN's cellmate, a fellow ICE detainee, discovered Mr. OWEN hanging in their shared cell and alerted other detainees of the emergency. Another ICE detainee activated the emergency button. At approximately 7:26 p.m., custody officers (CO) arrived on the scene, discovered Mr. OWEN hanging from a pillar in the cell with a ligature. The officers removed Mr. OWEN from the hanging position, checked for responsiveness, initiated cardiopulmonary resuscitation (CPR), activated emergency medical services (EMS), and notified medical staff. At approximately 7:30 p.m., medical staff arrived. The officers paused CPR, carried Mr. OWEN downstairs to the stretcher, transferred him to the booking area, resumed CPR, and applied oxygen and the automated external defibrillator (AED). At approximately 7:48 p.m., community Fire and Rescue and EMS personnel arrived, assumed care, and approximately two minutes later, pronounced Mr. OWEN deceased.

Mortality Finding:

As a result of Mr. OWEN's death, the IHSC Assistant Director requested a mortality review to learn from his death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

A mortality review committee (MRC) unanimously determined that Mr. OWEN's medical care at BCDC was not provided within the safe limits of practice. Specifically, the MRC determined BCDC's care, or lack thereof, could pose a significant future risk. Overall findings identified were: 1) BCDC custody and medical staff did not use cervical spine precautions when removing Mr. OWEN from the hanging position or transporting him to the stretcher, 2) BCDC custody staff transferred Mr. OWEN to the stretcher before the medical staff arrived to assess his injuries, 3) BCDC medical staff had a limited role during the emergency response, and 4) there was a lack of available medical equipment during the emergency response.

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Mortality Review - Ben James OWEN, A219 403 429

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The MPC convened on March 25, 2020, and consisted of the following members: Captain (CAPT) (b)(6); (b)(7)(C) MD, Krome Service Processing Center's Clinical Director, physician reviewer; Lieutenant Commander (LCDR) (b)(6); (b)(7)(C) Physician Assistant - certified, advanced practice provider (APP) reviewer; Lieutenant (LT) Oyinlola Olumuyiwa, Health Care Risk Management Program Manager, risk management reviewer; Commander (CDR) (b)(6); (b)(7)(C) registered nurse (RN), Eastern Regional Nurse Manager, nurse reviewer; LCDR (b)(6); (b)(7)(C) Western Regional Behavioral Health Consultant, mental health reviewer.

The following summary of events was based on: 1) Mr. OWEN's BCDC medical records and EMS reports; 2) incident and notification reports; 3) ICE ENFORCE Alien Removal Module (EARM) and ICE ENFORCE Alien Detention Module (EADM) database records; 4) Mr. OWEN's BCDC detention file; 5) Mr. OWEN's autopsy report; 6) video footage from January 25, 2020; 7) an on-site review and staff interviews conducted by fact-finder CDR (b)(6); (b)(7)(C) and IHSC's Western Regional Behavioral Health Consultant, LCDR (b)(6); (b)(7)(C) at BCDC on February 25 - 27, 2020; and 8) applicable BCDC policies and procedures, and ICE Detention Standards.

Summary of Events

On January 16, 2020, a licensed practical nurse (LPN) completed Mr. OWEN's medical intake screening and reviewed the VCBJ transfer summary, which did not list any medical, mental health history, or medications. Mr. OWEN's vital signs (VS) were normal, and he denied having any medical, mental health conditions, past suicide attempts, and/or current suicidal ideations. The LPN scheduled Mr. OWEN's physical assessment for January 24, 2020; however, he refused the evaluation.

During January 17 - 24, 2020, Mr. OWEN did not submit any sick call requests, and BCDC's medical staff did not complete any medical or mental health evaluations after his initial medical intake screening.

On January 25, 2020, at approximately 5:39 p.m., Mr. OWEN went to his cell after using the telephone, and placed the privacy curtain over the cell door window.

- At approximately 6:31 p.m., Mr. OWEN's cellmate knocked on the cell door, but Mr. OWEN did not respond.
- At approximately 7:24 p.m., Mr. OWEN's cellmate knocked on the cell door again, but Mr. OWEN did not respond. Mr. OWEN's cellmate stood on the railing outside of the cell, noticed Mr. OWEN hanging, and alerted other detainees for assistance; a detainee activated the emergency button to alert staff.
- At approximately 7:26 p.m., COs arrived on the scene, discovered

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Mortality Review - Ben James OWEN, A219 403 429

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Mr. OWEN hanging from a bed sheet wrapped around his neck, and tied to a pillar, that separated the shower from the toilet. The officers cut the ligature from around Mr. OWEN's neck and checked for responsiveness. A CO observed Mr. OWEN pulseless, not breathing, initiated CPR, and requested medical staff and EMS activation.

- At approximately 7:30 p.m., an RN and two LPNs arrived with a stretcher and a crash cart. They [medical staff] observed COs carrying Mr. OWEN downstairs to the stretcher with one officer holding his head and the other two officers holding each leg. The medical staff assisted the COs transporting Mr. OWEN to the booking area. Upon arrival to the booking area, an RN completed a visual assessment, found Mr. OWEN unresponsive, pulseless, not breathing, with pale skin, and fixed and dilated pupils. A CO resumed CPR and applied supplemental oxygen, at 25 liters per minute, via a bag valve mask, and inserted an oropharyngeal airway [(OPA); used to maintain or open a patient's airway]. The CO then applied an AED that advised "no shock." BCDC custody staff continued CPR until EMS arrived.
- At approximately 7:48 p.m., Fire and Rescue and EMS responders from Macclenny and Sanderson, FL, respectively, arrived and found Mr. OWEN on a stretcher, unresponsive, pulseless, not breathing, and with cold, mottled (discolored) skin. The EMS personnel transferred Mr. OWEN to their cardiac monitor, which showed an asystole rhythm (also known as flatline, a condition of cardiac arrest where there is no discernible electrical activity in the heart). The BCDC staff informed EMS personnel that Mr. OWEN was found hanging and unresponsive for an unknown length of time, their initiation of CPR, and use of an AED, with no shock advised. As a result, the EMS personnel did not continue CPR, or life-saving measures, and determined continued efforts would not change Mr. OWEN's chance of survival.
- At approximately 7:50 p.m., a paramedic pronounced Mr. OWEN deceased. Based on Florida's EMS local operating procedures for medical emergencies, a paramedic may terminate resuscitative efforts if certain criteria are observed.

The final autopsy report revealed Mr. OWEN's cause of death was asphyxia due to hanging. The coroner observed physical markings that indicated irregular ligature abrasions at the upper neck ascending towards the posterior scalp. The coroner determined the manner of death as suicide.

LCDR (b)(6); (b)(7)(C), Western Regional Behavioral Health Consultant, performed Mr. OWEN's psychological autopsy (procedure for analyzing the cause of death by reconstructing what the person thought, felt, and did before death, based on gathered information). The final psychological autopsy report is pending. Fact-finder, CDR (b)(6); (b)(7)(C) will issue an addendum once the report is completed.

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Mortality Review - Ben James OWEN, A219 403 429
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ICE detention standards used for this review: ICE National Detention Standards (NDS) 2000. The following are identified program strengths, weaknesses, and recommendations found during this review.

Strengths

Strengths identified during this investigation were: 1) BCDC custody staff initiated CPR prior to medical staff's arrival to the scene; 2) BCDC's licensed mental health counselor has correctional health care experience; 3) the BCDC health services administrator arrived to the facility in a timely manner following the death to assist staff with coping; and 3) although BCDC is not currently accredited by the National Commission on Correctional Health Care (NCCHC) or the American Correctional Association (ACA), BCDC health care services have implemented local policies to coincide with these standards.

Weaknesses

1. Patient safety.

- On January 25, 2020, during the medical emergency, medical staff failed to apply a cervical collar to Mr. OWEN's neck, or use cervical spine precautions, for immobilization and avoidance of further injury.
- During the medical emergency response, custody staff moved Mr. OWEN before the medical staff performed an initial assessment of his injuries.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- Up to Date, *Evaluation and initial management of cervical spinal column injuries in adults* (2020). Accessed March 5, 2020. https://uptodate.com/contents/evaluation-and-initial-management-of-cervical-spinal-column-injuries-in-adults?source=history_widget.
- Southern Correctional Medicine (SCM), D-07, *Emergency Services and Response Plan*.

2. Training.

- Several BCDC staff reported a lack of man-down drills and scenario-based patient or situational simulation exercises.
- Several BCDC medical staff reported lack of medical equipment training, specifically the stretcher.

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Mortality Review - Ben James OWEN, A219 403 429

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- Several BCDC medical staff reported lack of emergency response training; therefore, they were not aware of their role during the emergency, which resulted in lack of involvement during the emergency response.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- SCM, D-07, *Emergency Services and Response Plan*.

3. Emergency response.

- On January 25, 2020, during the medical emergency, the medical staff did not actively participate in the emergency response. Custody staff led and managed the emergency response efforts (i.e., performed CPR, applied the AED, inserted the OPA, and gave report to EMS).
- During the medical emergency, a BCDC CO performed beyond the scope of a CO, leading and managing the emergency response efforts. The BCDC CO reported completing an emergency medical technician course but could not provide evidence of a current EMT certification.
- Several BCDC medical staff reported, emergency equipment, specifically, a cervical collar and back board, were not available during the emergency.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- SCM, D-07, *Emergency Services and Response Plan*.

4. Policies and standards.

- Inconsistency with following policies versus delivery of care. BCDC nursing staff did not consistently adhere to facility guidance. The nurses did not perform an initial or secondary assessment. Additionally, three nurses responded to the emergency; however, only one nurse documented in the medical record.

Applicable standards of care for this finding:

- ICE NDS 2000, Medical Care., section III.H. *First Aid and Medical Emergencies*.
- SCM, D-07, *Emergency Services and Response Plan*.

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Mortality Review - Ben James OWEN, A219 403 429
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Recommendations

- Forward these findings to the IHSC Deputy Assistant Director (DAD) of Health Care Compliance (HCC).
- The IHSC DAD of HCC will share these findings through appropriate communication channels to ICE, the BCDC administrator and health authority for review and any action(s) deemed appropriate.
- The respective IHSC HCC Unit and ICE will ensure the Corrective Action Plan is implemented and sustained.

End of report.

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U.S. Immigration
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Enforcement

July 17, 2020

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE STEWART D
Assistant Director SMITH
ICE Health Service Corps

THROUGH: (b)(6); (b)(7)(C) ID (b)(6); (b)(7)(C)
Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps

(b)(6); (b)(7)(C) MS (b)(6); (b)(7)(C)
Chief of Staff
ICE Health Service Corps

(b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C)
Chief, Investigations Unit
ICE Health Service Corps

FROM: (b)(6); (b)(7)(C) RN/NP (b)(6); (b)(7)(C)
Senior Investigator
ICE Health Service Corps

SUBJECT: Mortality Review – Report of Findings
Maria Celeste OCHOA-Yoc de Ramirez, A213 441 658

Digitally signed by
STEWART D SMITH
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Executive Summary:

On March 9, 2020, U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of ICE detainee Maria Celeste OCHOA-Yoc de Ramirez. Ms. OCHOA, a 22-year-old Guatemalan female, was in ICE custody from September 5, 2019 to March 8, 2020. During her detention period, ICE housed Ms. OCHOA at the El Valle Detention Center (EVDC) in Raymondville, Texas (TX), from September 6 to 12, 2019, and Kay County Detention Center (KCDC) in Newkirk, Oklahoma (OK), from September 12, 2019 to February 13, 2020, and Prairieland Detention Center (PDC) in Alvarado, TX, from February 13 to March 8, 2020, the date of her death. An autopsy ruled Ms. OCHOA's cause of death as liver failure due to complications of probable viral hepatitis, and her manner of death was ruled as

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Mortality Review – Maria Celeste OCHOA-Yoc de Ramirez, A213 441 658
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natural.

Prior to ICE custody, on September 5, 2019, U.S. Border Patrol (USBP) arrested Ms. OCHOA in the Rio Grande Valley, TX, for illegal entry into the U.S. Ms. OCHOA claimed credible fear of returning to Guatemala. On September 6, 2019, USBP transferred Ms. OCHOA to the custody of ICE Enforcement and Removal Operations (ERO) San Antonio, TX, and ERO housed Ms. OCHOA at EVDC. On September 23, 2019, U.S. Citizenship and Immigration Services issued a positive fear finding. The Department of Justice's Executive Office for Immigration Review scheduled a review of Ms. OCHOA's case for December 16, 2019; however, it was pending rescheduling at the time of her death.

While in ICE custody, Ms. OCHOA denied a history of medical conditions; however, she reported a history of spousal abuse in 2015, mental health treatment related to a sexual assault at age 19, and admitted feeling extremely depressed.

September 21, 2019 – February 5, 2020, Ms. OCHOA was evaluated and treated for multiple complaints, i.e., cold related symptoms, dental pain, allergies, abdominal pain, nightmares, constipation, and painful urination.

On February 6, 2020, a licensed practical nurse (LPN) evaluated Ms. OCHOA for complaints of anxiety, fast heart rate, weight loss, and poor sleep; consulted with the on-call medical provider, and placed Ms. OCHOA in the medical housing unit for observation. The advanced practice provider (APP) ordered Ensure (nutritional supplement), weekly weight checks, and the following tests: complete blood count (CBC), comprehensive metabolic panel (CMP), and a hepatic panel (liver function test).

On February 7, 2020, an APP referred Ms. OCHOA to Mercy Hospital emergency department (ED) in Ponca City, OK, due to critically elevated liver function test results and weight loss. Ms. OCHOA was diagnosed with cholecystitis (inflammation of gall bladder) and acute pancreatitis (inflammation of pancreas). On February 8, 2020, a cholecystectomy (surgical removal of gall bladder) was performed, and Ms. OCHOA was reportedly stable post-operatively.

On February 10, 2020, Ms. OCHOA was returned to KCDC and housed in medical. On February 11, 2020, an APP evaluated Ms. OCHOA. The APP's assessment included sclera and skin slightly yellow, and sinus tachycardia. The APP scheduled a routine follow-up without any additional orders. That same day, a licensed professional clinical counselor (LPCC) also evaluated Ms. OCHOA and placed her on suicide watch (SW) after self-reporting an eating disorder, wanting jail personnel to kill her, anxiety, and insomnia for the past 18 days.

On February 12, 2020, ERO Dallas transferred Ms. OCHOA to PDC for further mental health evaluation of possible PTSD and bulimia.

On February 18, 2020, PDC transferred Ms. OCHOA to Texas Health Huguey Hospital

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(THHH) ED in Burleson, TX, where she was admitted for abdominal pain, nausea/vomiting (N/V), elevated liver enzymes, jaundice, acute pancreatitis, and status post (s/p) cholecystectomy.

On February 28, 2020, THHH transferred Ms. OCHOA to Texas Health Harris Methodist Hospital-Fort Worth for a higher level of care.

On March 5, 2020, Ms. OCHOA had difficulty breathing, tachycardia, elevated lactic acid (organic acid present normally in muscle tissue as a by-product of the breakdown of glucose) levels and was transferred to the intensive care unit (ICU).

On March 6, 2020, Ms. OCHOA was diagnosed with the following conditions: pneumonia, septic shock, hyperbilirubinemia, elevated liver enzymes, supraventricular tachycardia [(SVT); abnormal fast heart rhythm], acute respiratory syndrome [(ARS); condition that causes fluid to build up in the lungs and prevent oxygenation], seizure, cardiomyopathy (disease of the heart muscle that makes it difficult to pump blood to the body), thrombocytopenia (low platelet count), and organ failure. Ms. OCHOA was intubated (placement of a tube into the trachea to assist with breathing) and placed on ventilator support.

On March 8, 2020, Ms. OCHOA's condition continued to worsen, and she experienced cardiac arrest with an unsuccessful resuscitation attempt, and was pronounced dead at 8:45 a.m.

Mortality Finding:

As a result of Ms. OCHOA's death, the IHSC Assistant Director requested a mortality review to learn from her death by reviewing the care provided and the circumstances leading up to her death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

A mortality review committee (MRC) unanimously determined that Ms. OCHOA's medical care at EVDC, KCDC, and PDC was provided within the safe limits of practice and did not directly contribute to her death. However, the MRC identified indirect findings during this review, which are included in the summary of events report below. The MRC concurred that these findings could pose a significant risk of adverse outcomes to other patients, if not remedied.

The MRC convened on June 24, 2020, and consisted of the following IHSC staff members: Captain (CAPT) (b)(6); (b)(7)(C) physician reviewer: CAPT (b)(6); (b)(7)(C) MD, Infectious Disease Consultant; Commander (CDR) (b)(6); (b)(7)(C) Physician Assistant - certified, APP reviewer; CDR (b)(6); (b)(7)(C) RN, Western Regional Nurse Manager, nurse reviewer; and CDR (b)(6); (b)(7)(C) psychologist, Behavioral Health Consultant, behavioral health reviewer.

The following summary of events were based on (b)(5)

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(b)(5); (b)(6); (b)(7)(C)

Summary of Events

On September 6, 2019, at EVDC, a registered nurse (RN) completed Ms. OCHOA's intake screening. Ms. OCHOA denied a history of medical and mental health conditions; however, she did report an allergy to gentamycin (antibiotic) and history of spousal physical abuse in 2015. Her vital signs (VS) were normal, and she weighed 118 pounds (lbs.). The RN cleared Ms. OCHOA for general population (GP) with a referral to a mental health provider (MHP). On September 9, 2019, Ms. OCHOA refused mental health services, stating she was emotionally stable.

On September 11, 2019, an RN completed Ms. OCHOA's transfer summary, and cleared her for transfer to KCDC.

On September 12, 2019, at KCDC, an LPN reviewed Ms. OCHOA's transfer summary, which noted tuberculosis screening and allergies, and completed Ms. OCHOA's intake screening. Ms. OCHOA denied a history of medical or mental health conditions; however, she reported a history of spousal physical abuse in 2015, and mental health treatment related to a sexual assault at age 19. Her VS were normal, and her weight (wt.) was 116 pounds (lbs.). The LPN cleared Ms. OCHOA for GP.

On September 13, 2019, an LPCC evaluated Ms. OCHOA due to a self-request, and she reported a history of prior sexual assault at age 19, and nightly disruptive nightmares causing her to sleep excessively during the day. Her mental status exam (MSE) was normal, except dysphoric/sad mood and flat affect. The LPCC diagnosed Ms. OCHOA with post-traumatic stress disorder [(PTSD); anxiety disorder that develops in relation to an event which creates psychological trauma in response to actual or threatened death, serious injury or sexual violation], and noted a severe marked impact on Ms. OCHOA's ability to function satisfactorily in the current setting. The LPCC noted Ms. OCHOA's disposition as stable mental health condition, cleared for GP, consider terazosin [*anti-hypertensive; also, an off-label use is being studied for the alleviation of nightmares associated with PTSD*], and submitted a routine medical referral.

On September 20, 2019, the MD prescribed terazosin, one tablet, 2 milligrams (mg), orally at bedtime.

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On September 21, 2019, an RN completed Ms. OCHOA's health assessment. Ms. OCHOA denied history of medical and mental health conditions, except tachycardia (fast heart rate) related to anxiety. The RN noted terazosin as Ms. OCHOA's current medication. Her VS were normal, except for a pulse (P) of 115 beats per minute [(bpm); normal 60-100 bpm]. The RN documented Ms. OCHOA's assessment as unremarkable, and to follow up as needed.

October 11, 2019 – January 31, 2020, Ms. OCHOA was evaluated and treated for various complaints: dental pain, allergy related symptoms, cold symptoms, N/V, constipation, urinary symptoms and discharge, and a right elbow injury.

On February 2, 2020, an LPN evaluated Ms. OCHOA for vomiting, wt. loss, muscle aches, and an episode of black stool. Her VS were normal, except a P of 123 bpm and a current wt. of 106 lbs. Ms. OCHOA lost 14 lbs. since November 20, 2019, 120 lbs. to 106 lbs., respectively. The LPN referred Ms. OCHOA to a medical provider for her presenting symptoms.

On February 3, 2020, an RN evaluated Ms. OCHOA for complaints of shortness of breath and nausea. On examination, Ms. OCHOA's P was 110 bpm and she had diminished right lung sounds. The RN referred Ms. OCHOA to a medical provider for evaluation, and a chest x-ray was ordered, which was negative.

On February 4, 2020, an APP evaluated Ms. OCHOA for follow-up of previous symptoms. Ms. OCHOA denied any complaints, except a runny nose. Her exam was unremarkable, except P of 104 bpm. The APP ordered Flonase (allergy nasal spray) daily with routine follow up.

On February 5, 2020, custody staff reported to medical staff that fellow detainees witnessed Ms. OCHOA self-induce vomiting after meals.

On February 6, 2020, an RN assessed Ms. OCHOA for anxiety, poor sleep, feeling as though she was dying, and her heart was stopping. Her VS were normal, except P of 118 bpm and wt. of 105 lbs. On examination, the RN noted positive tachycardia, light straw tint to both eyes, and abnormal urinalysis (UA) dipstick results (positive ketones, blood, elevated bilirubin, leukocytes, and protein). The RN admitted Ms. OCHOA to medical housing for observation and referred her to the medical provider and MHP for evaluation.

- On this same date, the APP ordered Ensure two times daily, weekly wt. checks for thirty-days, and the following tests: CBC, CMP, and a hepatic panel.
- At 7:30 p.m., Ms. OCHOA complained of a nosebleed, but denied pain or injury. The LPN held pressure, the bleeding stopped, and Ms. OCHOA returned to her bed.

On February 7, 2020, at 8:13 a.m., the APP received the following critical laboratory results: bilirubin (yellow compound found in the liver, excreted in bile, and stored in the gall bladder) level of 6.5 mg/deciliter (dL) (normal 0.2 -1.2 mg/dL), AST (liver enzyme) level of 1747 international units (IU)/liter (L) (normal 14 – 20 IU/L), and alkaline phosphate level of 434 IU/L

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(normal 44 – 147 IU/L). The APP referred Ms. OCHOA to Mercy Hospital ED for further evaluation.

- Ms. OCHOA was diagnosed with cholecystitis, acute pancreatitis, and admitted as an in-patient.

On February 8, 2020, a cholecystectomy was performed, and Ms. OCHOA was reportedly stable post-operatively. Ms. OCHOA was discharged to KCDC on February 10, 2020.

On February 10, 2020, Ms. OCHOA was returned to KCDC and placed in medical housing pending a provider's evaluation. Ms. OCHOA complained of not sleeping for thirty days. The MD gave a verbal order for acetaminophen and ketorolac (non-steroidal anti-inflammatory for moderate pain), as needed, for breakthrough pain. Prior to Ms. OCHOA's hospitalization, custody staff removed Ms. OCHOA's property from the dorm and discovered several pills [*type unknown*] under Ms. OCHOA's mattress.

On February 11, 2020, an APP evaluated Ms. OCHOA s/p cholecystectomy. Ms. OCHOA refused medications and reported they [medications] were making her crazy. Ms. OCHOA reported she wants to die, but she has no plans or desire to self-inflict injury. Her VS were stable, except for P of 120 bpm. The APP placed Ms. OCHOA in medical housing on SW and referred her to mental health services for evaluation.

- An LPCC evaluated Ms. OCHOA, who voiced the need for medication to the extent she no longer wanted to feel anything, and admitted to having an eating disorder. Ms. OCHOA also reported she wanted medical staff to kill her, and she wanted to die, but denied plans or a desire to self-inflict injury. The LPCC documented her MSE as: disheveled, mildly agitated, hand tremors, dysphoric/sad, pressured speech, poor insight and judgement, and low engagement. The LPCC diagnosed Ms. OCHOA with 1) eating disorder – rule out bulimia, 2) depressive disorder, and 3) personality disorder – not otherwise specified (NOS) with severity rating as marked impact on [detainee's] ability to function satisfactorily in the current setting. The LPCC noted Ms. OCHOA did not appear to be a high risk for self-harm, but ordered continued SW, consider referral to a higher level of care, and submitted a routine referral for a psychiatrist evaluation.

On February 13, 2020, an LPN completed Ms. OCHOA's transfer summary, and ERO Dallas transferred Ms. OCHOA to PDC for further mental health evaluation of possible PTSD and bulimia.

On February 13, 2020, at PDC, an RN reviewed Ms. OCHOA's transfer summary, which did not include any diagnoses, but noted the following medications: Zyrtec, Tylenol, nasal spray, multivitamin, Colace, terazosin, amoxicillin, and naproxen. The RN completed Ms. OCHOA's intake screening, using clinic staff as a Spanish interpreter, and Ms. OCHOA reported her gall bladder was removed four days ago, admitted to history of spousal physical and sexual abuse

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three years ago, but denied medical and mental health conditions, and medications. Her VS were normal, and wt. was 106 lbs. The RN cleared Ms. OCHOA to GP and referred to the MHP for an evaluation.

On February 14, 2020, a licensed marriage and family counseling therapist - associate (LMFT-A) completed Ms. OCHOA's initial mental health evaluation. Ms. OCHOA reported her spouse [*reportedly ex-husband*] had raped her three years ago and stated she has not been able to sleep. Ms. OCHOA denied any pre-incarceration medical or mental health conditions. Her MSE was normal. The LMFT-A assessed Ms. OCHOA with PTSD, submitted a referral for a psychiatric evaluation, and recommended to continue with current medication and instructed Ms. OCHOA to follow up, as needed.

- An APP completed Ms. OCHOA's initial chronic condition evaluation. Ms. OCHOA reported gallbladder surgery a few days ago, but denied any other medical or mental health conditions, or current complaints, except weakness, insomnia, and that her last menstrual period was four months ago. Her VS were normal, except a P of 112 bpm, and wt. of 105 lbs. Exam: yellow sclera and skin. The APP's assessment was 1) unspecified jaundice, 2) post cholecystectomy, 3) anorexia, and 4) PTSD. The APP ordered one liter of normal saline intravenously for rehydration, continue previous medication, Ensure with additional fruit tray, and the following tests: CBC, UA, hepatitis panel, amylase, lipase.

February 15 - 17, 2020, Ms. OCHOA refused her terazosin medication, and signed a refusal form.

On February 17, 2020, an APP evaluated Ms. OCHOA for chronic condition follow up. Ms. OCHOA denied any complaints, except decreased appetite. VS normal, except P of 124 bpm, and wt. of 99 lbs. Abnormal laboratory tests results were: white blood cells (WBC) 3.2/microliter (mcL) (normal 4.0 – 11.0/mcL), hemoglobin 10.0 g/dL (normal 12-16 g/dL), hematocrit 30 percent (%) (normal 37 - 47%), creatinine .37 mg/dL (normal .6 – 1.2 mg/dL), albumin 2.1 g/dL (normal 3.5 – 5.5 g/dL), total bilirubin 3.2 mg/dL (normal 0.2 – 1.2 mg/dL), alkaline phosphatase 1006 IU/L (normal 44-147 IU/L), AST 917 mcg/L (normal 10 – 40 mcg/L), ALT 194 mcg/L (normal 7 – 56 mcg/L), amylase 130 mcg/L (normal 30 – 110 mcg/L), and lipase 1226 mcg/L (normal 0-160 mcg/L). The APP's assessment was obstructive jaundice, pancreatitis, and s/p cholecystectomy - day five; ordered repeat CMP, amylase, and lipase, and instructions to consider referral to ED, if laboratory results are increased.

On February 18, 2020, an APP referred Ms. OCHOA to THHH for abdominal pain, N/V, and elevated laboratory results. The THHH's ED MD admitted Ms. OCHOA as in-patient for abdominal pain with N/V, elevated liver enzymes (alkaline phosphate – 1424 IU/L, AST – 1275 mcg/L, ALT – 196 mcg/L), acute pancreatitis, and s/p cholecystectomy.

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- The PDC psychiatrist reviewed Ms. OCHOA's medical record, but was unable to complete an evaluation for medication management, because she was inpatient at THHH.

February 19 – 28, 2020, Ms. OCHOA remained at THHH and received specialty consults, i.e., cardiology, gastroenterology, and diagnostic testing. Her VS were stable, except a P of 102 bpm, temperature (T) of 99.5 degrees (°) Fahrenheit (F) (normal 97.8 - 99.1° F), and oxygen saturation [(SpO2); fraction of oxygen saturated hemoglobin in the blood] of 92% (normal 95 - 100 %). The following are Ms. OCHOA's procedure results:

- Abdominal computed tomography (CT) scan: findings could be related to pancreatitis; however, this is less likely; mild hepatomegaly (enlarged liver); hypodense (abnormal) focus involving the right adnexa (appendages of the uterus), which could be related to a prominent ovarian cyst, bilateral atelectasis (partial collapse of lung) with trace left pleural effusion (build-up of fluid in the lining of the lungs).
- Liver biopsy: moderate diffuse macro vesicular steatosis (abnormal retention of fat within the liver) with mild periportal hepatitis without fibrosis (thickening and scarring of connective tissue).
- Chest x-ray: mild atypical pneumonitis (inflammation of the lungs) and mild diffuse bilateral alveolar disease.

February 29 – March 3, 2020, Ms. OCHOA's condition improved, VS were stable, and discharge was anticipated on March 4, 2020. During this time frame, a gastroenterologist evaluated Ms. OCHOA, noting an unremarkable exam, except positive jaundice, abnormal laboratory results (AST – 904 mcg/L, ALT – 112 mcg/L, alkaline phosphate – 501 IU/L, and bilirubin – 10 mg/dL), and liver biopsy.

On March 4, 2020, during the hospital discharge process, Ms. OCHOA presented weak and incontinent of urine; therefore, the discharge was halted.

On March 5, 2020, at approximately 7:45 p.m., Ms. OCHOA had difficulty breathing, an elevated P of 168 bpm, elevated lactic acid level of 8.4 millimoles (mmol)/L (normal 0.5 – 1 mmol/L) and was transferred to the progressive intensive care unit (PICU). Cardiology was consulted. Later this day, Ms. OCHOA experienced seizure-like activity, and she was emergently transferred to the neuro critical care ICU.

On March 6, 2020, at 12:05 a.m., Ms. OCHOA required intubation and placement on a ventilator. Her blood pressure (BP) was 81/50 millimeters of mercury [(mmHg); normal 90/60 – 120/80 mmHg], and her condition continued to worsen.

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- At 9:53 a.m., Ms. OCHOA was diagnosed with pneumonia, septic shock, hyperbilirubinemia, elevated liver enzymes, SVT, ARS, seizure, cardiomyopathy, thrombocytopenia, and organ failure.
- At 11:10 a.m., Ms. OCHOA's lactic acid level was greater than 13.0 mmol/L.
- At 2:53 p.m., Ms. OCHOA's urine culture was positive for staphylococcus aureus (bacteria), and her abdominal CT scan results revealed ascites (accumulation of fluid in abdominal cavity). Ms. OCHOA was diagnosed with bacteremia (bacteria in the blood), pneumonia, and intravenous antibiotics were initiated.
- At 9:10 p.m., Ms. OCHOA was diagnosed with widespread infection [(sepsis); a life-threatening condition when the body's response to infection causes injury to its own tissues and organs], and placed on renal dialysis, but was discontinued due to treatment failure.

☐ **On March 7, 2020**, Ms. OCHOA's condition continued to deteriorate, and showed impaired temperature regulation, multi-organ system failure, and no evidence of brain activity.

On March 8, 2020, Ms. OCHOA experienced cardiac arrest three times with unsuccessful resuscitation, and was pronounced dead at 8:45 a.m.

The final autopsy report revealed Ms. OCHOA's cause of death was liver failure due to complications of probable acute viral hepatitis and ruled her manner of death as natural.

ICE detention standards used for this review were: ICE Performance-Based National Detention Standards (PBNDS) 2011, revised in December 2016, and the American Correctional Association (ACA) Standards Supplement, 2014. The following are identified program strengths, weaknesses, and recommendations found.

Strengths

(b)(5)

Weaknesses

(b)(5)

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(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.J. *Medical and Mental Health Screening of New Arrivals*.
- ACA standard: 4-ALDF-4C-22, *Health Screens*.
- KCDC policy: E-02, *Receiving Screening*.
- KCDC policy: E-04, *Initial Health Assessment*.

2. Transfer summary.

(b)(5)

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Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section BB.4. *Transfer and Release of Detainees*.
- PBNDS 2011: 7.4., *Detainee Transfers*.
- PBNDS 2011: 4.3, Medical Care; section V. Z. *Continuity of Care*.

3. Appropriateness of care.

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(b)(5); (b)(6); (b)(7)(C)

(b)(5); (b)(6); (b)(7)(C)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes.*
- PBNDS 2011: 4.3, Medical Care; section V. Z. *Continuity of Care.*

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- PBNDS 2011: 4.3, Medical Care; section V.P. *Referrals for Sexual Abuse Victims*.
- ACA standard: 4-ALDF-4D-02, *Provision of Treatment*.
- ACA standard: 4-ALDF-4C-07, *Treatment Plan*.
- KCDC policy: F-01, *Patients with Chronic Disease and other Special Needs*.

(b)(5)

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.N. *Medical/Psychiatric Alerts and Holds*.
- PBNDS 2011: 4.6, Significant Self-harm and Suicide Prevention; section V.G. *Communication*.

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- KCDC policy: F-03, *Mental Health Services*.
- KCDC policy: E-05, *Mental Health Screening and Evaluation*.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes*.
- PBNDS 2011: 4.3, Medical Care; section V.I. *Medical Personnel*.

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(b)(5)

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.S. *Sick Call*.
- KCDC: E-08, *Nursing Assessment Protocols and Procedures*.
- KCDC policy: E-07, *Non-Emergency Health Care Requests and Services*.
- Knox, Catherine. *Correctional Nursing: Scope and Standards of Practice. Patient Plan and Documentation*. American Nursing Association (2013).

7. Medication administration.

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(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V.G. *Pharmaceutical Management*.
- PBNDS 2011: 4.3, Medical Care; section V. U. *Delivery of Medication*.
- KCDC policy: D-01, *Pharmaceutical Operations*.

8. Access to care and language services.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section II. *Expected Outcomes*.
- PBNDS 2011: 4.3, Medical Care; section V.E. *Translation and Language Access for Detainees with Limited English Proficiency*.
- KCDC policy: A-01, *Access to Care*.

9. Hospital records.

(b)(5)

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Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section BB. *Medical Records*.
- KCDC policy: D-08, *Hospital and Specialty Care*.
- KCDC policy: A-08, *Health Records*.

10. Communication.

(b)(5)

Applicable standards of care for this finding:

- PBNDS 2011: 4.3, Medical Care; section V. Z. *Continuity of Care*.
- ACA standard: 4-ALDF-4C-07, *Treatment Plan*.
- PBNDS 2011:4.3, Medical Care; section EE.2. *Healthcare Internal Review and Quality Assurance*.

17. Incidental findings.

(b)(5)

Recommendations

(b)(5)

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(b)(5)



End of report.

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U.S. Immigration
and Customs
Enforcement

August 28, 2020

MEMORANDUM FOR: Stewart D. Smith, DHSc, FACHE
Assistant Director
ICE Health Service Corps

THROUGH: (b)(6); (b)(7)(C) MD (b)(6); (b)(7)(C) Deputy Assistant Director of Clinical Services/Medical Director
ICE Health Service Corps
(b)(6); (b)(7)(C) MS (b)(6); (b)(7)(C) Chief of Staff
ICE Health Service Corps
(b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C) Chief, Investigations Unit
ICE Health Service Corps

FROM: (b)(6); (b)(7)(C), RN (b)(6); (b)(7)(C) Investigator
ICE Health Service Corps

SUBJECT: Mortality Review – Report of Findings
Ramiro HERNANDEZ Ibarra, A097 743 041

Executive Summary:

On March 21, 2020, U.S. Immigration and Customs Enforcement (ICE) Health Service Corps (IHSC) received notification of the death of ICE detainee Ramiro HERNANDEZ Ibarra. Mr. HERNANDEZ, a 42-year-old Mexican male, was in ICE custody from January 15 – March 21, 2020, and assigned to Port Isabel Detention Center (PIDC) in Los Fresnos, Texas (TX), on the date of his death.

Prior to ICE custody, on December 20, 2019, Hidalgo County Sheriff's Office arrested Mr. HERNANDEZ on charges of assault. On December 21, 2019, Enforcement and Removal Operations (ERO) San Antonio encountered Mr. HERNANDEZ at the Hidalgo County Jail

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(HCJ) in Edinburg, TX, served him a Notice to Appear, form I-862, charging removability as an alien, present without admission or parole by an immigration officer. On January 15, 2020, HCJ released Mr. HERNADEZ to ERO San Antonio. ERO transferred Mr. HERNADEZ to PIDC for housing.

During Mr. HERNADEZ's custody at PIDC, he reported a history of diabetes mellitus [(DM); a chronic condition characterized by high blood sugar, because the body does not produce enough insulin to meet its needs] and hypertension [(HTN); a chronic condition characterized by high blood pressure]. Mr. HERNADEZ reported taking medications and denied any mental health conditions, or suicidal history. On January 16, 2020, an advanced practice provider (APP) completed Mr. HERNADEZ's physical examination, ordered his DM and HTN medications, laboratory studies, and an electrocardiogram [(EKG); measures the electrical activity of the heart].

On March 18, 2020, at approximately 11:14 p.m., Mr. HERNADEZ's housing officer requested medical assistance over the radio, after he witnessed Mr. HERNADEZ's multiple episodes of vomiting. The shift captain (Capt.), custody officers (COs), two registered nurses (RN), and a licensed vocational nurse (LVN) arrived on the scene, assessed Mr. HERNADEZ, and transported him to the medical clinic for further evaluation. Because Mr. HERNADEZ continued with nausea, vomiting, and diarrhea, the medical staff notified the on-call APP, who gave a verbal order to place Mr. HERNADEZ in the medical housing unit (MHU) for observation. At approximately 5:25 a.m., a control center officer radioed for medical assistance after he witnessed, via video surveillance, Mr. HERNADEZ fall in his cell and hit his head on the sink and wall. Shortly thereafter, several nursing staff and COs arrived to Mr. HERNADEZ's cell. Mr. HERNADEZ reported having flank pain and requested ibuprofen. The RN assessed Mr. HERNADEZ, did not observe any injuries, and called the on-call APP, who gave a verbal order to transfer Mr. HERNADEZ to Valley Baptist Medical Center (VBMC) in Harlingen, TX, for further evaluation. Emergency medical services (EMS) arrived at approximately 5:52 a.m., observed Mr. HERNADEZ as alert and oriented, with normal respirations, flank and lower back pain, and transported him to VBMC.

A VBMC medical doctor (MD) evaluated Mr. HERNADEZ, diagnosed him with nausea, vomiting, shortness of breath, and altered mental status, requiring subsequent admission. Mr. HERNADEZ became hypothermic (low temperature), hypotensive (low blood pressure), suffered metabolic acidosis (condition where too much acid accumulates in the body), electrolyte imbalance, and respiratory failure. The MD ordered emergent hemodialysis (a treatment to filter wastes and water from the body), subsequent dialysis therapy, intubation for Mr. HERNADEZ's impending respiratory failure and confusion, and transferred him to the intensive care unit (ICU). Mr. HERNADEZ eventually suffered multi-organ failure and became unresponsive. VBMC suspected possible septic shock (widespread infection causing organ failure) versus multifactorial hypovolemic shock (a medical emergency in which blood volume drops to a dangerous level) and suspected his condition to be related to metformin (medication

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used to treat diabetes) overdose. On March 21, 2020, Mr. HERNANDEZ's condition deteriorated, and he no longer tolerated dialysis treatments. At approximately 5:46 a.m., Mr. HERNANDEZ expired while on ventilatory support, and a VBMC medical doctor (MD) pronounced him deceased. An autopsy was requested, but not completed, because IHSC could not locate a medical examiner who would accept the case and perform the exam.

Mortality Finding:

As a result of Mr. HERNANDEZ's death, the IHSC Assistant Director requested a mortality review to learn from his death by reviewing the care provided and the circumstances leading up to his death. The goal of the mortality review is to determine the appropriateness of clinical care; ascertain whether changes to policies, procedures, or practices are warranted; and identify issues that require further study.

A mortality review committee (MRC) unanimously determined that Mr. HERNANDEZ's medical care at PIDC was not provided within the safe limits of practice. Specifically, the MRC determined PIDC's care or lack thereof, could pose a significant future risk. Overall findings identified were: 1) PIDC nursing staff did not complete nursing assessments to document Mr. HERNANDEZ's symptoms, 2) poor documentation of the care provided to Mr. HERNANDEZ, and 3) the nursing staff failed to refer Mr. HERNANDEZ to a higher level of care for his worsening symptoms.

The MRC convened on July 16, 2020, and consisted of the following members:
Eugene Charbonneau, Doctor of Osteopathic Medicine (DO), Houston Detention Center's Clinical Director, physician reviewer; Lieutenant Commander (LCDR) (b)(6); (b)(7)(C) Physician Assistant - certified, advanced practice provider (APP) reviewer; Lieutenant (LT) (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Health Care Risk Management Program Manager, risk management reviewer; Captain (CAPT) (b)(6); (b)(7)(C) registered nurse (RN), Chief Nurse, nurse reviewer; and Commander (CDR) (b)(6); (b)(7)(C), Behavioral Health Consultant, mental health reviewer.

The following summary of events was based on: (b)(5)

(b)(5)

(b)(5) (b)(6); (b)(7)(C) (b)(5)

(b)(5) (b)(6); (b)(7)(C) (b)(5)

(b)(5)

Summary of Events

On January 15, 2020, an LVN completed Mr. HERNANDEZ's medical intake screening. Mr. HERNANDEZ reported a history of DM and HTN, controlled with medications, but could not

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recall the medication names. He denied pain, discomfort, mental health illness or history of suicide. His vital signs (VS) were normal except for an elevated blood pressure (BP) of 145/91 millimeters of mercury [(mmHg); normal range 90/60 – 120/80] and an elevated blood sugar (BS) of 175 milligrams/deciliter [(mg/dl); normal range 70 – 100 mg/dl].

On January 16, 2020, an APP completed Mr. HERNANDEZ's physical examination. Mr. HERNANDEZ reported a five-year history of DM, HTN, and taking metformin 1000 mg, one tablet by mouth, two times daily. Mr. HERNANDEZ did not recall the name of his HTN medication(s). The APP ordered Mr. HERNANDEZ the following medications: metformin 1000 mg, one tablet by mouth, two times daily, lisinopril (anti-hypertensive medication) 20 mg daily, ammonium lactate cream for dry skin, an EKG, and laboratory studies for DM and HTN.

On February 7, 2020, an APP completed Mr. HERNANDEZ's chronic care evaluation, reviewed his laboratory results, that showed normal results, except for elevated lipids (triglycerides - 341 mg/dl; normal level less than 150 mg/dl), glucose (123 mg/dl), hemoglobin A1C (9.4 percent) [(%); the average level of blood sugar over the past two to three months; normal level is less than 6.0 %], and trace protein and ketones (by-products of the breakdown of fatty acids) in his urine. Mr. HERNANDEZ complained of left flank (area on side of the body between abdomen and the back) pain, reported past kidney issues, and decreased water intake. The APP prescribed Mr. HERNANDEZ atorvastatin (medication used to treat elevated cholesterol and triglyceride levels) 10 mg, one tablet by mouth, daily; Pedialyte (rehydration mixture for treatment of dehydration); and instructed him to increase his fluid intake.

On February 7, 9, 12, 15, and 16, 2020, Mr. HERNANDEZ refused his lisinopril and metformin medications. The nursing staff notified the APP of Mr. HERNANDEZ's medication non-compliance. An APP educated Mr. HERNANDEZ on February 7, 2020, on the importance of his medication compliance; however, there is no documentary evidence that a medical provider counseled Mr. HERNANDEZ after that date.

Between February 13 – 17, 2020, an RN and APP evaluated Mr. HERNANDEZ for acute left flank pain, radiating to his lower back. On February 17, 2020, Mr. HERNANDEZ reported having pain with ambulation, movement, and no relief with pain medication. An RN noted Mr. HERNANDEZ's difficulty with ambulation, notified the on-call provider, and received a verbal order to transfer Mr. HERNANDEZ to VBMC emergency department (ED), via EMS for evaluation.

On February 18, 2020, a VBMC MD evaluated and diagnosed Mr. HERNANDEZ with low back pain and a urinary tract infection (UTI).

- At approximately 1:52 a.m., the MD discharged Mr. HERNANDEZ with the following medications: cephalexin (antibiotic), cyclobenzaprine (muscle relaxer), and ibuprofen (pain reliever).

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- At approximately 4:00 a.m., Mr. HERNADEZ returned to PIDC and an RN evaluated him, reviewed his VBMC discharge summary, and contacted the on-call provider. An APP gave a verbal order to start sulfamethoxazole/trimethoprim (antibiotic), ibuprofen, and to house Mr. HERNADEZ in the MHU for observation.
- At approximately 2:26 p.m., an APP evaluated Mr. HERNADEZ in the MHU. Mr. HERNADEZ requested to return to the dorm with keep-on-person (KOP) medications versus direct observation on pill line, due to his difficulty with ambulation. He denied having back pain, dysuria (painful urination), hematuria (blood in urine), chills, or sweats. The APP discharged Mr. HERNADEZ from the MHU with KOP medications, despite Mr. HERNADEZ's previous history of non-compliance to medications.

On February 24, 2020, an APP completed Mr. HERNADEZ's post MHU discharge follow up evaluation. Mr. HERNADEZ reported having lower back pain, due to cold weather. The APP reviewed Mr. HERNADEZ's VBMC laboratory and imaging studies, documented Mr. HERNADEZ's resolved UTI, normal gait, full range of motion, and lower back tenderness with palpation to area. The APP ordered Mr. HERNADEZ tramadol (pain reliever) 50 mg, two times daily, as needed, encouraged him to increase his water intake, and authorized a lower bunk with an extra mattress.

On March 18, 2020, at approximately 11:14 p.m., Mr. HERNADEZ's housing officer requested medical assistance over the radio after he witnessed Mr. HERNADEZ's multiple episodes of vomiting at his bedside and in the bathroom. The shift Capt., COs, two RNs, and an LVN arrived on the scene. Another detainee reported Mr. HERNADEZ swallowed some pills and gave the officer a note, which contained two names, telephone numbers, and Mr. HERNADEZ's apology. *[Investigator's note: none of the COs were able to identify the detainee or acknowledge receiving the note.]* The housing officer informed the medical staff that Mr. HERNADEZ allegedly ingested several pills. The medical staff assessed Mr. HERNADEZ in the dorm, witnessed an episode of vomiting, and transported him to the medical clinic, via wheelchair.

- At approximately 11:35 p.m., an RN evaluated Mr. HERNADEZ in the urgent care room. A CO gave Mr. HERNADEZ's bag of medications to the RN and the RN observed an empty metformin bottle, but Mr. HERNADEZ denied taking any medications. Mr. HERNADEZ reported non-compliance with his DM medication for a few days and last meal of Hot Cheetos with subsequent diarrhea (five bowel movements). Mr. HERNADEZ denied having any other symptoms. The RN noted normal VS, except for a slightly elevated heart rate of 109 beats per minute [(bpm); normal 60-100 bpm] and an elevated blood sugar of 205 mg/dl. The RN notified the on-call APP, received a verbal order to admit Mr. HERNADEZ into the MHU, administer oral and intramuscular medications to treat his nausea and vomiting, and encourage oral hydration. *[Investigator's note: The RN did not report the possible overdose to the on-call APP.]*

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On March 19, 2020, PIDC's MHU video surveillance footage showed an RN transferred Mr. HERNADEZ from the urgent care room to the MHU via wheelchair. Mr. HERNADEZ independently transferred himself from the wheelchair to the bed. While in the bed, Mr. HERNADEZ presented as restless, alternately moving from the head to the foot of the bed.

- At approximately 4:58 a.m., Mr. HERNADEZ stumbled to the toilet with an unsteady gait, lost his balance, and placed his hands on the floor to prevent falling. As he stood up from the toilet with an unsteady gait, he stumbled back to his bed with his pants around his ankles and pulled up his pants after lying on the bed.
- At approximately 5:08 a.m., Mr. HERNADEZ attempted to ambulate to the toilet but stumbled and fell to the ground. Approximately thirty seconds later, a CO entered the room, noticed Mr. HERNADEZ lying on the floor, briefly spoke to him, and Mr. HERNADEZ crawled back to the bed. Shortly thereafter, an RN came to the doorway but did not assess Mr. HERNADEZ.
- At approximately 5:17 a.m., an RN administered Mr. HERNADEZ ibuprofen 400 mg, by mouth for flank and back pain. Throughout the night, Mr. HERNADEZ ambulated multiple times to the toilet in his cell.
- At approximately 5:26 a.m., Mr. HERNADEZ ambulated to the toilet again with an unsteady gait and fell to the floor. After a few minutes, Mr. HERNADEZ sat up, dazed, and crawled back to the bed.
- At approximately 5:28 a.m., three nurses and a CO arrived to Mr. HERNADEZ's cell, attempted to obtain his VS, but Mr. HERNADEZ presented confused, restless, and constantly moving his extremities.
- At approximately 5:37 a.m., during video surveillance monitoring, a control center officer witnessed Mr. HERNADEZ fall and hit his head on the wall and sink, and radioed for medical assistance. A few seconds later, medical staff and COs arrived. Mr. HERNADEZ reported 9 out of 10 [(normal range 0 (pain free) - 10 (severe pain))] flank pain and requested ibuprofen. The RN documented no injuries; however, review of the video surveillance footage did not indicate the RN completed Mr. HERNADEZ's assessment. After COs assisted Mr. HERNADEZ up from the ground, Mr. HERNADEZ ambulated a couple of steps, then fell backwards. The COs assisted him to the floor, and the nursing staff attempted to obtain his vital signs, but to no avail, due to Mr. HERNADEZ's continued movement of his extremities. The COs assisted Mr. HERNADEZ to the bed.
- An RN notified the on-call APP and received a verbal order to transfer Mr. HERNADEZ to VBMC for further evaluation.

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- At approximately 5:45 a.m., EMS arrived, observed Mr. HERNADEZ alert oriented, with normal respirations, but with flank and lower back pain.
- At approximately 5:56 a.m., EMS departed PIDC.
- At approximately 6:49 a.m., VBMC ED personnel evaluated Mr. HERNADEZ, ordered laboratory and radiology studies, which showed Mr. HERNADEZ had severely impaired kidney function and severe metabolic acidosis. His VS were normal, except for a low BP of 81/44 mmHg.
- At approximately 8:10 a.m., a PIDC RN informed the VBMC ED medical staff of Mr. HERNADEZ's potential ingestion of "a lot" of pills, but did not provide the names or number of pills ingested. However, the RN provided Mr. HERNADEZ's KOP medication list and noted empty bottles of metformin, lisinopril, and ibuprofen.
- At approximately 9:36 a.m., while in the ED, Mr. HERNADEZ's condition worsened, and he developed altered mental status, hypotension (92/61 mmHg), hypothermia (rectal temperature of 88.6 degrees (°) Fahrenheit [(F); normal range is 98.6-100.6°F], and shortness of breath, requiring ICU admission and intubation, due to impending respiratory failure and confusion. The MD ordered antibiotics, vasopressors (medications used to stabilize low blood pressure levels), and a nephrology consult.
- At approximately 6:31 p.m., a nephrologist diagnosed Mr. HERNADEZ with kidney failure, severe metabolic acidosis, and ordered hemodialysis.

On March 20, 2020, at approximately 1:15 a.m., Mr. HERNADEZ's condition improved and his BP readings increased within normal limits; however, he remained on antibiotics, epinephrine (for blood pressure support), and continued dialysis.

- At approximately, 5:15 a.m., Mr. HERNADEZ's condition worsened.
- At approximately 9:15 a.m., Mr. HERNADEZ became unresponsive, in kidney failure, and in critical condition with imminent death. The VBMC medical staff contributed Mr. HERNADEZ's condition as a result of metformin overdose.
- At approximately 4:20 p.m., a VBMC MD informed IHSC of Mr. HERNADEZ's multi-organ failure and unresponsiveness.

On March 21, 2020, at approximately 12:30 a.m., Mr. HERNADEZ continued to decompensate, and he no longer tolerated his dialysis treatments.

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- At approximately 5:46 a.m., Mr. HERNADEZ expired while on ventilatory support, and a VBMC MD pronounced him dead.

Mr. HERNADEZ's death certificate showed the cause of death was due to multi-organ failure related to metformin overdose. An autopsy was requested, but not completed, because IHSC could not locate a medical examiner who would accept the case and perform the exam.

CDR (b)(6); (b)(7)(C), Behavioral Health Consultant, performed Mr. HERNADEZ's psychological autopsy (procedure for analyzing the cause of death by reconstructing what the person thought, felt, and did before death, based on gathered information). The final psychological autopsy report is pending.

ICE detention standards used for this review: ICE Performance-based National Detention Standards (PBNDS) 2011. The following are identified program strengths, weaknesses, and recommendations found during this review.

Strengths

Strengths identified during this investigation were (b)(5)

(b)(5)

Weaknesses

(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011, Medical Care., section T. *Emergency Medical Services and First Aid.*
- IHSC Operations Memorandum (OM), 16-027, *Clinical Nursing Guidelines (Interim RN Guidelines).*

2. Patient assessments.

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(b)(5)

Applicable standards of care for this finding:

- IHSC OM, 16-027, *Clinical Nursing Guidelines (Interim RN Guidelines)*.
- IHSC Directive, 02-08, *Refusal of treatment*.
- National Commission on Correctional Health Care (NCCHC), J-E-09, *Continuity, Coordination, and Quality of Care During Incarceration*.

3. Documentation.

(b)(5)

Applicable standards of care for this finding:

- IHSC OM, 16-027, *Clinical Nursing Guidelines (Interim RN Guidelines)*.
- IHSC OM, 16-022, *IHSC Health Records Management*.
- NCCHC, J-A-08, *Health Records*.

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(b)(5)

Applicable standards of care for this finding:

- ICE PBNDS 2011, Medical Care., section BB. 4. *Transfer and Release of Detainees.*
- IHSC OM, 16-027, *Clinical Nursing Guidelines (Interim RN Guidelines).*
- ICE PBNDS 2011, Detainee Transfers., C. *Responsibilities of the Health Care Provider at the Sending Facility.*
- NCCHC, J-B-08, *Patient Safety.*
- NCCHC, J-D-08, *Hospital and Specialty Care.*
- NCCHC, J-E-09, *Continuity, Coordination, and Quality of Care during Incarceration.*

Recommendations

(b)(5)

End of report.

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