



Office of Information Governance and Privacy

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



U.S. Immigration
and Customs
Enforcement

December 11, 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
Second Interim Production**

Dear Mr. Evers:

This letter is the second 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 500 pages of records were reviewed for this interim production. The 500 pages of records were located pursuant to a search of the ICE, Office of Professional Responsibilities (OPR). Of those 500 pages, ICE determined that 68 pages were deemed nonresponsive. The remaining 432 pages of records have been marked 2020-ICLI-00057-147 through 2020-ICLI-00057-578. Upon review, ICE has determined that portions of the 432 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

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client based upon, and thus reflecting, those facts, as well as communications between attorneys 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,

ROLANDO VELASCO JR

Digitally signed by
ROLANDO VELASCO JR
Date: 2020.12.11
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Senior Paralegal, ICE FOIA for
Fernando Pineiro Jr.
(A)FOIA Officer

Enclosure(s): 432 page(s)

cc:

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Civil Division
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U.S. Immigration
and Customs
Enforcement

FEB 24 2020

MEMORANDUM FOR: Enrique M. Lucero
Executive Associate Director
Office of Enforcement and Removal Operations

THROUGH: (b)(6); (b)(7)(C)
Associate Director

FROM: (b)(6); (b)(7)(C)
Division Chief, Inspections and Detention Oversight

SUBJECT: Detainee Death Review Findings – Abel REYES-Clemente
(b)(7)(E)

The U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) has completed its review of the facts and circumstances surrounding the death of ICE detainee Abel REYES-Clemente (REYES), who died on April 3, 2019, while in the custody of ICE at Florence Service Processing Center (FSPC) in Florence, Arizona (AZ). The Pinal County Medical Examiner's Office documented REYES's cause of death as complications of liver cirrhosis,¹ diabetes mellitus,² and hypertensive cardiovascular disease,³ and that the manner of death was natural.⁴

Abbreviated Chronology⁵

REYES was apprehended near the Arizona-Mexico border and was granted voluntarily return to Mexico on five occasions. On January 8, 2017, the Phoenix Police Department arrested REYES for driving under the influence, driving without insurance, and driving without a valid driver's license.

On January 14, 2019, REYES self-surrendered to the Maricopa County Sheriff's Office Lower Buckeye Jail in Maricopa, AZ pursuant his conviction for driving under the influence.

On February 26, 2019, the Maricopa County Sheriff's Office Lower Buckeye Jail in Maricopa, AZ, released REYES to the custody of the ICE Office of Enforcement and Removal Operations

¹ Liver cirrhosis is a condition in which the liver does not function properly due to long-term damage.

² Type 2 diabetes is a condition that causes blood glucose to rise higher than normal.

³ Hypertensive cardiovascular disease refers to heart conditions caused by high blood pressure and affects the way the body processes blood glucose.

⁴ See Pinal County Forensic Examination Report, dated April 25, 2019.

⁵ See accompanying Detainee Death Review for complete chronology.

(ERO) Phoenix Field Office (ERO Phoenix). ERO Phoenix served REYES with a Notice to Appear (Form I-862) and transferred him to the Florence Staging Facility (FSF) in Florence, AZ.

On February 26, 2019, REYES arrived at FSF. On February 27, 2019, a Registered Nurse (RN) conducted REYES's medical pre-screening assessment. Later that day, an RN conducted REYES's medical and mental health intake. REYES reported he was diagnosed with Type 2 diabetes mellitus three years prior and was taking metformin twice daily. REYES's vital signs were normal except for an elevated blood glucose fingerstick reading. The RN informed the Physician Assistant (PA) of REYES's medical history, and the PA ordered metformin twice daily as a keep on person (KOP) medication and Accu-checks twice daily, but no sliding scale insulin.

On February 28, 2019, the PA completed REYES's initial physical examination. In addition to Type 2 diabetes, REYES reported he was previously hospitalized with hyperglycemia, had a history of labile hypertension, and complained of restless legs syndrome. The PA ordered gabapentin and laboratory studies.

On March 20, 2019, FSPC transferred REYES to La Palma Correctional Center due to a varicella cohort at FSPC. On March 21, 2019, LPCC transferred REYES back to FSPC.

On April 1, 2019 at 11:07 a.m., the PA evaluated REYES for flu-like symptoms, including a fever, chills, sore throat, and cough. The PA documented REYES's heart rate and temperature were elevated. The PA diagnosed REYES with influenza, prescribed Tamiflu on pill line and Tylenol as KOP, and returned him to his housing unit.

At 3:04 p.m., a Control Officer called medical to report REYES was too sick to walk to the clinic and needed a wheelchair. At 3:22 p.m., a Licensed Practical Nurse (LPN) visited the housing unit and administered REYES his medication. Upon returning to the clinic, the LPN reported her observations of REYES to an RN. The RN informed the PA of REYES's limited mobility and strength; the PA then directed REYES's transfer to medical segregation.

On April 2, 2019 at 5:44 a.m., an RN saw REYES for morning pill pass. REYES reported feeling weak and needed assistance to sit up. The RN and an officer helped REYES sit up, opened his food tray, and gave him Tamiflu. The RN then took REYES's temperature and documented that it was 100 degrees.

At 12:08 p.m., an RN conducted a segregation nursing round. During the round, an officer informed the RN that REYES had been lying in his bunk all morning and had not showered. The RN asked REYES to exit the cell and go to the dayroom table. As REYES struggled to get up, the RN assisted him to the table. The RN took REYES's vital signs and determined his blood pressure was low, heart rate was slightly elevated, and pulse oxygen was extremely low. The RN had REYES walk around the dayroom and took his pulse oxygen again, which was still low. Upon returning to the clinic, the RN reported his findings to the PA. The PA later stated that he directed the RN to re-check REYES's pulse oxygen level after REYES took several deep breaths. However, according to the RN, the PA did not provide this direction.

At 2:57 p.m., the RN completed a chart review with the vital sign information from his 12:08 p.m. nursing round with REYES and documented his conversation with the PA but did not note the PA's orders to re-check REYES's pulse oxygen level.

At 4:42 p.m., the same RN conducted afternoon pill pass and noticed REYES sitting at the dayroom table. The RN administered REYES Tamiflu, gabapentin, metformin, and as-needed Tylenol.

On April 3, 2019 at 4:39 a.m., an RN conducted morning pill pass. The RN and an officer entered REYES's cell and the officer assisted REYES into an upright position. REYES refused his morning medication of Tamiflu. The RN took REYES's vital signs and determined his temperature was normal, heart rate was on the high end of normal, and pulse oxygen was slightly low.

At 6:07 a.m., an officer conducted a security round and noticed REYES was propped on the bed rail and appeared to be sleeping with his eyes partially open. The officer notified the shift lieutenant via telephone that REYES did not look well and had not eaten breakfast; the shift lieutenant then called the clinic, requesting medical staff report to medical segregation. An officer entered REYES's cell to check if he was okay, but he was unresponsive. Additional officers began to arrive at REYES's cell but did not initiate cardiopulmonary resuscitation (CPR).

At approximately 6:14 a.m., the Control Officer called a medical emergency. Within minutes of calling the code 10-10, another lieutenant arrived at medical segregation and directed officers to initiate CPR and radioed the control center to call 911. At 6:15 a.m., medical staff arrived at REYES's cell and assisted with CPR. Medical staff directed security officers to call 911 and requested the automated external defibrillator (AED). At 6:25 a.m., emergency responders arrived onsite and assumed CPR duties. At 6:33 a.m., emergency responders called the physician overseeing their actions, who pronounced REYES dead.

On April 4, 2019, the ERO Phoenix Field Office Director notified the Mexican consulate of REYES's death.

On April 25, 2019, the Pinal County Medical Examiner completed REYES's autopsy and documented the cause of death as complications of liver cirrhosis, diabetes mellitus, and hypertensive cardiovascular disease, and that the manner of death was natural.

Identified Deficiencies with ICE Detention Standards

ERAU reviewed the medical care REYES received while at FSPC, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. (b)(5)

(b)(5)

(b)(5)

(b)(5)

If you have any questions, please contact me or have a member of your staff contact OPR ERAU
Unit Chief (b)(6); (b)(7)(C) at (202) 73 (b)(6);

Enclosure

Abel REYES-Clemente Detainee Death Review Report



Detainee Death Review Report

Abel REYES-Clemente

Date of Death: April 3, 2019

Alien File Number: 215 881 614

Joint Integrity Case Management System (JICMS) Number: (b)(5); (b)(7)(E)

February 24, 2020

U.S. Immigration and Customs Enforcement
Office of Professional Responsibility

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DETAILS OF REVIEW

From May 7 to 9, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Florence Service Processing Center (FSPC) to review the circumstances surrounding Abel REYES-Clemente's (REYES) death. ERAU was assisted in its review by contract subject matter experts in correctional healthcare and security who are employed by Creative Corrections, a national management consulting firm.¹ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to REYES, in addition to conducting in-person interviews of individuals employed by FSPC, ICE Health Service Corps (IHSC) staff assigned to FSPC, and the local Office of Enforcement and Removal Operation (ERO) field office. REYES was detained at FSPC from February 26, 2019 through April 3, 2019, where he remained until his transfer to the hospital. The Pinal County Forensic Medical Examiner documented² REYES's cause of death as complications of liver cirrhosis,³ diabetes mellitus,⁴ and hypertensive cardiovascular disease.⁵

FACILITY PROFILE

FSPC is owned and managed by the ICE ERO Phoenix Field Office. FSPC is an ICE Service Processing Center and required to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. Medical care at FSPC is provided by IHSC and supported by contract company STG International (STG). Asset Protection and Security Services, LLP (Asset) provides custody and security services for FSPC. FSPC houses male detainees for periods in excess of 72 hours. On the day of REYES's death, FSPC was at capacity with 392 detainees.

IMMIGRATION AND CRIMINAL HISTORY

REYES was apprehended near the Arizona-Mexico border on five occasions; he was granted voluntary return to Mexico on the following dates: December 28, 1999; December 29, 1999; January 3, 2000; June 12, 2008; and July 7, 2008.⁶

On January 8, 2017, the Phoenix Police Department arrested REYES for driving under the influence, driving without insurance, and driving without a valid driver's license.⁷

On September 19, 2017, the Phoenix Municipal Court convicted REYES for driving under the influence and sentenced him to 10 days in jail.⁸ The Court also convicted REYES for extreme

¹ See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis.

² See Exhibit 2: Pinal County Forensic Examination Final Summary, date stamped April 29, 2019.

³ Liver cirrhosis is a condition in which the liver does not function properly due to long-term damage.

⁴ Type 2 diabetes is a condition that causes blood glucose to rise higher than normal and affects the way the body processes blood glucose.

⁵ Hypertensive cardiovascular disease refers to heart conditions caused by high blood pressure.

⁶ See EARM, Encounters.

⁷ See Arizona Traffic Ticket and Complaint, dated January 8, 2017.

⁸ See Federal Bureau of Investigation, Criminal History Record, dated April 3, 2019.

driving under the influence due to a blood alcohol concentration of greater than 0.20 and sentenced him to 135 days in jail and 36 months of probation.

On October 27, 2017, REYES failed to appear for his jail sentence and the Phoenix Municipal Court issued a warrant for his arrest.⁹

On November 8, 2018, REYES failed to appear for his jail sentence and the Phoenix Municipal Court issued a warrant for his arrest.¹⁰

On January 14, 2019, REYES self-surrendered to the Maricopa County Sheriff's Office Lower Buckeye Jail in Maricopa, AZ pursuant his conviction for driving under the influence.¹¹

On February 26, 2019, the Maricopa County Sheriff's Office Lower Buckeye Jail in Maricopa, AZ, released REYES into ERO Phoenix's custody. ERO Phoenix served REYES with a Form I-862, Notice to Appear, and transferred him to the Florence Staging Facility (FSF) in Florence, AZ.¹²

CHRONOLOGY OF EVENTS

February 27, 2019

At 12:14 a.m.,¹³ RN (b)(6); (b)(7)(C) conducted REYES's medical pre-screening assessment and documented REYES's appearance, behavior, and breathing were normal, and that he spoke Spanish.¹⁴ RN (b)(6); (b)(7)(C) ordered a chest X-ray, which was negative for active tuberculosis.¹⁵ Due to the language barrier, RN (b)(6); (b)(7)(C) only conducted a visual assessment of REYES and assigned him for priority intake screening.

At 4:30 a.m., an unknown officer admitted¹⁶ REYES into FSF.¹⁷ The officer inventoried REYES's personal property and listed a cellphone with battery, a Mastercard debit card,¹⁸ a Mexican

⁹ See Phoenix Municipal Court Petition to Revoke Probation Summons and Order for Warrant, dated October 27, 2017.

¹⁰ See Phoenix Municipal Court Petition to Revoke Probation Summons and Order for Warrant, dated November 8, 2018.

¹¹ See I-213, Record of Deportable/Inadmissible Alien, February 26, 2019.

¹² See Form I-862, Notice to Appear, dated February 26, 2019.

¹³ ERAU notes the IHSC eClinical Works (eCW) electronic medical record system documents separate timestamps for vital signs and electronic signatures. For this reason, ERAU was unable to determine when medical staff began their encounters with REYES. When citing medical entries within this report, ERAU utilized timestamps for vital signs or electronic signatures.

¹⁴ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated February 27, 2019.

¹⁵ See Radiology Report, dated February 27, 2019.

¹⁶ See Form I-385, Alien Booking Record, dated February 26, 2019. The officer, badge number (b)(6); (b)(7)(C) did not identify himself or herself by name on the form.

¹⁷ FSF is adjacent to FSPC. At FSF, officers conduct a detainee's classification assessment, determine housing assignment and inventory their property. Medical staff conduct a detainee's medical and mental health assessment. Once the intake process is complete, detainees are housed at FSPC.

¹⁸ See DHS Form 589, Property Receipt, dated February 26, 2019.

identification card,¹⁹ a wallet, eyeglasses, a photo album, personal clothing, and toiletries.²⁰ REYES signed a form acknowledging he did not arrive with any funds, viewed the detainee orientation video, and received the detainee handbook and the Sexual Assault and Abuse Prevention and Intervention pamphlet, both of which were available in English and Spanish.²¹

At 8:58 a.m., Deportation Officer (b)(6); (b)(7)(C) completed REYES's classification rating using the ICE Risk Classification Assessment and appropriately classified REYES as medium-low.²² Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) approved the classification rating later that day, at 1:32 p.m.

At approximately 9:44 a.m., RN (b)(6); (b)(7)(C) conducted REYES's medical and mental health intake assessment and documented²³ the following:

- REYES spoke fluent English.
- REYES reported he was diagnosed with Type 2 diabetes mellitus three years prior and was taking metformin (500 mg) twice daily.²⁴
- REYES denied a history of alcohol or illicit drug use, and other medical or mental health concerns.
- REYES's vital signs were within normal²⁵ limits except for an elevated blood glucose fingerstick reading of 144 milligrams per deciliter (mg/dl).

RN (b)(6); (b)(7)(C) called IHSC Commander (b)(6); (b)(7)(C) Physician Assistant (PA) to inform him of REYES's medical history. PA (b)(6); (b)(7)(C) verbally ordered metformin (500 mg) twice daily²⁶ as a KOP medication,²⁷ Accu-checks²⁸ twice daily, no sliding scale insulin,²⁹ and notification to a provider if REYES's blood glucose exceeded 400 mg/dl.³⁰ RN (b)(6); (b)(7)(C) documented she read back and verified the order; however, PA (b)(6); (b)(7)(C) did not sign the order to indicate he reviewed it. RN (b)(6); (b)(7)(C) educated REYES on obtaining access to medical care and the grievance process, and medically cleared him for custody. REYES signed the IHSC General Medical Consent Form.³¹

¹⁹ See FSF/FLO Identification Document Transmittal, dated February 27, 2019.

²⁰ See Detainee Personal Property Record, dated February 27, 2019.

²¹ See Detainee Summary Supplement Form, dated February 27, 2019.

²² See Risk Classification Assessment Detailed Summary dated February 27, 2019.

²³ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated February 27, 2019.

²⁴ Metformin is a diabetes medication used to control blood glucose levels.

²⁵ Normal temperature is 98.6 degrees; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; normal blood pressure is 120/80 or less; and normal pulse oximeter readings range from 95% to 100%. A normal blood glucose level ranges roughly from 90 to 130 mg/dl.

²⁶ See eCW Progress Note, no signature, date, or time.

²⁷ When ordered by a provider, patients receive a supply of KOP medications for self-administration per the instructions on the label. ERAU cannot determine when REYES received the KOP medications due to FSF's/FSPC's transition to an electronic Medication Administration Record (MAR) during his detention.

²⁸ Accu-check is a medical device used to obtain fingerstick blood glucose readings.

²⁹ An order for sliding scale insulin requires nurses to administer as-needed doses for blood glucose out of range.

³⁰ The Federal Bureau of Prisons (FBOP) Clinical Guidelines call for interventions for readings over 300 mg/dl. PA (b)(6); (b)(7)(C) stated 400 mg/dl is the set threshold for provider notification at FSPC.

³¹ See IHSC Medical Consent Form, dated February 27, 2019.

At 3:30 p.m., an unknown nurse conducted REYES's Accu-check, which read 123 mg/dl.³²

February 28, 2019

At approximately 8:02 a.m., PA (b)(6); (b)(7)(C) conducted REYES's initial physical examination and documented³³ the following:

- REYES spoke English fluently.³⁴
- REYES reported he was diagnosed with Type 2 diabetes three years ago and was hospitalized once for hyperglycemia.³⁵ He also reported taking metformin (500 mg) twice daily and visiting his doctor every three to four months.
- REYES reported a history of labile hypertension,³⁶ for which he was not receiving treatment.
- REYES complained of restless legs syndrome,³⁷ which he usually treated with compression wraps at home.
- REYES denied any pain, alcohol or drug abuse in the past 12 months, and any history of abuse or mental health disorders.
- REYES's vital signs were normal, his lungs were clear, and his heart rate and rhythm were normal.

PA (b)(6); (b)(7)(C) assessment findings were Type 2 diabetes, restless legs syndrome, fungus infection in the toenails, and a noncancerous growth to REYES's eye. PA (b)(6); (b)(7)(C) ordered gabapentin³⁸ (200 mg) daily in the evenings for 30 days and laboratory studies to be drawn on March 4, 2019, to include a complete blood count (CBC) with platelets and differential,³⁹ comprehensive metabolic panel (CMP),⁴⁰ lipid profile,⁴¹ hemoglobin A1c,⁴² and urinalysis for microalbumin creatinine ratio.⁴³ PA (b)(6); (b)(7)(C) documented the plan of care was to continue current medications, start gabapentin, complete the laboratory studies, and monitor REYES's blood pressure. If liver function results were normal, he would consider ordering an oral antifungal for the fungus infection on REYES's feet. PA (b)(6); (b)(7)(C) ordered a follow-up appointment in one week and cleared REYES for custody. PA (b)(6); (b)(7)(C) stated he expected nurses to notify a provider if eCW flagged

³² See MAR, dated February 2019. Nurses recorded Accu-check readings twice a day as ordered except for the mornings of February 28, 2019, and March 4, 2019, and the afternoon of March 17, 2019 (See MAR, dated March 2019).

³³ See eCW Progress Note by PA (b)(6); (b)(7)(C) dated February 28, 2019.

³⁴ ERAU notes PA (b)(6); (b)(7)(C) is fluent in Spanish and consequently would not have needed interpretation assistance if it were required.

³⁵ Hyperglycemia is high blood glucose.

³⁶ Labile hypertension describes fluctuations in blood pressure from normal to high.

³⁷ Restless legs syndrome is a condition that causes an uncontrollable urge to move the legs, usually causing an uncomfortable sensation at night.

³⁸ Gabapentin is a medication used to treat nerve pain and improve the symptoms of restless legs syndrome.

³⁹ CBC with differential and platelets is a blood test that provides doctors with information about the cells in a patient's blood, the concentration of various proteins and minerals, and the number of blood clotting cells.

⁴⁰ CMP is a blood test that provides doctors with information about the body's fluid balance, levels of electrolytes, and how well the kidneys and liver are working.

⁴¹ Lipid profile is a panel of blood tests that provides information about cholesterol and triglycerides.

⁴² Hemoglobin A1c is a blood test that provides a three-month average of glucose concentration in the blood.

⁴³ Urinalysis microalbumin creatinine ratio is a urine test to measure the amount of protein and kidney waste products in the urine.

REYES's blood pressure as elevated during future encounters.⁴⁴ According to PA (b)(6); (b)(7)(C), he did not order an electrocardiogram (EKG),⁴⁵ despite REYES's age and history of labile hypertension, because the current American Diabetic Association guidelines did not recommend EKGs for asymptomatic patients.

March 1, 2019

At 3:30 p.m., Officer (b)(6); (b)(7)(C) escorted REYES to FSPC housing, Jail Unit 1.⁴⁶

March 4, 2019

At approximately 7:56 a.m., RN (b)(6); (b)(7)(C) assessed REYES at sick call for chronic pain in his feet and documented⁴⁷ the following:

- She used interpretation services because REYES spoke Spanish.
- REYES complained of chronic pain in his feet and rated his pain level as eight on the standardized pain scale.⁴⁸
- REYES was alert and oriented, did not appear to be in acute distress, and his vital signs were within normal limits.
- REYES had dry, cracked skin on the top of his feet but no signs of an infection.
- RN (b)(6); (b)(7)(C) followed IHSC's Interim RN Guidelines for Wound Care and Pain, issued REYES antibiotic ointment, and directed REYES to return to sick call if symptoms worsened.

At 10:37 a.m., RN (b)(6); (b)(7)(C) notified PA (b)(6); (b)(7)(C) that REYES submitted a sick call request due to foot pain and gabapentin not controlling his pain; she asked PA (b)(6); (b)(7)(C) whether further care was necessary.⁴⁹ PA (b)(6); (b)(7)(C) did not document acknowledgement of the notification or issue new orders. IHSC Commander (b)(6); (b)(7)(C) Health Services Administrator (HSA), stated providers typically mark the notifications as reviewed to acknowledge receipt.⁵⁰

March 7, 2019

At approximately 7:52 a.m., PA (b)(6); (b)(7)(C) evaluated REYES for his follow-up appointment scheduled during the initial physical examination and documented⁵¹ the following:

- REYES's vital signs were within normal limits.

⁴⁴ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

⁴⁵ An EKG is a test that records the electrical signals in the heart to detect heart problems.

⁴⁶ See Florence Jail 1 Logbook, dated March 1, 2019.

⁴⁷ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated March 4, 2019.

⁴⁸ The standardized pain scale measures the level of discomfort on a scale of zero to ten, with zero being no pain and ten being the worst pain ever experienced.

⁴⁹ See Telephone Encounter by RN (b)(6); (b)(7)(C) dated March 4, 2019. Telephone encounters document nurses' electronic transmission of information to providers.

⁵⁰ See HSA (b)(6); (b)(7)(C) mail, dated May 8, 2019.

⁵¹ See eClinical Works Progress Note by PA (b)(6); (b)(7)(C) dated March 7, 2019.

- REYES complained of restless legs syndrome, which was affecting his sleep, and that the gabapentin was not helping.
- PA (b)(6); (b)(7)(C) reviewed the laboratory results he ordered on February 28, 2019.⁵² REYES's laboratory results were abnormal: creatinine was 0.59;⁵³ potassium was 3.4;⁵⁴ alkaline phosphatase was 153;⁵⁵ red blood cell count was 4.11;⁵⁶ hematocrit was 37.4;⁵⁷ and hemoglobin A1c was 6.1%.⁵⁸

PA (b)(6); (b)(7)(C) increased REYES's gabapentin dosage from 200 mg to 400 mg daily for 30 days, prescribed aspirin (81 mg) daily for 90 days, KOP, and scheduled REYES for a follow-up appointment in four weeks. REYES received the increased dosage of gabapentin as ordered by PA (b)(6); (b)(7)(C).⁵⁹ PA (b)(6); (b)(7)(C) stated although the laboratory results were outside of the normal range, none of the results were alarming, and he believed they were likely due to dehydration.⁶⁰ PA (b)(6); (b)(7)(C) further stated REYES's hemoglobin A1c was within treatment goals for Type 2 diabetes.

March 17, 2019

At approximately 3:12 p.m., REYES refused to go to medical for an Accu-check.⁶¹ RN (b)(6); (b)(7)(C) completed the IHSC Refusal Form printed in English and Spanish and documented the possible consequences for refusing an Accu-check as decreased therapeutic effect and worsening condition. RN (b)(6); (b)(7)(C) and REYES both signed the form, and IHSC Lieutenant Commander (b)(6); (b)(7)(C) Assistant HSA, co-signed the following day. Following the refusal, RN (b)(6); (b)(7)(C) notified PA (b)(6); (b)(7)(C) that REYES refused the afternoon Accu-check.⁶² PA (b)(6); (b)(7)(C) did not mark the notification as reviewed or issue new orders.

On this date, REYES also submitted an FSPC Detainee Request Form in Spanish stating he was having difficulties walking, and the medication was not working.⁶³

⁵² See Laboratory Report, received March 5, 2019.

⁵³ Creatinine is a waste product produced by muscles and removed from the body through the kidneys. Normal range is 0.76 – 1.27.

⁵⁴ Potassium is an electrolyte in the body that helps maintain fluid levels, helps with heart, nerve, and muscle functions, and moves nutrients through cells. Normal range is 3.5 – 5.2.

⁵⁵ Alkaline phosphate is an enzyme found in tissues throughout the body. Normal range is 39 – 117.

⁵⁶ Red blood cell count is a blood test used to determine how many red blood cells an individual has. Normal range is 4.14 – 5.80.

⁵⁷ Hematocrit is a blood test measuring the ratio of red blood cells to the total volume of blood. Normal range is 37.5 – 51.0.

⁵⁸ Hemoglobin A1c test measures the amount of blood glucose to hemoglobin. Hemoglobin carries oxygen in the blood. Normal hemoglobin A1c is 4.14% to 5.6%. The FBOP Clinical Guidelines set 7.5% or below as the treatment goal for older adults with diabetes.

⁵⁹ See MAR and sSMART MAR, dated March 2019. sSMART MAR is an electronic MAR. During REYES's custody at FSPC, IHSC was converting to the sSMART MAR; therefore, his medical record contained paper MARs and sSMART MARs.

⁶⁰ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

⁶¹ See IHSC Form 820-S, Refusal Form, dated March 17, 2019.

⁶² See Telephone Encounter by RN (b)(6); (b)(7)(C), dated March 17, 2019.

⁶³ See FSPC Detainee Request Form, dated March 17, 2019.

March 18, 2019

At an unknown time, Assistant HSA (b)(6); (b)(7)(C) replied to the Detainee Request Form informing REYES, in English and Spanish, to put his name on the sick call list if he did not feel well.⁶⁴

March 19, 2019

At approximately 1:47 p.m., RN (b)(6); (b)(7)(C) completed REYES's Transfer Summary to La Palma Correctional Center (LPCC), noting his current medications, diagnoses, laboratory results, and chest X-ray screening, and cleared REYES for travel.⁶⁵ Assistant Officer in Charge (AOIC) Shane Kitchen stated REYES and 59 other detainees were transferred to LPCC to vacate a housing unit for a varicella cohort.⁶⁶

March 20, 2019

At 6:45 a.m., transportation officers transferred 60 detainees, including REYES, to LPCC.⁶⁷

La Palma Correctional Center

At 1:17 p.m., RN (b)(6); (b)(7)(C) conducted REYES's medical intake screening, using Spanish interpretation services, and documented⁶⁸ the following:

- REYES's vital signs and blood glucose were normal.
- REYES was diabetic and reported bilateral knee pain with a pain level of three.
- REYES's medication prescriptions were metformin (500 mg) twice a day, gabapentin (400 mg) daily in the evenings, and aspirin (81 mg) twice a day. He arrived to LPCC with doses of metformin and aspirin.
- REYES denied suicidal ideation.

RN (b)(6); (b)(7)(C) cleared REYES for general population, made routine referrals to dental and mental health, and an urgent referral to a provider due to REYES's chronic medical conditions.

March 21, 2019

At 10:58 a.m., Family Nurse Practitioner (FNP) (b)(6); (b)(7)(C) conducted REYES's initial physical examination and documented⁶⁹ the following:

- REYES's vital signs were within normal limits.
- REYES reported his lower legs sometimes felt hot, but he currently felt well.

⁶⁴ See ICE Detainee Request Form, dated March 18, 2019.

⁶⁵ See eCW Progress Note, Transfer Summary by RN (b)(6); dated March 19, 2019.

⁶⁶ ERAU interview with AOIC Kitchen, dated May 7, 2019.

⁶⁷ See Florence Jail 1 Logbook, dated March 20, 2019.

⁶⁸ See LPCC Initial Intake Screening, dated March 20, 2019.

⁶⁹ See Inmate/Resident Health Appraisal Form, dated March 21, 2019.

- REYES was diagnosed with Type 2 diabetes and his last hemoglobin A1c reading was 6.1%.
- REYES's left great toenail was cut too short.

FNP (b)(6); (b)(7)(C) reviewed the FSPC laboratory results, decided to continue REYES on his current medication, and prescribed antibiotic ointment for the left toenail. Per REYES's request, FNP (b)(6); (b)(7)(C) stopped his Accu-checks and ordered follow-up laboratory studies and an EKG for June 7, 2019.

Florence Service Processing Center

At 9:13 p.m., transportation officers returned REYES and 46 other detainees to FSF.⁷⁰

At 11:46 p.m., RN (b)(6); (b)(7)(C) completed REYES's medical pre-screening assessment and documented that a transfer summary from LPCC was not available.⁷¹ She also documented REYES spoke Spanish and conducted a visual assessment of his appearance, behavior, and breathing, which were all normal. RN (b)(6); (b)(7)(C) listed his current medications and noted he did not arrive with medications. Due to the language barrier, RN (b)(6); (b)(7)(C) designated REYES for priority intake screening.

March 22, 2019

At 2:23 a.m., Officer (b)(6); (b)(7)(C) escorted 10 detainees, including REYES, to Echo Pod.⁷²

At approximately 3:39 a.m.,⁷³ RN (b)(6); (b)(7)(C) completed REYES's intake screening and documented⁷⁴ the following:

- REYES spoke Spanish but also spoke English fluently.
- REYES's current diagnoses were diabetes and neuropathy.⁷⁵
- REYES arrived to FSPC with the following prescribed medications: aspirin (81 mg) daily; gabapentin (400 mg) daily; and metformin (500 mg) twice a day.⁷⁶
- REYES's vital signs were within normal limits but he had an elevated blood glucose reading of 160 mg/dl.

RN (b)(6); (b)(7)(C) categorized REYES's intake screening as abnormal and referred him for a physical examination the same day. RN (b)(6); (b)(7)(C) sent a Telephone Encounter to PA (b)(6); (b)(7)(C) listing REYES's

⁷⁰ See LPCC to FSF Logbook, dated March 21, 2019.

⁷¹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated March 21, 2019.

⁷² See Echo Logbook, dated March 22, 2019.

⁷³ ERAU notes it is unknown the exact time REYES went to medical. Echo Logbook indicates that at 2:30 a.m. a detainee went to medical, but it does not state the detainee's name.

⁷⁴ See Intake Screening, dated March 22, 2019.

⁷⁵ Neuropathy is a condition that is common among people with diabetes and causes weakness, numbness, and tingling in the hands and feet.

⁷⁶ ERAU notes this information is inconsistent with RN (b)(6); (b)(7)(C) encounter on March 21, 2019 at 11:46 p.m. ERAU was unable to confirm through documentation review or interviews whether REYES arrived to FSPC with medications.

current medications.⁷⁷ PA (b)(6); (b)(7)(C) did not document acknowledgment of the notification or issue orders to restart medications. During an interview, HSA (b)(6); (b)(7)(C) stated REYES would not have received gabapentin, metformin, or aspirin without a provider order; furthermore, any medication REYES arrived to FSPC with should have been confiscated by security officers and turned over to medical.⁷⁸

March 25, 2019

At approximately 9:29 a.m., PA (b)(6); (b)(7)(C) conducted REYES's physical examination and documented⁷⁹ the following:

- REYES's last physical examination at FSPC was on January 28, 2015,⁸⁰ and there had been no changes since that time.
- REYES denied being in any pain.
- REYES's vital signs were elevated: his heart rate was 105 beats per minute; his temperature was 100.5 degrees tympanic,⁸¹ and his fingerstick blood glucose was 306 mg/dl⁸².

PA (b)(6); (b)(7)(C) re-checked REYES's temperature, by mouth, which was 98.3 degrees. PA (b)(6); (b)(7)(C) started REYES on gabapentin again through pill line and prescribed aspirin and metformin as KOP, all with the previously prescribed doses and frequencies.⁸³ PA (b)(6); (b)(7)(C) discontinued blood glucose monitoring and ordered a follow-up appointment in four weeks. PA (b)(6); (b)(7)(C) stated he was not concerned about REYES's elevated blood glucose because it was likely due to a missed dose of metformin during the transfer process; he ultimately decided to discontinue blood glucose monitoring because REYES's hemoglobin was within normal limits.⁸⁴

March 26, 2019

At 8:24 a.m., Licensed Practical Nurse (LPN) (b)(6); (b)(7)(C) assessed REYES during sick call and documented⁸⁵ the following:

- REYES's vital signs were within normal limits except for a low-grade fever of 99.1 degrees.

⁷⁷ See Telephone Encounter by RN (b)(6); (b)(7)(C), dated March 22, 2019.

⁷⁸ ERAU interview with HSA (b)(6); (b)(7)(C), dated May 7, 2019.

⁷⁹ See eCW Progress Note by PA (b)(6); (b)(7)(C), dated March 25, 2019. ERAU notes, per ICE PBNDS 2011, PA (b)(6); (b)(7)(C) did not complete a new examination because REYES received a health examination fewer than 90 days earlier.

⁸⁰ During an interview, PA (b)(6); (b)(7)(C) stated he entered this date by mistake. The correct date of REYES's last physical examination at FSPC was February 28, 2019.

⁸¹ Tympanic measures the body's temperature in the capillary bed of the ear canal.

⁸² See *infra* note 25.

⁸³ See SMART MAR, dated March 2019.

⁸⁴ ERAU interview with PA (b)(6); (b)(7)(C), dated May 7, 2019. Hemoglobin is a red protein responsible for carrying oxygen in the blood to vertebrates. Normal hemoglobin levels range from 13.5 to 17.5 grams per deciliter for men.

⁸⁵ See eCW Progress Note by LPN (b)(6); (b)(7)(C), dated March 26, 2019. ERAU notes LPN (b)(6); (b)(7)(C) did not document a language barrier or use of interpretation assistance for this encounter.

- REYES asked why he was at sick call because he did not submit a sick call request. LPN (b)(6); (b)(7)(C) explained his name appeared on the sick call list and after determining REYES did not have a fever the day before, returned him to his housing unit.⁸⁶

March 28, 2019

At approximately 8:13 a.m., RN (b)(6); (b)(7)(C) assessed REYES at sick call for chronic pain in both feet and documented⁸⁷ the following:

- She used a Spanish interpreter.
- REYES rated his pain level at 6 out of 10 and stated he wanted to go home to get the medication that works for him.
- REYES had red coloration but no inflammation to both feet and dry skin from his ankles to lower legs, with no wounds or signs of an infection.
- REYES's vital signs were all within normal limits.

RN (b)(6); (b)(7)(C) documented she consulted PA (b)(6); (b)(7)(C) to discuss REYES's medical history, medication regimen, and her assessment findings. PA (b)(6); (b)(7)(C) directed RN (b)(6); (b)(7)(C) to continue REYES on his prescribed medications and schedule a provider appointment for April 4, 2019.

March 30, 2019

At approximately 8:27 a.m., a security officer escorted REYES to medical because he was in possession of an expired metformin bottle.⁸⁸ RN (b)(6); (b)(7)(C) evaluated REYES and documented⁸⁹ the following:

- She used a Spanish interpreter.
- REYES's vital signs were all within normal limits.
- REYES denied any chest pain or shortness of breath.
- REYES had current bottles of metformin and aspirin on his person and he denied having any expired medication. REYES further clarified that the medication found by security staff was extra and that he was taking all his medications as ordered.
- RN (b)(6); (b)(7)(C) recommended a chart review by a provider and scheduled REYES for a follow-up appointment on April 4, 2019.
- REYES returned to his housing unit with current medication in his possession.

RN (b)(6); (b)(7)(C) stated she believed REYES's self-report of medication compliance; therefore, she did not check his blood glucose.⁹⁰ She stated he may have been in possession of expired metformin due to his brief transfer to LPCC, resulting in his retention of extra medication. RN (b)(6); (b)(7)(C) did not inspect the medication bottle to verify the dispensing facility, the date, or the number of pills remaining but recalled she turned in the extra medication to the pharmacy. IHSC Chief Pharmacist

⁸⁶ ERAU did not find a sick call request or other documentation explaining REYES's inclusion on the sick call list.

⁸⁷ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated March 28, 2019.

⁸⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated March 30, 2019.

⁸⁹ *Ibid.*

⁹⁰ ERAU interview with RN (b)(6); (b)(7)(C), dated May 9, 2019.

(b)(6); (b)(7)(C) stated pharmacy personnel do not check patients' medication compliance when nurses turn in medications.⁹¹

April 1, 2019

At approximately 10:46 a.m., Lieutenant (LT) (b)(6); (b)(7)(C) RN assessed REYES at sick call for flu-like symptoms.⁹² RN (b)(6); (b)(7)(C) stated he does not speak Spanish; therefore, a licensed vocational nurse (LVN) assisted with interpretation.⁹³ RN (b)(6); (b)(7)(C) recalled REYES walked slowly and appeared weak and ill. REYES's temperature was 102 degrees, his heart rate was a bit fast, his blood pressure was slightly low, his pulse oxygen was in the high 80s, and his lungs were clear, but his breaths were shallow. RN (b)(6); (b)(7)(C) observed REYES had a slight hand tremor and complained of back pain. RN (b)(6); (b)(7)(C) thought REYES might have an upper respiratory infection or possibly pneumonia. RN (b)(6); (b)(7)(C) informed PA (b)(6); (b)(7)(C) of his findings; PA (b)(6); (b)(7)(C) instructed him to check REYES's pulse oxygen level again. RN (b)(6); (b)(7)(C) recalled the new pulse oxygen reading was 90% but did not document the new reading. RN (b)(6); (b)(7)(C) stated he did not think to check REYES's blood glucose during this encounter because the nursing guidelines did not require it and because nurses need a provider order to check a diabetic patient's blood glucose. HSA (b)(6); (b)(7)(C) subsequently clarified nurses do not need a provider order.

At approximately 11:07 a.m., PA (b)(6); (b)(7)(C) evaluated REYES for flu-like symptoms and documented⁹⁴ the following:

- REYES stated he had a fever, chills, sore throat, and a mild cough when lying down.
- REYES had an elevated heart rate of 114 beats per minute and a temperature of 100.1 degrees, but his pulse oxygen was normal at 96%.
- REYES appeared ill with mucus discharge from his nasal cavity, and minimal redness and post-nasal drainage to his throat.
- PA (b)(6); (b)(7)(C) diagnosed REYES with influenza⁹⁵ and prescribed Tamiflu⁹⁶ 75 mg twice a day for five days on pill line, and acetaminophen (Tylenol) 325 mg to 650 mg four times a day as needed for five days, KOP.
- PA (b)(6); (b)(7)(C) instructed REYES to increase fluids, scheduled a follow-up appointment for April 4, 2019, and cleared REYES to return to the housing unit.

PA (b)(6); (b)(7)(C) stated he was not concerned about REYES's diabetes because he believed REYES was compliant with his metformin medication.⁹⁷ Additionally, PA (b)(6); (b)(7)(C) stated the expired metformin found in REYES's possession on March 30, 2019, could have been from when he was transferred to (and from) LPCC, if they were not confiscated upon REYES's return to FSPC.

⁹¹ ERAU interview with Chief Pharmacist (b)(6); (b)(7)(C) dated May 7, 2019.

⁹² The assessment findings are based on RN (b)(6); (b)(7)(C)'s recollection of this encounter with REYES. Although RN (b)(6); (b)(7)(C) initiated a sick call note in eCW, which included REYES's full vital signs, he did not lock the note. Consequently, with the exception of blood pressure and respiration readings at 10:46 a.m., the medical record does not document RN (b)(6); (b)(7)(C)'s assessment of REYES because PA (b)(6); (b)(7)(C) resumed the note at 11:07 a.m.

⁹³ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019. RN (b)(6); (b)(7)(C) could not recall the name of the LVN.

⁹⁴ See eCW Progress Note by PA (b)(6); (b)(7)(C) dated April 1, 2019.

⁹⁵ Influenza is a highly contagious viral infection of the respiratory system causing a fever and severe aching.

⁹⁶ Tamiflu is an antiviral medication used to treat influenza.

⁹⁷ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

At 12:59 p.m., Officer (b)(6); (b)(7)(C), assigned to the Echo Control Room, documented REYES required assistance to get out of bed to shower.⁹⁸ At 1:12 p.m., Officer (b)(6); (b)(7)(C) documented she called medical to report REYES's condition and medical staff informed her medical would continue to monitor him. At 1:52 p.m., Officer (b)(6); (b)(7)(C) relieved Officer (b)(6); (b)(7)(C).

At 3:04 p.m., Officer (b)(6); (b)(7)(C) documented she notified medical that REYES was too sick to walk to the clinic and needed a wheelchair. At 3:08 p.m., medical staff informed Officer (b)(6); (b)(7)(C) that a nurse would go to the housing unit to evaluate REYES. At 3:22 p.m., Officer (b)(6); (b)(7)(C) documented nurse (b)(6); (b)(7)(C) entered Echo Pod and gave REYES his medication. ERAU notes that although Officer (b)(6); (b)(7)(C) documented Nurse (b)(6); (b)(7)(C) delivered REYES his medication, RN (b)(6); (b)(7)(C) confirmed that LPN (b)(6); (b)(7)(C) delivered the medication.⁹⁹

At 3:35 p.m., RN (b)(6); (b)(7)(C) completed a Special Needs form to admit REYES to medical segregation after LPN (b)(6); (b)(7)(C), who supported RN (b)(6); (b)(7)(C) assignment of REYES to medical segregation, delivered REYES his medication because he was too weak to go the clinic.¹⁰⁰ At 4:12 p.m., RN (b)(6); (b)(7)(C) signed the Administrative Segregation Order and cleared REYES for medical segregation.¹⁰¹ RN (b)(6); (b)(7)(C) stated that although he documented evaluation and clearance of REYES for segregation, he did not evaluate REYES in person.¹⁰² RN (b)(6); (b)(7)(C) indicated he had informed PA (b)(6); (b)(7)(C) of REYES's placement in medical segregation after an officer called medical to suggest his placement in segregation because he was moving slowly and could not walk to meals or pill call, or shower without assistance.¹⁰³

At 4:27 p.m., Officer (b)(6); (b)(7)(C) placed REYES in Jail Special Housing Unit, J-2 cell 2.¹⁰⁴ In the evening, Officer (b)(6); (b)(7)(C) documented REYES did not eat his dinner meal.¹⁰⁵

At 5:23 p.m., RN (b)(6); (b)(7)(C) documented on a Telephone Encounter that PA (b)(6); (b)(7)(C) directed REYES's transfer to medical segregation due to his limited mobility and strength, with daily nursing rounds.¹⁰⁶ ERAU notes PA (b)(6); (b)(7)(C) did not acknowledge receipt of the Telephone Encounter.

IHSC RN (b)(6); (b)(7)(C) clarified that daily nursing rounds in segregation involve verifying a detainee's welfare and taking a full set of vital signs, including blood glucose, when appropriate.¹⁰⁷

⁹⁸ See Echo Logbook, dated April 1, 2019. ERAU notes Officer (b)(6); (b)(7)(C) did not document why REYES required assistance to get out of bed.

⁹⁹ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

¹⁰⁰ See Special Needs form, dated April 1, 2019; ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

¹⁰¹ See Administrative Segregation Order, dated April 1, 2019.

¹⁰² ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

¹⁰³ *Ibid.*

¹⁰⁴ See Jail 2 Administrative Segregation Logbook, dated April 1, 2019. J-2 is FSPC's medical segregation unit and is one of three units that semi-encircle a control center, designated Jail Control. J-1 and J-3 are general population units. The Jail Control Officer provides general oversight and controls access to the area. One officer is assigned to each of the three units and is responsible for providing direct detainee supervision and performing duties specified in post orders. In addition, a Jail Wing officer performs rover functions and aids as needed, including assisting with population counts.

¹⁰⁵ See Special Management Housing Record, dated April 1, 2019.

¹⁰⁶ See Telephone Encounter by RN (b)(6); (b)(7)(C) dated April 1, 2019.

¹⁰⁷ ERAU interview with RN (b)(6); (b)(7)(C) dated May 8, 2019.

When nurses conduct rounds in segregation, they take the medical segregation bag, which contains necessary supplies, to include a portable blood pressure cuff, stethoscope, pulse oximeter, thermometer, glucometer, and common over-the-counter medications authorized for RN administration per the nursing guidelines.

On the same day, Lieutenant (b)(6); (b)(7)(C) completed an initial Administrative Segregation Review and documented REYES had been in medical segregation for one hour.¹⁰⁸ AOIC (b)(6); (b)(7)(C) signed the form the following day, recommending no change to REYES's status.

April 2, 2019

At 4:52 a.m., Officer (b)(6); (b)(7)(C) documented food service arrived and he distributed meals to all detainees.¹⁰⁹

At approximately 5:44 a.m., RN (b)(6); (b)(7)(C) saw REYES for morning pill pass.¹¹⁰ After REYES reported feeling weak, RN (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) entered his cell, helped him sit up, opened his food tray, and gave REYES Tamiflu, which was his only scheduled morning medication. RN (b)(6); (b)(7)(C) stated because she was performing pill pass, not a nursing round, she did not bring the medical segregation bag but called the clinic to have a nurse bring it to segregation so she could take REYES's temperature.¹¹¹

RN (b)(6); (b)(7)(C) assessed REYES and documented¹¹² the following:

- She communicated with REYES in Spanish.
- REYES was alert and oriented to person, place, and time.
- REYES denied any pain, dizziness, tingling, numbness, or transient vision changes.
- REYES's temperature was 100 degrees.
- REYES had KOP Tylenol, which she encouraged him to take; she also encouraged REYES to remove his jacket to lower his temperature.
- RN (b)(6); (b)(7)(C) observed REYES eating his breakfast and informed him to tell staff if he felt worse.

RN (b)(6); (b)(7)(C) recalled checking REYES's heart rate and pulse oxygen but did not document it.¹¹³ RN (b)(6); (b)(7)(C) stated despite REYES's weakness, she did not complete a full set of vital signs because he was alert, oriented, and eating. She further stated it did not occur to her to check REYES's blood glucose because she didn't know REYES was diabetic, noting nurses do not review patients' medical records as part of the pill pass process.¹¹⁴

¹⁰⁸ See Initial Administrative Segregation Review, dated April 1, 2019.

¹⁰⁹ See Jail 2 Segregation Logbook, dated April 2, 2019.

¹¹⁰ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 2, 2019.

¹¹¹ ERAU interview with RN (b)(6); (b)(7)(C), dated May 8, 2019.

¹¹² See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 2, 2019.

¹¹³ *Ibid.* See also *infra* note 111.

¹¹⁴ See IHSC Daily Assignments and Shift Reports, dated April 1, 2019 and April 2, 2019. ERAU notes the IHSC shift reports, which document patient information passed on to nurses and providers each shift, stated REYES was in segregation for medical observation due to a fever and that he was on Tamiflu; however, these shift reports were void of any diabetes-related information.

ERAU notes RN (b)(6); (b)(7)(C) did not take REYES's KOP medications before exiting REYES's cell. HSA (b)(6); PA (b)(6); Chief Pharmacist (b)(6); and all nurses ERAU interviewed confirmed that FSPC does not allow detainees in segregation to maintain their KOP medication.¹¹⁵ RN (b)(6); acknowledged he did not perform medication reconciliation when he processed REYES's assignment to segregation; therefore, he was not aware REYES had KOP metformin, aspirin, and Tylenol to confiscate and change to pill line.¹¹⁶

At 6:00 a.m., RN (b)(6); (b)(7)(C) sent a Telephone Encounter to PA (b)(6); describing her encounter with REYES during morning pill pass.¹¹⁷ ERAU notes PA (b)(6); did not acknowledge receipt of the Telephone Encounter but stated he recalled the Charge Nurse¹¹⁸ providing the same information during the oncoming shift report.¹¹⁹

At 12:08 p.m., RN (b)(6); (b)(7)(C) conducted a segregation nursing round.¹²⁰ RN (b)(6); (b)(7)(C) stated when he arrived, an officer informed him REYES had been lying in his bunk all morning and had not showered.¹²¹ RN (b)(6); (b)(7)(C) stated when he approached REYES's cell, he observed him in bed, covered with a blanket. He asked REYES to stand up and come to the table in the dayroom, but REYES struggled to do so. RN (b)(6); entered REYES's cell and helped him out of his bunk to the dayroom table, where he proceeded to complete the nursing round.

During the nursing round, RN (b)(6); (b)(7)(C) documented¹²² the following:

- An interpreter was not available for the encounter.¹²³
- REYES's speech was spontaneous, and he answered questions appropriately.
- REYES's behavior, affect, and cognitive function were normal; he did not appear to have any acute or unresolved medical conditions that may worsen in segregation.
- REYES's respirations and temperature were normal; his blood pressure was low at 98/62; he had a slightly elevated heart rate at 103 beats per minute; and his pulse oxygen was extremely low at 83%.

RN (b)(6); (b)(7)(C) talked with REYES in the dayroom, and although REYES moved slowly, he did not need assistance.¹²⁴ After walking with REYES in the dayroom, RN (b)(6); stated he checked his

¹¹⁵ ERAU notes HSA (b)(6); stated that when security personnel place detainees in segregation cells, they confiscate any medication and turn it over to medical; however, CO (b)(6); stated officers do not take any medication from detainees assigned to segregation as a matter of course. ERAU interview with COS (b)(6); dated May 7, 2019.

¹¹⁶ ERAU interview with RN (b)(6); dated May 9, 2019.

¹¹⁷ See Telephone Encounter by RN (b)(6); dated April 2, 2019.

¹¹⁸ FSPC medical staff interviewed were unable to confirm who the Charge Nurse was on this date.

¹¹⁹ ERAU interview with PA (b)(6); dated May 7, 2019.

¹²⁰ See Jail Special Housing, Camera 42 Video Surveillance, dated April 2, 2019.

¹²¹ ERAU interview with RN (b)(6); dated May 9, 2019.

¹²² See eCW Progress Note by RN (b)(6); dated April 2, 2019. ERAU notes that although the Progress Note detailed the encounter at 2:53 p.m., RN (b)(6); stated this was due to it being his first opportunity to document the round after returning to the clinic. ERAU interview with RN (b)(6); dated May 9, 2019.

¹²³ During his interview with ERAU, RN (b)(6); stated it is difficult to get an outside telephone line to utilize interpretation services in segregation. He also stated the phone in segregation is located at the officer's desk, where patient privacy is lacking. ERAU interview with RN (b)(6); dated May 9, 2019.

¹²⁴ See Jail Special Housing, Camera 42 Video Surveillance, dated April 2, 2019.

pulse oxygen again and recalled it was not above 90%.¹²⁵ RN (b)(6); (b)(7)(C) also stated although he was concerned with REYES's abnormal vital signs, he did not believe REYES was at imminent risk.

During the nursing round, RN (b)(6); (b)(7)(C) entered REYES's cell and exited with a small bag.¹²⁶ The bag contained five medication bottles, including metformin and aspirin, which he turned in to the pharmacy after his nursing round.¹²⁷ RN (b)(6); (b)(7)(C) stated he did not document the prescription information on the bottles or count the pills, but he recalled one bottle was approximately half-full.¹²⁸ RN (b)(6); (b)(7)(C) stated he did not ask REYES if he took his metformin or aspirin that day. ERAU notes that although RN (b)(6); (b)(7)(C) confiscated the bottles and turned them in to the pharmacy, REYES's medical record does not reflect that RN T (b)(6); (b)(7)(C) changed the metformin, aspirin, and Tylenol from KOP to pill line.

RN (b)(6); (b)(7)(C) stated he informed PA (b)(6); (b)(7)(C) in person of his nursing round with REYES.¹²⁹ PA (b)(6); (b)(7)(C) recalled RN (b)(6); (b)(7)(C) told him REYES's pulse oxygen was 83% but that his lungs were clear, he had no shortness of breath, spoke in complete sentences, and seemed to be doing better overall.¹³⁰ PA (b)(6); (b)(7)(C) stated the clinical presentation of the patient as described by RN (b)(6); (b)(7)(C) did not correlate with the pulse oxygen reading of 83%, and he directed RN (b)(6); (b)(7)(C) to return to segregation and check REYES's pulse oxygen level again after the detainee took several deep breaths. However, according to RN (b)(6); (b)(7)(C), PA (b)(6); (b)(7)(C) did not provide this direction.

At 2:56 p.m., RN (b)(6); (b)(7)(C) sent a Telephone Encounter to PA (b)(6); (b)(7)(C) of his nursing round with REYES.¹³¹ RN (b)(6); (b)(7)(C) documented REYES's pulse oxygen was 79% to 83%¹³² and his heart rate was 103 to 110 with regular rhythm. RN (b)(6); (b)(7)(C) documented REYES was not compliant with the medication regimen because he had several bottles of metformin in his cell.¹³³ RN (b)(6); (b)(7)(C) further documented REYES was ambulatory and denied any pain except in his knees after walking. RN (b)(6); (b)(7)(C) stated he did not consider checking REYES's blood glucose because a provider did not order blood glucose checks.¹³⁴ ERAU notes PA (b)(6); (b)(7)(C) did not document whether he reviewed the Telephone Encounter.

At 2:57 p.m., RN (b)(6); (b)(7)(C) completed a chart review and entered the vital signs from his 12:08 p.m. nursing round.¹³⁵ PA (b)(6); (b)(7)(C) stated he expected RN (b)(6); (b)(7)(C) return to segregation and re-check REYES's pulse oxygen per his direction, instead of completing a chart review with the abnormal vital signs taken hours earlier.¹³⁶ PA (b)(6); (b)(7)(C) further stated when RN (b)(6); (b)(7)(C) found REYES's pulse

¹²⁵ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019. RN (b)(6); (b)(7)(C) did not document a second pulse oxygen reading.

¹²⁶ See Jail Special Housing, Camera 42 Video Surveillance, dated April 2, 2019.

¹²⁷ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

¹²⁸ ERAU was unable to determine how or why REYES was in possession of five bottles as his only KOP medications were metformin, aspirin, and Tylenol.

¹²⁹ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

¹³⁰ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

¹³¹ See Telephone Encounter by RN (b)(6); (b)(7)(C) dated April 2, 2019.

¹³² ERAU notes RN (b)(6); (b)(7)(C) documented REYES's pulse oxygen level at 83% during the nursing round.

¹³³ ERAU was unable to corroborate this information because during her interview with ERAU on May 9, 2019, RN (b)(6); (b)(7)(C) stated she confiscated the extra medication and turned it into the pharmacy.

¹³⁴ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

¹³⁵ See eCW Chart Review, dated April 2, 2019.

¹³⁶ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

oxygen was 83%, he should have taken REYES to the clinic to check his pulse oxygen using the vital sign machine with an attached pulse oximeter.

At 4:42 p.m., RN (b)(6) returned to segregation to distribute medication and saw REYES sitting at the dayroom table.¹³⁷ RN (b)(6); (b)(7)(C) stated REYES was not in distress and his appearance was the same as earlier.¹³⁸ Despite RN (b)(6); (b)(7)(C) findings during the afternoon nursing round, he did not take the medical segregation bag to check REYES's vital signs, stating he was only in segregation for pill pass. REYES took the offered medications: Tamiflu; gabapentin; metformin; and Tylenol.¹³⁹

On the SMU Housing Record, officers documented REYES ate breakfast, lunch, and dinner, went to indoor recreation, and showered.¹⁴⁰

Day of Death

From April 2, 2019 at 10:00 p.m. to April 3, 2019 at 6:00 a.m., Officer (b)(6); (b)(7)(C) documented regular security rounds every 15 minutes.

April 3, 2019

At 4:39 a.m., RN (b)(6); (b)(7)(C) entered segregation for morning pill pass.¹⁴¹ RN (b)(6); (b)(7)(C) stated she and Officer (b)(6); entered REYES's cell because he needed assistance sitting up.¹⁴² Officer (b)(6); stated he assisted RN (b)(6); in moving REYES to an upright position and kept his hand on REYES's back to hold him up.¹⁴³ He also stated REYES was groaning and coughed frequently during his shift. REYES refused the Tamiflu, but RN (b)(6); (b)(7)(C) stated she was not concerned because, although he appeared sleepy, he did not look weak, ill, flush, or pale. RN (b)(6); (b)(7)(C) documented REYES's temperature was normal at 98.6 degrees, his heart rate was at the high end of normal at 100 beats per minute, and his pulse oxygen was 94%.¹⁴⁴ RN (b)(6); (b)(7)(C) stated she did not take any other vital signs because she did not see the need. She documented her intent to complete a refusal form later this day but stated she did not have the opportunity to complete the form before the medical emergency occurred.¹⁴⁵ At 4:46 a.m., RN (b)(6); (b)(7)(C) completed pill pass and exited segregation.¹⁴⁶

¹³⁷ See Jail Special Housing, Camera 42 Video Surveillance, dated April 2, 2019.

¹³⁸ ERAU interview with RN (b)(6); dated May 9, 2019.

¹³⁹ See sSMART MAR, dated April 2019. RN (b)(6); did not document the reason he gave REYES Tylenol. ERAU notes that despite RN (b)(6); acknowledging he did not switch REYES's KOP medications to pill line during his transfer to the SMU, documentation shows the last confirmed administration of REYES's medications occurring during the 4:42 p.m. pill pass.

¹⁴⁰ See SMU Housing Record, dated April 2, 2019.

¹⁴¹ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁴² ERAU interview with RN (b)(6); dated May 8, 2019.

¹⁴³ ERAU interview with Officer (b)(6); (b)(7)(C) dated May 8, 2019. ERAU notes Officer (b)(6); (b)(7)(C) did not document in the Jail 2 Segregation Logbook that REYES was too ill to sit up on his own when the nurse offered his medications or that he held him upright while the nurse spoke with him.

¹⁴⁴ See eCW Progress Note by RN (b)(6); dated April 3, 2019.

¹⁴⁵ ERAU interview with RN (b)(6); (b)(7)(C) dated May 8, 2019.

¹⁴⁶ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

At 5:07 a.m., food service arrived and Officer (b)(6); (b)(7)(C) placed a breakfast tray on the food slot of REYES's cell door.¹⁴⁷ Officer (b)(6); (b)(7)(C) documented he took the tray into the cell after REYES nodded when asked if he wanted the meal.¹⁴⁸ At 5:24 a.m., Officer (b)(6); (b)(7)(C) walked past the other cells, picking up the food trays.¹⁴⁹ Officer (b)(6); (b)(7)(C) indicated that he also returned to REYES's cell and encouraged him to eat.¹⁵⁰

At 5:52 a.m., Officer (b)(6); (b)(7)(C) documented he observed REYES's meal tray was untouched, and he was lying on his bunk looking at the ceiling with his chest moving up and down.¹⁵¹ ERAU notes video surveillance does not show Officer (b)(6); (b)(7)(C) at or near REYES's cell at this time.

At 6:00 a.m., Officer (b)(6); (b)(7)(C) relieved Officer (b)(6); (b)(7)(C).¹⁵² Officer (b)(6); (b)(7)(C) informed Officer (b)(6); (b)(7)(C) that REYES was sick and had not eaten his breakfast.¹⁵³

At 6:07 a.m., Officer (b)(6); (b)(7)(C) conducted a security round past each cell.¹⁵⁴ He documented REYES was propped on the bed rail on his right side, and his eyes were partially open, but he appeared to be sleeping.¹⁵⁵ Officer (b)(6); (b)(7)(C) returned to the officer's station to document the security round in the logbook. Officer (b)(6); (b)(7)(C), serving as the Jail Wing Officer, entered J-2 to conduct his initial security check, and Officer (b)(6); (b)(7)(C) told him REYES was sick and had not eaten.¹⁵⁶ Officer (b)(6); (b)(7)(C) asked Officer (b)(6); (b)(7)(C) if REYES was breathing and Officer (b)(6); (b)(7)(C) said he would check. Officer (b)(6); (b)(7)(C) left J-2 to continue conducting security rounds of the other Jail Housing Units. Officer (b)(6); (b)(7)(C) returned to REYES's cell and determined REYES was still sleeping.¹⁵⁷ Officer (b)(6); (b)(7)(C) returned to the officer's station and called (b)(6); (b)(7)(C) on the telephone to inform him that REYES did not look well and had not eaten breakfast.¹⁵⁸ (b)(6); (b)(7)(C) called Medical Officer (b)(6); (b)(7)(C) (first name unknown) to request medical personnel report to J-2 but provided no further explanation as to who needed medical attention.¹⁵⁹

At approximately 6:10 a.m., Officer (b)(6); (b)(7)(C) informed medical staff to report to the J-2 but initially did not provide any patient information.¹⁶⁰ RNs (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) retrieved the medical segregation bag and proceeded to J-2. Shortly thereafter, upon receipt of additional information, Officer (b)(6); (b)(7)(C) informed medical staff there was a medical emergency for detainee REYES and that he was having difficulty breathing. RN (b)(6); (b)(7)(C) and LPN (b)(6); (b)(7)(C) retrieved the medical emergency bag and mobile oxygen tank and proceeded to segregation.

¹⁴⁷ *Ibid.*

¹⁴⁸ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁴⁹ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁵⁰ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁵¹ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019. See also Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁵² See Jail 2 Segregation Logbook, dated April 3, 2019.

¹⁵³ See Incident Statements by Officers (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁵⁴ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁵⁵ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁵⁶ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁵⁷ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁵⁸ ERAU interview with Officer (b)(6); (b)(7)(C) dated May 8, 2019.

¹⁵⁹ See Incident Statement by Lt. (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁶⁰ See MQMU (acronym unknown) Incident Report, dated April 3, 2019.

Simultaneously, Officer (b)(6); (b)(7)(C) called Jail Control Officer (b)(6); (b)(7)(C) requesting assistance in J-2.¹⁶¹ Officer (b)(6); (b)(7)(C) asked (b)(6); (b)(7)(C) to report to J-2. When Officer (b)(6); (b)(7)(C) arrived to J-2, Officer (b)(6); (b)(7)(C) informed him that REYES was unresponsive.¹⁶² Officer (b)(6); (b)(7)(C) entered REYES's cell, shook his right leg, and asked if he was okay; while still warm to the touch, REYES was unresponsive and his eyes were open.¹⁶³ Officer (b)(6); (b)(7)(C) called Officer (b)(6); (b)(7)(C) to report to J-2, who immediately responded.¹⁶⁴ Officer (b)(6); (b)(7)(C) stated REYES's eyes were wide open, but his chest did not rise and fall.¹⁶⁵ Officer (b)(6); (b)(7)(C) went to Jail Control to notify Officer (b)(6); (b)(7)(C) of a code 10-10 medical emergency in J-2.¹⁶⁶ Officer (b)(6); (b)(7)(C) stated he did not immediately call code 10-10 via the radio because he didn't know if medical staff were already en route.¹⁶⁷ He also stated he considered starting cardiopulmonary resuscitation (CPR) but didn't because he believed that REYES was already dead.

At 6:14 a.m., Officer (b)(6); (b)(7)(C) called a code 10-10 in J-2 via the radio.¹⁶⁸ Officer (b)(6); (b)(7)(C) instructed Officer (b)(6); (b)(7)(C) to call (b)(6); (b)(7)(C) and proceeded to enter REYES's cell.¹⁶⁹ Within minutes of calling the code 10-10, Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) arrived to J-2.¹⁷⁰ Officer (b)(6); (b)(7)(C) notified her of the emergency.¹⁷¹ When Officer (b)(6); (b)(7)(C) arrived to J-2, Officer (b)(6); (b)(7)(C) informed her REYES was not breathing, at which time she instructed the officers to initiate CPR.¹⁷² She then radioed control to call 911.

At 6:15 a.m., medical staff and Chief of Security (COS) (b)(6); (b)(7)(C) arrived to J-2 and proceeded to REYES's cell.¹⁷³ RN (b)(6); (b)(7)(C) observed (unidentified) officers performing CPR on the bed.¹⁷⁴ Medical staff directed security personnel to call 911 and instructed the officers to move REYES to the floor.¹⁷⁵ RN (b)(6); (b)(7)(C) relieved Officer (b)(6); (b)(7)(C) from compressions, and LPN (b)(6); (b)(7)(C) assisted on the ambu-bag.¹⁷⁶ Nurses felt a weak, thready pulse and placed a pulse oximeter on REYES's left index finger, which did not detect a heart rate or pulse oxygen.¹⁷⁷ Nurses requested the automated external defibrillator (AED),¹⁷⁸ and Officer (b)(6); (b)(7)(C) retrieved it from Jail Control.¹⁷⁹ The AED did not advise for a shock to be delivered; consequently medical personnel

¹⁶¹ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁶² See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁶³ ERAU interview with Officer (b)(6); (b)(7)(C) dated May 8, 2019.

¹⁶⁴ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁶⁵ ERAU interview with Officer (b)(6); (b)(7)(C) dated May 8, 2019.

¹⁶⁶ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁶⁷ ERAU interview with Officer (b)(6); (b)(7)(C) dated May 8, 2019.

¹⁶⁸ See Jail Control Logbook, dated April 3, 2019.

¹⁶⁹ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁷⁰ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁷¹ ERAU interview with Officer (b)(6); (b)(7)(C) dated May 7, 2019.

¹⁷² See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁷³ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019. COS (b)(6); (b)(7)(C) heard the code 10-10 via the radio.

¹⁷⁴ See Incident Statement by RN (b)(6); (b)(7)(C) undated.

¹⁷⁵ ERAU notes that neither documentation nor interviews confirmed who called 911.

¹⁷⁶ See Incident Statement by RN (b)(6); (b)(7)(C) undated. An ambu-bag is a handheld device used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

¹⁷⁷ See MQMU Incident Report, dated April 3, 2019.

¹⁷⁸ An AED is a portable device that delivers an electric shock through the chest to the heart.

¹⁷⁹ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2019.

continued with compressions.¹⁸⁰ A nurse wiped away brown liquid secretion coming from REYES's mouth, and nurses and officers continued taking turns performing chest compressions.

COS (b)(6); (b)(7)(C) requested the video camera from Jail Control, but an officer informed him the video camera was not functioning properly.¹⁸¹ (b)(6); (b)(7)(C) arrived with the facility supervisor's camera and began recording.

At 6:18 a.m., Officer (b)(6); (b)(7)(C) notified RN (b)(6); (b)(7)(C) and IHSC (b)(6); (b)(7)(C) RN, that medical staff needed a suction machine for the medical emergency in J-2. At 6:19 a.m., the RNs arrived at the medical emergency with the suction machine, and RN (b)(6); (b)(7)(C) performed oral suction, extracting about five to ten milliliters of fluid while chest compressions continued.¹⁸²

At 6:23 a.m., the Florence Fire Department Emergency Medical Services (EMS) responders arrived at FSPC.¹⁸³ At 6:25 a.m., EMS responders arrived to REYES's cell, found him lying flat on the floor with CPR in progress and AED attached. EMS responders assumed CPR responsibilities and confirmed REYES was pulseless, not breathing, and the EKG showed no heart rhythm. REYES's pupils were non-reactive to light, and there were no lung sounds. EMS responders did not notice any signs of trauma, but there was discoloration on REYES's right leg with apparent lividity.¹⁸⁴ REYES's face appeared discolored and mottled.¹⁸⁵ EMS responders rolled REYES to his right side and noticed discoloration/lividity to the thoracic region.¹⁸⁶ EMS responder (b)(6); (b)(7)(C) called the physician overseeing EMS actions, who pronounced REYES dead at 6:33 a.m. At 6:36 a.m., EMS responders departed FSPC.¹⁸⁷

After EMS responders left the scene, RNs (b)(6); (b)(7)(C) examined the body.¹⁸⁸ The RNs did not find wounds but noticed vomit and diarrhea. The body was warm and flexible, and they did not notice lividity. RN (b)(6); (b)(7)(C) stated that, although EMS responders documented lividity, she and RN (b)(6); (b)(7)(C) did not see any until the coroner arrived over an hour later.¹⁸⁹

ERAU notes Officer (b)(6); (b)(7)(C) did not document any events related to the medical emergency in the Jail 2 Segregation Logbook.

At 7:43 a.m., the Pinal County Coroner arrived to REYES's cell.¹⁹⁰ HSA Stephen and RNs (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were at the scene. The RNs and AOIC (b)(6); (b)(7)(C) stated the coroner took possession

¹⁸⁰ See MQMU Incident Report by HSA (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁸¹ See Incident Statement by COS (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁸² See MQMU Incident Report by HSA (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁸³ See Florence Fire Department Patient Care Report, dated April 3, 2019.

¹⁸⁴ Lividity is a red to blue/purple discoloration of the skin due to the settling or pooling of blood and fluid under the influence of gravity following death. Lividity can begin about two hours after death.

¹⁸⁵ Mottling occurs when the heart can no longer pump blood effectively and blood flow throughout the body slows. Mottled skin has a red or purple marbled appearance, is cool to the touch, and usually begins in the legs and feet.

¹⁸⁶ The thoracic region refers to the upper part of the body from the neck to the diaphragm.

¹⁸⁷ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁸⁸ See Incident Statement by RN (b)(6); (b)(7)(C) dated April 3, 2019.

¹⁸⁹ ERAU interview with RN (b)(6); (b)(7)(C) dated May 7, 2019.

¹⁹⁰ See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

of REYES's cell belongings, including a paper bag that contained cash and papers.¹⁹¹ At 8:13 a.m., the coroner exited J-2 with REYES's body.¹⁹²

Post-Death Actions

Immediately following REYES's death, facility leadership conducted an after-action review with all involved staff members and identified the following corrective actions:¹⁹³

- Implement procedures requiring designated officers to respond to all emergencies with a video camera.
- At shift roll call, supervisory staff will discuss officers' expectations during medical emergencies, to include calling code 10-10, bringing the AED to the scene, and initiating CPR.

COS (b)(6); (b)(7)(C) stated the facility offered employee assistance to all officers.¹⁹⁴ AOIC (b)(6); (b)(7)(C) mailed REYES's stored property to the Mexican Consulate.¹⁹⁵

On April 4, 2019, the ERO Phoenix Field Office Director notified the Mexican consulate of REYES's death.¹⁹⁶

On April 29, 2019, Pinal County Forensic Chief Medical Examiner, (b)(6); (b)(7)(C) documented the cause of death as complications of liver cirrhosis, diabetes mellitus, and hypertensive cardiovascular disease, and the manner of death was natural.¹⁹⁷

FINDINGS

ERAU reviewed the medical care FSPC provided REYES, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found FSPC failed to comply with three of the requirements of the ICE PBNDS 2011.^{(b)(5)}

(b)(5)

(b)(5)

¹⁹¹ Interviews with AOIC (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) dated May 7, 2019 and May 8, 2019, respectively.

¹⁹² See Jail Special Housing, Camera 42 Video Surveillance, dated April 3, 2019.

¹⁹³ ERAU interview with COS (b)(6); (b)(7)(C) dated May 7, 2019.

¹⁹⁴ ERAU interviews with COS (b)(6); (b)(7)(C) dated May 7, 2019.

¹⁹⁵ See United Parcel Service receipt dated April 17, 2019. During his interview on May 7, 2019, AOIC (b)(6); (b)(7)(C) stated the facility did not inventory REYES's belongings that were in his cell because it was turned over to the coroner when the body was picked up.

¹⁹⁶ See Condolence Letter, dated April 4, 2019.

¹⁹⁷ See Exhibit 2: Pinal County Forensic Examination Final Summary, date stamped April 29, 2019.

- During REYES's detention at FSPC, although several medical staff stated or noted they communicated with REYES in English, it's unclear whether he was proficient. Furthermore, staff did not consistently utilize interpretation services when communicating with REYES. Specifically, RN (b)(6); (b)(7)(C) used interpretation services during a medical encounter on April 1, 2019, but he did not use these services during his medical encounter with REYES the following day.
2. **Emergency Plans, Section (V)(D)(7)**, which states, "At least one video camera shall be maintained in the control center for use in emergency situations, and the facility administrator shall ensure that it is maintained, tested and supplied as required in 'K. Maintaining Audiovisual Recording Equipment and Records' found in standard '2.15 Use of Force and Restraints.'"
 - On April 3, 2019, responding security officers did not take a video camera to the emergency. When COS (b)(6); (b)(7)(C) requested the video camera, officers discovered it was inoperable.
 3. **Special Management Units, Section (V)(M)**, which states, "Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly."
 - On April 3, 2019, Officer (b)(6); (b)(7)(C) did not conduct irregular security rounds; rather, he logged rounds every 14 to 16 minutes.¹⁹⁸ At 5:24 a.m., video surveillance shows that while picking up food trays, Officer (b)(6); (b)(7)(C) walked past REYES's cell but did not look in the cell to observe him.

Although not violations of the ICE PBNDS 2011, ERAU noted the following violations of IHSC directives and FSPC policy:

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

¹⁹⁸ This also violates FSPC policy 2.12, *Special Management Units*, which states, "The Special Housing Officer will personally observe each detainee at least every 30 minutes on an irregular schedule."

Although not violations of the ICE PBNDS 2011, ERAU noted the following concerns regarding REYES's medical care, safety, and security at FSPC:

1. On February 27, 2019, PA (b)(6); (b)(7)(C) did not sign the prescription order he verbally gave to RN (b)(6); (b)(7)(C) to indicate he reviewed it. Additionally, he did not sign Telephone Encounters on March 4, March 17, March 22, April 1, and April 2, 2019.
2. On March 21, 2019, LPCC did not provide a transfer summary listing REYES' medications when he was transferred back to FSPC, which further resulted in a provider not immediately re-ordering gabapentin via pill pass or KOP metformin and aspirin.¹⁹⁹ Although PA (b)(6); (b)(7)(C) re-ordered the medications on March 25, 2019, ERAU cannot determine whether REYES was in possession of any KOP medications between March 21 and 25, 2019.
3. Although it is unknown how REYES had expired metformin in his possession on March 30, 2019, several medical staff stated they thought it might have resulted from REYES's return from LPCC on March 22, 2019, as they believed security staff did not confiscate the medication during the intake process.
4. On April 1, 2019, following REYES's placement in medical segregation for flu-like symptoms, nurses did not check his blood glucose levels. ERAU acknowledges PA (b)(6); (b)(7)(C) discontinued Accu-checks on March 25, 2019, due to REYES's hemoglobin being within normal limits; however, when REYES's health began to deteriorate, neither the nurses nor PA (b)(6); (b)(7)(C) reviewed his medical record to determine whether blood glucose monitoring should

¹⁹⁹ The ICE PBNDS 2011, *Medical Care Standard*, Section (V)(BB)(4)(c)(1), states, "When a detainee is transferred to another detention facility, the sending facility shall ensure that a Medical Transfer Summary accompanies the detainee, as required in 'C. Responsibilities of the Health Care Provider at the Sending Facility' found in Standard 7.4 'Detainee Transfers.'" Although the requirement for facilities to provide transfer summaries for detainees are covered within PBNDS 2011, ERAU's review of detention standard compliance was focused solely on FSPC. ERAU was unable to confirm if there was additional documentation or reasoning related to the transfer summary and any other matters related to REYES' time at LPCC; as such, these details are being provided for informational purposes only.

recommence. The last time nurses checked REYES's blood glucose was on March 25, 2019, at which time his blood glucose was elevated.

5. On April 2, 2019, RN (b)(6); (b)(7)(C) documented he gave REYES as-needed Tylenol without documenting the basis or need, and aspirin and metformin without asking if REYES had taken his doses before RN (b)(6); (b)(7)(C) confiscated the KOP medications earlier that afternoon.
6. On April 2, 2019, RN (b)(6); (b)(7)(C) did not take REYES to the clinic for further assessment after he found REYES's pulse oxygen was at 83% during a nursing round. When RN (b)(6); (b)(7)(C) returned to the clinic, he informed PA (b)(6); (b)(7)(C) of his nursing round with REYES and PA (b)(6); (b)(7)(C) recalled RN (b)(6); (b)(7)(C) stated that despite the low pulse oxygen, REYES appeared to be doing better. PA (b)(6); (b)(7)(C) directed RN (b)(6); (b)(7)(C) to return to segregation and check REYES's pulse oxygen level again. Three hours later, when RN (b)(6); (b)(7)(C) returned to segregation for pill pass, he did not take REYES's VS or otherwise assess him, although he did document administration of Tamiflu, gabapentin, metformin, and Tylenol.
7. On April 2 and 3, 2019, RN (b)(6); (b)(7)(C) and REYES was weak and sleepy during morning pill pass. The RNs took partial sets of vital signs and, per Creative Corrections, exercised imprudent nursing judgment by not escorting him to the clinic for further assessment.
8. On April 3, 2019, after determining REYES was unresponsive, Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) did not immediately call a medical emergency. Officer (b)(6); (b)(7)(C) informed Jail Control Officer (b)(6); (b)(7)(C) of REYES's state, whereupon Officer (b)(6); (b)(7)(C) called code 10-10, approximately seven minutes after Officer (b)(6); (b)(7)(C) first looked in REYES's cell and five minutes after the officers confirmed REYES was unresponsive. Furthermore, the officers who discovered REYES unresponsive did not initiate CPR until instructed to do so several minutes later by (b)(6); (b)(7)(C) nor did they retrieve the AED until directed to do so by medical staff.
9. On April 3, 2019, during the last hour of his shift in J-2, Officer (b)(6); (b)(7)(C) logged rounds at 5:29 a.m. and 5:45 a.m.; however, video surveillance does not show he conducted these rounds at these times.²⁰⁰ Additionally, although Officer (b)(6); (b)(7)(C) documented in his incident statement that he observed REYES's chest moving up and down at 5:52 a.m., video surveillance does not show Officer (b)(6); (b)(7)(C) at REYES's cell at this time. J-2 has 14 single occupancy cells with metal bars that open to a dayroom. Adjacent to the dayroom is a long, narrow range for officers to walk from Jail Control to a post at the opposite end of J-2, which is also separated from the dayroom by metal bars. There is a camera located at the end of the dayroom, which captures the dayroom but does not view into the cells. This camera is motion activated and will turn on when officers conduct security rounds in the dayroom area but does not activate when officers walk down the range. Therefore, if Officer (b)(6); (b)(7)(C) conducted the above-mentioned rounds in the range, they would not have been captured by the J-2 camera.
10. In contradiction with medical staff statements and IHSC Directive 03-06, *Health Evaluation of Detainees in Special Management Units*, COS (b)(6); (b)(7)(C) stated detainees in segregation may retain their KOP medications. Collaborative review by medical and facility leadership of IHSC

²⁰⁰ This also violates FSPC policy 2.4, *Facility Security and Control/Inspections*, which requires that officers "conduct detainee welfare and security inspections at a minimum of every 15 minutes between the hours of 2200 and 0600."

directives and current facility practices, to include clarification of responsibilities with respect to confiscation of medications and addressing inconsistencies, would benefit all personnel.

11. As noted in the related deficiency above, security officers are required to personally observe detainees in segregation at least every 30 minutes on an irregular basis. Although security officers interviewed stated they understand they are to observe living, breathing flesh by seeing the chest rise and fall, the facility's segregation policy does not address this expectation.

EXHIBITS

1. Creative Corrections Healthcare and Security Compliance Analysis
2. Pinal County Forensic Examination Final Summary, date stamped April 29, 2019.

Detainee Death Review: Abel REYES-Clemente, A215881614
Medical and Security Compliance Analysis
Florence Service Processing Center, Florence, Arizona

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Abel REYES-Clemente (REYES), while in the custody of the Florence Service Processing Center (FSPC), Florence, Arizona. A team consisting of ERAU personnel (b)(6); (b)(7)(C) Management and Program Analyst and team leader, (b)(6); (b)(7)(C), Inspection and Compliance Specialist, and contract subject matter experts in correctional healthcare and security (b)(6); (b)(7)(C) ERAU requested contractor participation to determine compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011 (revised 2016), governing healthcare and security operations.

Included in this report is a case synopsis, description of the facility and its medical services, a narrative description of events, and conclusions. The information and findings herein are based on analysis of REYES's medical record and detention file, tour of the housing area and medical clinic, interviews of staff, and review of policies, video surveillance recordings, and available incident related documentation.

SYNOPSIS

Abel REYES-Clemente, 54 years old, was booked into FSPC on February 26, 2019. His reported medical conditions included non-insulin dependent diabetes and Restless Leg Syndrome, both treated while he was detained; and hypertension which did not require treatment.

On April 1, 2019, healthcare staff directed REYES's placement on medical observation status in the special management unit for flu-like symptoms. Shortly after 6:00 a.m. on April 3, 2019, security personnel discovered REYES unresponsive and lifeless and called medical emergency. Resuscitation efforts by FSPC healthcare and Emergency Medical Services responders did not succeed. A hospital physician remotely pronounced REYES's time of death as 6:33 a.m.

The Pinal County Forensic Examination Report Final Summary documents the cause of death as complications of cirrhosis of the liver, diabetes mellitus, and hypertensive cardiovascular disease. The manner of death was natural. He had a bacterial pneumonia and was negative for influenza.

FACILITY DESCRIPTION

FSPC is an ICE owned and operated processing center. It has two distinct sections, the staging facility where staff medically screen and classify arriving detainees, and the detention center where detainees are housed if not deported, released, or transferred after processing. The average length of stay at the staging facility is 72 hours; the average length of stay at the detention center is 14 days. FSPC's combined capacity of 712 includes 320 beds in staging and 392 in the detention center. On the day of REYES's death, the detention center was at capacity. FSPC typically houses only male detainees classified low or medium-low.

The facility has a double fence with razor wire on top and between the fences. The interior fence is equipped with an alarm system to alert to and deter escapes. The secure fencing is not equipped with stun technology. Staff and visitors enter the detention center from the main lobby, first placing their belongings through an x-ray machine, then passing through a metal detector. All persons entering the secure section of the facility must display a staff or visitor identification badge. There are video surveillance cameras positioned throughout the facility to monitor and record events. The video surveillance cameras in the housing units operate only when they detect motion.

Asset Protection and Security Services, LLP (Asset) provides custody and security services under contract with ICE. The Asset rank structure includes a Chief of Security, lieutenants, and officers. An ICE Enforcement and Removal Operations (ERO) Officer in Charge (OIC) and two Assistant OICs provide operational oversight.

HEALTHCARE SERVICES

The ICE Health Service Corps (IHSC) and contractor STG International provide healthcare services at FSPC. The health services department is open 24 hours a day, seven days a week. The staffing plan authorizes 42 total positions, 13 for Commissioned Officers of the U.S. Public Health Service (USPHS). At the time of ERAU's site visit, ten of the 13 USPHS positions were filled, including the Health Services Administrator (HSA), assistant HSA, one advanced practice provider (APP)¹, program manager, three registered nurses (RN), pharmacist, dentist, and registered dental hygienist. Vacant USPHS positions included the Clinical Director (CD), one nurse manager and one APP. According to the HSA, the CD position has been vacant for 26 months, during which a regional physician and a headquarters physician have shared clinical oversight. Full time STG positions total 26, 23 filled and three were vacant at the time of the

¹ APP refers to a group of medical professionals that include nurse practitioners and certified physician assistants.

site visit. The filled positions included one APP, 11 RNs, six licensed practical nurses (LPN), a psychologist, radiology technician, pharmacy technician, four medical records, and an administrative assistant. Vacant contract positions included a licensed certified social worker and two RNs. The STG contract also authorizes six as-needed RN positions. ERAU verified current, primary-source verified licensure and credentials of healthcare personnel.

FSPC has four rooms equipped with negative air pressure for respiratory isolation, designated as the Temporary Isolation Facility (TIF). The facility does not have an infirmary or a dedicated medical observation unit. Detainees requiring observation or segregation for health reasons are assigned to the special housing area of the detention center.

FSPC uses the IHSC e-Clinical Works (eCW) electronic medical record system. Lionbridge and Interpretalk are FSPC's two language interpretation services. RNs follow IHSC Nursing Guidelines for patient care within their scope; providers apply the Federal Bureau of Prisons (FBOP) Clinical Guidelines and other professional association guidelines as applicable.

NARRATIVE

On February 26, 2019 at 10:51 p.m., REYES arrived at FSPC with 26 other detainees.²

On February 27, 2019 at 12:14 a.m., [REDACTED] RN, electronically signed an encounter note documenting that she conducted REYES's medical pre-screening assessment.³ She did not record the time. RN [REDACTED] noted his appearance, behavior and breathing were normal, and that he spoke Spanish. Because of the language barrier, she designated him for priority intake screening. RN [REDACTED] ordered a chest X-ray, which was negative for active tuberculosis and other pulmonary findings.⁴

At 4:30 a.m., an unknown officer booked REYES into FSPC's Staging Facility (FSF).⁵ REYES signed an inventory of his personal property listing one cellphone with battery, a Mastercard Debit card, a Mexican identification card, a wallet, eyeglasses, a photo album, and a few items of personal clothing and toiletries.⁶ REYES also signed a form acknowledging the following⁷:

² See Control Center logbook.

³ See Pre-Screen by RN [REDACTED] dated February 27, 2019.

⁴ See Radiology Report, dated February 27, 2019. REYES later developed suspected influenza and according to the autopsy report, had pneumonia at the time of death.

⁵ The officer, badge number 2012, did not identify himself by name. See Detention File Checklist and booking documents.

⁶ See Detainee Personal Property Record, dated February 27, 2019.

⁷ See Detainee Summary Supplement Form, dated February 27, 2019.

- He had no funds.
- He received the Detainee Handbook and the Sexual Assault and Abuse Prevention and Intervention pamphlet.
- He viewed the detainee orientation and Know Your Rights videos.
- He received a telephone Personal Identification Number, had the opportunity to make one free domestic phone call, and was shown how to use the telephone system.
- He participated in a Question and Answer session.

(b)(6); (b)(7)(C) RN, completed REYES's medical and mental health intake screening at approximately 9:44 a.m.⁸. She noted the following⁹:

- REYES spoke English fluently¹⁰.
- REYES reported that he was diagnosed with Type 2 diabetes mellitus¹¹ three years ago and was taking metformin¹² 500 milligrams (mg) twice daily.
- REYES denied a history of alcohol or illicit drug use.
- REYES reported no other medical or mental health concerns.
- REYES's vital signs within normal limits were blood pressure, heart rate, respiratory rate, temperature, oxygen saturation (pulse oxygen)¹³, and weight¹⁴. His blood glucose fingerstick reading was 144 milligrams per deciliter (mg/dl)¹⁵.

RN (b)(6); (b)(7)(C) obtained a telephone order from Commander (CDR) (b)(6); (b)(7)(C) Physician Assistant-Certified (PA-C) to start metformin 500 mg by mouth twice daily¹⁶ on a keep on

⁸ Encounter times are based on the time medical staff entered vital signs unless otherwise indicated in the note.

⁹ See Intake Medical Screening, dated February 27, 2019.

¹⁰ Based on documented and reported information, REYES variably spoke English and Spanish; however, his English language proficiency is unknown.

¹¹ According to the American Diabetic Association, Type 2 diabetes is a problem with the body that causes blood glucose to rise higher than normal.

¹² Metformin is a diabetes medication used to control blood sugar levels.

¹³ Oxygen saturation, or pulse oxygen, is the percentage of oxygen in the blood. It is tested by way of pulse oximetry, which measures how well oxygen is being sent to parts of a patient's body furthest from the heart. The device used to measure pulse oxygen is called a pulse oximeter, which is a small device placed on the finger to determine the percentage of oxyhemoglobin pulsating through the capillaries. According to Lippencott, Manual of Nursing Practice, 9th Edition, normal pulse oxygen levels are 95 percent to 100 percent for adults.

¹⁴ See Table 1 for REYES's vital signs for the course of detention.

¹⁵ According to the FBOP Clinical Guidelines, a normal fasting or non-fasting blood glucose (sugar) level in an otherwise healthy adult is roughly 90 – 130 mg/dl.

¹⁶ See After Hours Medication Order, not dated and not timed.

person (KOP) basis¹⁷. RN (b)(6); (b)(7)(C) documented she read back and verified the order; however, PA (b)(6); (b)(7)(C) did not co-sign it. PA (b)(6); (b)(7)(C) also ordered Accu-Checks¹⁸ twice daily, no sliding scale insulin¹⁹, and to notify the provider if REYES's blood sugar exceeded 400 mg/dl²⁰. RN (b)(6); (b)(7)(C) provided patient education and written brochures and medically cleared REYES for custody. REYES's blood sugar level was 123 when checked in the afternoon²¹.

At 1:32 p.m., Supervisory Detention and Deportation Officer (b)(6); (b)(7)(C) approved a classification rating of medium-low.²²

On February 28, 2019 at approximately 8:02 a.m., PA (b)(6); (b)(7)(C) completed REYES's initial physical examination²³. He noted the following:

- REYES speaks English fluently.²⁴
- REYES reported a history of diabetes Type 2 diagnosed three years ago and that he was hospitalized once with hyperglycemia.²⁵ He takes metformin 500 mg twice a day and reported compliance with his medication regimen. He sees his doctor every three to four months.
- REYES reported a history of labile hypertension²⁶ for which treated in the past, but not recently.
- REYES's current complaint was Restless Leg Syndrome²⁷ he treated at home with compression wraps. He reported no pain at the time of the examination.
- REYES denied any alcohol or drug use in the past 12 months.

¹⁷ When ordered by a provider, patients are given a supply of KOP medications for self-administration per the instructions on the label. ERAU cannot determine when REYES received the ordered supplies of KOP medications due FSPC's transition to an electronic medication administration during his detention.

¹⁸ Accu-Check is a medical device used to obtain fingerstick blood glucose readings.

¹⁹ An order for sliding scale insulin requires nurses to administer as needed doses for blood sugar out of range.

²⁰ The FBOP Clinical Guidelines call for interventions for readings over 300 mg/dl. PA (b)(6); (b)(7)(C) stated 400 mg/dl is the set threshold for provider notification at FSPC.

²¹ See Vital Signs Flowsheet. Nurses recorded Accu-check readings twice a day as ordered except for the mornings of February 28, 2019 and March 4, 2019, and the afternoon of March 17, 2019. See Table 2 for recorded blood sugar readings.

²² See Risk Classification Assessment Detailed Summary dated February 27, 2019. Based on the summary, ERAU concludes the classification was appropriate.

²³ See Physical Examination – initial, dated February 28, 2019.

²⁴ PA Neinhuis is fluent in Spanish.

²⁵ Hyperglycemia is high blood glucose.

²⁶ Labile hypertension describes fluctuations in blood pressure from normal to high.

²⁷ Restless leg syndrome is a condition that causes an uncontrollable urge to move legs, usually causing an uncomfortable sensation. It typically happens at night. A higher percentage of people with diabetes have restless leg syndrome.

- REYES's was cooperative and oriented to person, place and time. He denied any history of abuse or mental health disorders.
- REYES's vital signs were within normal limits. His lungs were clear to auscultation bilaterally²⁸ and heart sounds, to include, rate and rhythm, were normal.

PA (b)(6); (b)(7)(C) assessment findings were Type 2 diabetes, restless leg syndrome, tinea unguium²⁹, and pterygium³⁰ to REYES's eye. The PA ordered gabapentin³¹ 200 mg daily in the evening for 30 days, and laboratory studies to be drawn on March 4, 2019, to include a complete blood count (CBC) with platelets and differential³², comprehensive metabolic panel (CMP)³³, lipid profile³⁴, hemoglobin A1c³⁵, and urinalysis for microalbumin creatinine ratio³⁶. PA

(b)(6); (b)(7)(C) documented the plan of care was to continue current medications, start gabapentin, and complete the laboratory studies. If liver function results are normal, he would consider ordering an oral antifungal for the tinea unguium. He included continued monitoring of REYES's blood pressure in the care plan, explaining to ERAU that he expected nurses to notify a provider if eCW flagged REYES's blood pressure in red font when they entered vital signs during future encounters. He did not order an electrocardiogram (EKG)³⁷ despite REYES's age and history of labile blood pressure, stating current American Diabetic Association guidelines do not recommend EKGs for asymptomatic patients³⁸.

PA (b)(6); (b)(7)(C) concluded the physical examination by recommending a follow up appointment in one week, and cleared REYES for custody. Captain (CAP (b)(6); (b)(7)(C)) MD, IHSC Chief Medical Officer, co-signed the physical examination on March 6, 2019 at 11:44 a.m.³⁹

²⁸ Auscultation is a medical term for listening to the internal sounds of the body using a stethoscope. Bilateral means on both sides of the body, right and left sides.

²⁹ Tinea unguium is a common fungus infection to the toenails.

³⁰ A pterygium is a noncancerous growth to the eye.

³¹ Gabapentin is a medication used to treat nerve pain and improve the symptoms of Restless Leg Syndrome. REYES received his first dose this date and maintained compliance. See MAR.

³² CBC with differential and platelets is a blood test that gives doctors information about the cells in a patient's blood, the concentration of various proteins and minerals and the number of blood clotting cells.

³³ CMP is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes and how well the kidneys and liver are working.

³⁴ Lipid profile is a panel of blood tests to provide information about cholesterol and triglycerides.

³⁵ Hemoglobin A1c is a blood test that provides a three-month average of glucose concentration in the blood.

³⁶ Urinalysis microalbumin creatinine ratio is a urine test to measure the amount of protein and kidney waste products in the urine.

³⁷ EKG is a test that records the electrical signals in the heart to detect heart problems.

³⁸ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

³⁹ See (b)(6); (b)(7)(C) was not available for interview to discuss care expectations.

On March 1, 2019 at 3:30 p.m., security staff transferred REYES to FSPC's detention center, general population housing unit J-1⁴⁰.

On March 4, 2019 at approximately 7:56 a.m., (b)(6); (b)(7)(C) RN, assessed REYES at sick call for a chief complaint of chronic pain to his feet bilaterally⁴¹. She documented the following:

- REYES spoke Spanish and she used interpretation assistance.
- REYES was alert and oriented, maintained good eye contact, and did not appear to be in acute distress.
- REYES's vital signs were within normal limits, his lung sounds were clear and his heart rate and rhythm were regular.
- REYES rated his pain at level eight⁴² and stated prescription medication relieves the pain.
- RN (b)(6); (b)(7)(C) observed dry skin with no signs of infection to the feet. The dorsal surface of REYES's feet appeared dry with cracked skin. She assessed him as at risk for impaired skin integrity.

Following IHSC's Interim RN Guidelines for Wound Care and Pain, November 2008, RN (b)(6); (b)(7)(C) issued Bacitracin ointment⁴³, provided instruction on its application, and directed REYES to return to sick call if symptoms worsen. She also advised him to continue using body lotion for testicular dryness.

At 10:37 a.m., RN (b)(6); (b)(7)(C) submitted a Telephone Encounter to PA (b)(6); (b)(7)(C). She reported REYES requested a sick call visit due to foot pain and that the gabapentin was not controlling his pain. She also reported his vital signs were within normal limits, that he was stable, and that the dorsal surface of his feet were dry. She asked PA (b)(6); (b)(7)(C) for advice if REYES needs further care. PA (b)(6); (b)(7)(C) did not document any answer to the Telephone Encounter or issue new orders. HSA (b)(6); (b)(7)(C) informed ERAU that providers typically mark Telephone Encounters addressed to acknowledge receipt⁴⁵. The printed Telephone Encounter HSA (b)(6); (b)(7)(C) provided to ERAU did not document PA (b)(6); (b)(7)(C) addressed it.

⁴⁰ See Control Center logbook.

⁴¹ See Encounter note by RN (b)(6); (b)(7)(C) dated March 4, 2019.

⁴² The pain level is based on the standardized pain scale of zero to ten measuring a patient's self-report of pain. Zero is no pain and ten is the worst pain ever experienced.

⁴³ Bacitracin is an over the counter antibiotic ointment used to treat skin infections.

⁴⁴ See Telephone Encounter dated March 4, 2019. Telephone Encounters document nurses' electronic transmission of information to providers.

⁴⁵ See HSA (b)(6); (b)(7)(C) email dated May 8, 2019.

On March 5, 2019, REYES submitted an FSPC Detainee Request Form⁴⁶. ICE officer 1499 documented his or her reply on an ICE Detainee Request Form on March 7, 2019⁴⁷. The request and the reply were in Spanish.

On March 7, 2019 at approximately 7:52 a.m., PA (b)(6);
(b)(7)(C) completed the follow up appointment he scheduled at the time of REYES's initial physical examination on February 28, 2019. He documented the following:

- REYES's chief complaint was Restless Leg Syndrome for which he was not getting relief with gabapentin. He reported pain in his legs that occurs at night, affecting his sleep.
- REYES's vital signs were within normal limits.
- The examination results were unchanged from February 28, 2019.

PA (b)(6);
(b)(7)(C) reviewed laboratory results for studies he ordered on February 28, 2019⁴⁸. Abnormal results were as follows:

- Creatinine 0.59⁴⁹;
- Potassium 3.4⁵⁰;
- Alkaline phosphatase 153⁵¹;
- Red blood cell count 4.11⁵²;
- Hematocrit 37.4⁵³; and,
- Hemoglobin A1c 6.1%⁵⁴.

⁴⁶ See FSPC Detainee Request Form, dated March 5, 2019.

⁴⁷ See Department of Homeland Security, ICE Detainee Request form, dated March 7, 2019. The ICE officer did not identify himself by name.

⁴⁸ See Laboratory Report, received March 5, 2019.

⁴⁹ Creatinine is a waste product that is removed through the body through the kidneys. Normal range is 0.76 – 1.27.

⁵⁰ Potassium is an electrolyte in the body that helps maintain fluid levels, assists with nerve and muscle functioning, moves nutrients in and out of cells and helps with heart function. Normal range is 3.5 – 5.2.

⁵¹ Alkaline phosphate is an enzyme in the body that assists with many cell functions. Normal range is 39 – 117.

⁵² Red blood cell count is a blood test used to find out how many red blood cells an individual has. Red blood cells contain hemoglobin, which carries oxygen to the cell. Normal range is 4.14 - 5.80.

⁵³ Hematocrit is a blood test measuring the ratio of red blood cells to the total volume of blood. Normal range is 37.5 – 51.0.

⁵⁴ Normal hemoglobin A1c is 4.14 percent to 5.6 percent. Although 6.1 percent is elevated, the FBOP Clinical Guidelines on Diabetes Management sets 7.5 percent or below as the treatment goal for older adults with diabetes.

PA (b)(6); (b)(7)(C) stated that although outside normal range, none of the abnormal results was alarming and speculated that they were likely due to dehydration⁵⁵. He added REYES's hemoglobin A1c was within the range meeting treatment goals for Type 2 diabetes. PA (b)(6); (b)(7)(C) increased the gabapentin dosage from 200 mg to 400 mg daily for 30 days and prescribed enteric-coated aspirin 81 mg⁵⁶ daily for 90 days, KOP. REYES's MAR shows he received the increased dosage of gabapentin starting this date and continued to maintain compliance⁵⁷.

PA (b)(6); (b)(7)(C) scheduled REYES for a follow up appointment in four weeks. CAPT (b)(6); (b)(7)(C) co-signed PA (b)(6); (b)(7)(C)'s encounter note on March 12, 2019.

On March 17, 2019, RN (b)(6); (b)(7)(C) completed a Refusal Form printed in English and Spanish⁵⁸. She noted REYES refused an Accu-check because he believed his blood glucose was fine. RN (b)(6); (b)(7)(C) cited decreased therapeutic effect and worsening condition as possible or probable consequences of refusal. She and REYES both signed the form, which CDR (b)(6); (b)(7)(C) co-signed the following day. At 3:05 p.m. RN (b)(6); (b)(7)(C) notified PA (b)(6); (b)(7)(C) by way of Telephone Encounter that REYES refused the afternoon Accu-check⁵⁹. PA (b)(6); (b)(7)(C) did not mark the Telephone Encounter addressed or issue new orders.

Also on March 17, 2019, REYES submitted an FSPC Detainee Request Form, in Spanish. CDR (b)(6); (b)(7)(C) replied on March 18, 2019, informing REYES in English and in Spanish that if he does not feel well, he must put his name on the sick call list⁶⁰.

On March 19, 2019, (b)(6); (b)(7)(C) RN, completed a Transfer Summary listing La Palma Correctional Center (LPCC) as REYES's destination. She noted he had no known drug allergies, his current medications, diagnoses, laboratory results from March 4, 2019 and negative chest X-ray result and cleared REYES for travel⁶¹.

⁵⁵ ERAU Interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

⁵⁶ Aspirin therapy is an intervention for preventing serious cardiovascular events such as myocardial infarctions and stroke among people with diabetes.

⁵⁷ See MAR. REYES maintained compliance during the detention period.

⁵⁸ See IHSC form 820, Refusal Form, dated March 17, 2019.

⁵⁹ See Telephone Encounter dated March 17, 2019.

⁶⁰ See Detainee Request Form, dated March 17, 2019.

⁶¹ See Transfer Summary, dated March 19, 2019.

On **March 20, 2019** at 6:45 a.m., security staff transferred REYES to LPCC⁶². FSPC Assistant Officer in Charge (AOIC) (b)(6); (b)(7)(C) stated ERO directed the transfer of REYES and 59 other detainees to vacate a pod needed to house a varicella cohort⁶³.

REYES's medical record from LPCC shows (b)(6); (b)(7)(C) RN, completed his intake screening at 1:17 p.m. using Spanish interpretation services⁶⁴. RN (b)(6); (b)(7)(C) noted the following:

- REYES was diabetic.
- REYES's medications were metformin, gabapentin, and aspirin in the dosages and frequency documented on the transfer summary. LPCC received doses of metformin and aspirin with REYES.
- FSPC monitored REYES's blood glucose twice daily.
- REYES reported bilateral knee pain he rated at level three.
- REYES' vital signs and blood glucose were within normal limits.
- REYES's mental health examination was unremarkable.

RN (b)(6); (b)(7)(C) made routine referrals to dental and mental health and an urgent referral to a provider due to REYES's chronic medical conditions. The RN cleared REYES for general population.

On **March 21, 2019**, (b)(6); (b)(7)(C) Family Nurse Practitioner - Certified, completed REYES's initial physical examination at 10:58 a.m.⁶⁵ She noted the following:

- REYES's diagnosis of Type 2 diabetes and last hemoglobin A1c of 6.1.
- REYES' vital signs were within normal limits.
- REYES' examination was unremarkable, except the left great toenail was cut too short.
- NP (b)(6); (b)(7)(C) reviewed results of the laboratory studies completed at FSPC.

NP (b)(6); (b)(7)(C) continued REYES's current medication and prescribed antibiotic ointment for scant drainage at the left great toenail. She stopped blood glucose checks per REYES's request, and ordered follow up laboratory studies and an EKG for June 7, 2019.

At 9:13 p.m., security staff returned REYES and 46 other detainees to FSPC's staging facility⁶⁶. RN (b)(6); (b)(7)(C) completed the pre-screen at 11:46 p.m., noting a transfer summary from LPCC was

⁶² See Control Center logbook.

⁶³ ERAU Interview with AO (b)(6); (b)(7)(C) dated May 7, 2019.

⁶⁴ See Initial Intake Screening ICE Detainee form, dated March 20, 2019.

⁶⁵ See Inmate/Resident Health Appraisal Form, dated March 21, 2019.

⁶⁶ See Control Center logbook.

not available. She documented that REYES's appearance, behavior and breathing were normal, listed his current medications, and noted no medications arrived with him. She noted that he spoke Spanish and designated him for priority intake screening because of the language barrier.

On March 22, 2019 at 2:10 a.m., security personnel escorted REYES to Echo Pod⁶⁷. At approximately 3:39 a.m., (b)(6); (b)(7)(C) RN, completed the intake screening, noting that REYES spoke Spanish but also spoke English fluently⁶⁸. The RN noted his current diagnoses were diabetes and neuropathy⁶⁹, and his medications were aspirin 81mg daily, gabapentin 400 mg daily and metformin 500 mg twice a day, all of which LPCC sent to FSPC. REYES's vital signs were within normal limits and his blood glucose was slightly elevated at 160 mg/dl. The examination findings were unremarkable. Because of REYES's medications, RN (b)(6); (b)(7)(C) categorized his intake screening as abnormal and referred him for a physical examination complex (PE-C)⁷⁰ the same day.

RN (b)(6); (b)(7)(C) also sent a Telephone Encounter to PA (b)(6); (b)(7)(C) listing REYES's current medications. PA (b)(6); (b)(7)(C) did not mark the Telephone Encounter addressed to acknowledge receipt or issue orders restarting the medications. HSA Stephen said that without a provider order, REYES would not have been given his gabapentin, metformin and aspirin⁷¹. He informed ERAU that security would have confiscated and turned over to medical any medications returned to FSPC with REYES.

On March 25, 2019 at approximately 9:29 a.m., P (b)(6); (b)(7)(C) conducted a review of REYES's prior physical examination⁷². He noted the following:

- REYES's last physical examination at FSPC was on January 28, 2015⁷³ and there were no changes since that time.
- REYES denied any pain. His heart rate was slightly elevated at 105 beats per minute and his temperature was 100.5 degrees tympanic⁷⁴ and rechecked at 98.3 degrees by mouth. His fingerstick blood glucose was elevated at 306.

⁶⁷ See Control Center logbook.

⁶⁸ See Intake Screening, dated March 22, 2019.

⁶⁹ Neuropathy is a condition common among people with diabetes, causing loss or sensitivity, numbness or tingling in the hands and feet.

⁷⁰ A PE-C is the initial health appraisal of patients with chronic conditions, conducted by a provider.

⁷¹ ERAU interviews with HSA (b)(6); (b)(7)(C) dated May 7, 2019.

⁷² See PA (b)(6); (b)(7)(C) encounter note, dated March 25, 2019. As allowed by the Medical Care PBNDS 2011 (revised 2016), he did not complete a new examination because REYES had a health appraisal less than 90 days earlier.

⁷³ The correct date of REYES's last physical examination at FSPC was February 28, 2019.

⁷⁴ Tympanic measures the body's temperature in the capillary bed of the ear canal.

PA (b)(6); (b)(7)(C) re-ordered gabapentin at pill line and aspirin and metformin KOP in the previously prescribed doses and frequency⁷⁵. He discontinued blood glucose monitoring and recommended a follow up appointment for REYES in four weeks. PA (b)(6); (b)(7)(C) stated to ERAU that he was not concerned about REYES's elevated blood glucose because it was likely due to a missed dose of metformin during the transfer process. He discontinued blood glucose monitoring because REYES's hemoglobin was within goal. CAPT (b)(6); (b)(7)(C) co-signed PA (b)(6); (b)(7)(C) encounter note on March 28, 2019 at 2:42 p.m.

On March 26, 2019 at 8:24 a.m., (b)(6); (b)(7)(C) LPN, triaged REYES for RN sick call. REYES's vital signs were within normal limits except for a low-grade fever of 99.1 degrees. LPN (b)(6); (b)(7)(C) noted REYES asked why he was there because he did not request the sick call visit and was fine. LPN (b)(6); (b)(7)(C) told him his name appeared on the sick call list and finding no fever, returned REYES to his housing unit⁷⁶. LPN (b)(6); (b)(7)(C) did not address language or language interpretation assistance in his encounter note.

On March 28, 2019 at approximately 8:13 a.m., RN (b)(6); (b)(7)(C) assessed REYES at sick call for a chief complaint of chronic pain to his feet, bilaterally⁷⁷. She used an interpreter for this encounter. RN (b)(6); (b)(7)(C) noted the following:

- REYES rated his pain at level six and stated he wanted to go home to get the medication that works for him.
- REYES had erythema⁷⁸ with no inflammation bilateral; dry skin was present from his ankles to lower legs with no wounds or signs of infection.
- REYES's vital signs were within normal limits.

RN (b)(6); (b)(7)(C) documented she consulted PA (b)(6); (b)(7)(C) to review REYES's medical history, medication regimen and his status. She noted PA (b)(6); (b)(7)(C) directed that REYES continue his prescribed medications and a follow up provider appointment on April 4, 2019. RN (b)(6); (b)(7)(C) informed REYES of the appointment and educated him regarding the increased dose of the gabapentin he was receiving⁷⁹.

⁷⁵ Gabapentin was re-started this date and KOP metformin and aspirin were given. See MAR.

⁷⁶ See encounter note dated March 26, 2019. ERAU found no sick call request or other documentation explaining REYES's inclusion on the sick call list.

⁷⁷ See Encounter note dated March 28, 2019.

⁷⁸ Erythema is redness.

⁷⁹ See Encounter note, dated March 28, 2019.

On March 30, 2019 at approximately 8:27 a.m., a security staff person escorted REYES to medical because he was in possession of a bottle of expired metformin. RN (b)(6); (b)(7)(C) noted REYES spoke Spanish and English and that she used the interpretation service for the encounter⁸⁰. She documented REYES's vital signs were within normal limits, though his heart rate was at the high end of normal at 100 beats per minute⁸¹. He did not report chest pain or shortness of breath. RN (b)(6); (b)(7)(C) noted REYES had his current bottle of metformin and aspirin on his person, and that he denied security personnel's report that he possessed excess. REYES stated the medication found by security staff was extra and that he was taking all his prescription medications as ordered. RN (b)(6); (b)(7)(C) noted she recommended a chart review by the provider and that REYES was scheduled for a follow up appointment on April 4, 2019. She also noted she returned REYES to the housing unit with current bottles of metformin and aspirin. PA (b)(6); (b)(7)(C) co-signed RN (b)(6); (b)(7)(C) note on April 1, 2019 at 8:09 a.m.

RN (b)(6); (b)(7)(C) stated to ERAU that she accepted REYES's self-reported medication compliance and therefore, did not believe it was necessary to check his blood glucose⁸². She speculated he might have been in possession of the expired metformin due to his transfer to LPCC and return to FSPC within one day, resulting in his retention of the originally issued medication and reissuance upon transfer to one or both facilities. RN (b)(6); (b)(7)(C) stated she did not inspect the medication bottle to verify the dispensing facility, the date, and the number of pills remaining, but recalled she turned it in to the pharmacy. CDR (b)(6); (b)(7)(C) Chief Pharmacist, stated pharmacy personnel do not check patient's medication compliance when nurses turn in medications⁸³.

On April 1, 2019 at approximately 11:07 a.m., PA (b)(6); (b)(7)(C) evaluated REYES for chief complaint of flu-like symptoms that started Saturday night, to include fever, chills, sore throat and a mild cough when lying flat⁸⁴. PA (b)(6); (b)(7)(C) stated to ERAU that he agreed to see REYES after Lieutenant (L) (b)(6); (b)(7)(C) RN, reported to him that REYES came to sick call with flu-like symptoms⁸⁵. RN (b)(6); (b)(7)(C) confirmed this information and stated he assessed REYES before consulting with PA (b)(6); (b)(7)(C). RN (b)(6); (b)(7)(C) said he does not speak Spanish and tried to use the telephonic language interpretation service, but was unsuccessful due to technical difficulties. Instead, an LVN assisted. RN (b)(6); (b)(7)(C) called REYES's gait was slow and he appeared weak and

⁸⁰ See Encounter note dated March 30, 2019.

⁸¹ A normal heart rate is 6- to 100 beats per minute.

⁸² ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

⁸³ ERAU interview with Chief Pharmacist (b)(6); (b)(7)(C) dated May 7, 2019.

⁸⁴ See encounter note dated April 1, 2019.

⁸⁵ ERAU interview with PA (b)(6); (b)(7)(C).

⁸⁶ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

ill. He also recalled his temperature was 102 degrees; his heart rate was a bit fast; his blood pressure was slightly low; his pulse oxygen was in the high 80s, and his lungs were clear but his breaths were shallow. RN (b)(6); (b)(7)(C) observed REYES had a slight hand tremor and complained of minor back pain. Believing REYES may have an upper respiratory infection or possibly pneumonia, he informed PA (b)(6); (b)(7)(C) of his findings. PA (b)(6); (b)(7)(C) agreed to see REYES, but directed RN (b)(6); (b)(7)(C) re-check the pulse oxygen level after REYES took several deep breaths⁸⁷. RN (b)(6); (b)(7)(C) recalled the new reading was 90 percent⁸⁸. He did not document the new reading.

RN (b)(6); (b)(7)(C) stated he initiated a sick call encounter note in eCW that included REYES' the full set vital signs recalled to ERAU, but he did not lock it⁸⁹. Consequently, with the exception of blood pressure and respirations he entered at 10:46 a.m., the medical record does not document his own assessment of REYES. PA (b)(6); (b)(7)(C) resumed the note initiated by RN (b)(6); (b)(7)(C) documenting that at 11:07 a.m., REYES's heart rate was elevated at 114 beats per minute, his temperature was elevated at 100.1 degrees, and his pulse oxygen was within normal limits at 96 percent. PA (b)(6); (b)(7)(C) documented REYES appeared ill with mucoid discharge from his nasal cavity, minimal erythema and post-nasal drainage to his throat. His heart rate and rhythm were normal and his lungs were clear to auscultation⁹⁰. PA (b)(6); (b)(7)(C) diagnosed REYES with influenza⁹¹ and prescribed oseltamivir (Tamiflu)⁹² 75 mg twice a day for five days on pill line, and acetaminophen (Tylenol) 325 mg to 650 mg four times a day as needed for five days, KOP. PA (b)(6); (b)(7)(C) documented that he instructed REYES to increase fluids and rest, and scheduled a follow up appointment for April 4, 2019. He cleared REYES to return to the housing unit.

ERAU asked RN (b)(6); (b)(7)(C) and P (b)(6); (b)(7)(C) whether they considered checking REYES's blood glucose during their encounters⁹³. RN (b)(6); (b)(7)(C) stated the nursing guidelines for REYES's symptoms did not call for it, although he thought PA (b)(6); (b)(7)(C) would direct a fingerstick check or perform one on his own. When ERAU asked if he thought obtaining a blood glucose reading on a diabetic patient presenting with flu-like symptoms would be a prudent nursing intervention,

⁸⁷ ERAU interview with PA (b)(6); (b)(7)(C) dated May 7, 2019.

⁸⁸ ERAU interview with RN (b)(6); (b)(7)(C) dated May 9, 2019.

⁸⁹ *Id.*

⁹⁰ See Encounter note, dated April 1, 2019.

⁹¹ The Center for Disease Control defines influenza like illness (ILI) as temperature greater than or equal to 100.0 degrees plus a cough and/or sore throat in absence of a known cause other than influenza. Persons with diabetes are considered to be at high risk for influenza.

⁹² Tamiflu is an antiviral medication use to treat influenza. Antiviral treatment works best when started within two days of symptoms. However, these medications can still help when given after 48 hours to those that are very sick.

⁹³ According to the American Diabetic Association, diabetics who develop an illness are at risk for serious complications. Blood glucose levels can increase or decrease to dangerous levels if not monitored closely. REYES's blood glucose was last checked on March 25, 2019 and was not checked again before his death.

RN (b)(6); (b)(7)(C) stated nurses must have a provider order to do so⁹⁴. HSA (b)(6); (b)(7)(C) said RNs do not need an order to check diabetic patients' blood glucose⁹⁵. PA (b)(6); (b)(7)(C) stated he was not concerned about REYES's state of diabetes control because he believed his compliance with the metformin regimen was good. He speculated the expired metformin found the day before was the transfer supply sent to or from LPCC and not confiscated upon REYES's return to FSPC⁹⁶.

At 12:59 p.m., Echo Control Officer (b)(6); (b)(7)(C) documented that REYES required aid to get out of bed and to the shower⁹⁷. At 1:12 p.m., Officer (b)(6); (b)(7)(C) logged that she called Medical to report the information and an unnamed staff person told her medical staff would continue to monitor him. Approximately two hours later, at 3:04 pm, Officer (b)(6); (b)(7)(C) notified Medical that REYES was too sick to walk to the clinic and needed a wheelchair. An unnamed medical staff person then informed Officer (b)(6); (b)(7)(C) that a nurse would come to the housing unit to see REYES. Officer (b)(6); (b)(7)(C) logged that a nurse entered the unit at 3:22 p.m. and gave REYES his medication.

In a Telephone Encounter timed 5:23 p.m., RN (b)(6); (b)(7)(C) documented PA (b)(6); (b)(7)(C) directed REYES's transfer to segregation due to limited mobility and strength, with daily nursing checks⁹⁸. PA (b)(6); (b)(7)(C) did not address the Telephone Encounter to document it was received and accurate. In explaining the Telephone Encounter, RN (b)(6); (b)(7)(C) said that he contacted PA (b)(6); (b)(7)(C) after an officer on the housing unit called to suggest REYES's placement in segregation because he was moving slowly and could not ambulate for meals, medications, and showers without assistance. He confirmed that earlier in the afternoon, LPN (b)(6); (b)(7)(C) delivered REYES's medication to him in the housing unit because he was too weak to come to the clinic, and that she supported his assignment to segregation⁹⁹.

RN (b)(6); (b)(7)(C) completed a Special Needs form for security personnel to affect REYES's segregation for medical observation¹⁰⁰, and subsequently signed the Administrative Segregation Order prepared by Lieutenant (b)(6); (b)(7)(C). RN (b)(6); (b)(7)(C) marked on the Order that he evaluated REYES and cleared him for segregation; however, he acknowledged he did not see REYES to complete

⁹⁴ ERAU interview with RN (b)(6); (b)(7)(C) dated May 8, 2019.

⁹⁵ ERAU Interview with HSA (b)(6); (b)(7)(C) dated May 7, 2019.

⁹⁶ ERAU interview with PA (b)(6); (b)(7)(C).

⁹⁷ See Echo Unit logbook entry dated April 1, 2019.

⁹⁸ See Telephone Encounter dated April 1, 2019. LT (b)(6); (b)(7)(C), RN, stated daily nursing rounds in segregation involve verifying detainee welfare and taking a full set of vital signs, including blood sugar when appropriate. When nurses conduct rounds in segregation, they take the medical segregation bag which contains necessary supplies, including a portable blood pressure cuff and stethoscope, portable pulse oximeter, thermometer, glucometer and common over-the-counter medications authorized for RN administration per the nursing guidelines.

⁹⁹ ERAU interview with RN (b)(6); (b)(7)(C).

¹⁰⁰ See Special Needs form dated April 1, 2019.

¹⁰¹ Lieutenant (b)(6); (b)(7)(C)'s first name is unknown. See Administrative Segregation Order, dated April 1, 2019.

his segregation clearance¹⁰². He stated he should have had a nurse complete the clearance but as the assigned Charge Nurse for the day, was busy and forgot.

Officer (b)(6); (b)(7)(C) placed REYES in Jail Special Housing unit, cell 2 at 4:27 p.m.¹⁰³. The Jail Special Housing unit, J-2, is FSPC's SMU. J-2 is one of three units that semi-encircle a control center, designated Jail Control. The other two units, J-1 and J-3, both house general population detainees. The Jail Control officer provides general oversight and controls access for the area. There is one officer assigned to each of the three units responsible for providing direct detainee supervision and performing duties specified in post orders. In addition, a designated Jail Wing officer performs rover functions and provides back-up assistance, including assisting with population counts.

The SMU has 14 linear, single-occupancy cells that open into a dayroom area. Each cell has a metal bunk and desk with attached stool secured to the wall, and a combination stainless steel sink and toilet fixture with a stainless steel mirror mounted on the wall. The dayroom has a shower and two metal tables with attached stools. There is a range separated from the dayroom by steel bars, at the end of which is the officer's station. The station has a desk and phone. The unit has two security cameras mounted at ceiling level on each end of the range that capture the dayroom and range from two opposite angles. The cameras do not view into the cells.

Lieutenant (b)(6); (b)(7)(C) completed an initial Administrative Segregation Review documenting REYES had been in the SMU for medical observation for one hour¹⁰⁴. AOIC (b)(6); (b)(7)(C) signed the form the next day, April 2, 2019, recommending no change to REYES's status.

Officer (b)(6); (b)(7)(C) documented REYES did not eat the dinner meal¹⁰⁵.

On April 2, 2019 at approximately 5:44 a.m., (b)(6); (b)(7)(C) RN, saw REYES for morning pill pass¹⁰⁶. She communicated with him in Spanish. RN (b)(6); (b)(7)(C) noted REYES was alert and oriented to person, place and time, and denied pain, dizziness, tingling, numbness, or transient vision changes. REYES reported feeling weak and needed assistance to sit up. RN (b)(6); (b)(7)(C) and the officer entered the cell and helped him sit up and open his food tray¹⁰⁷. She

¹⁰² ERAU interview with R (b)(6); (b)(7)(C) IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units, requires RNs or medical providers to conduct a physical assessment of detainees placed in segregation. The physical assessment must include taking vital signs.

¹⁰³ See Jail 2 Administrative Segregation Log Book, April 1, 2019.

¹⁰⁴ See Initial Administrative Segregation Review, dated April 1, 2019.

¹⁰⁵ See Special Management Housing Record.

¹⁰⁶ See Encounter note dated April 2, 2019.

¹⁰⁷ Chief (b)(6); (b)(7)(C) stated that generally speaking, an officer in the SMU will not open a cell door unless a second officer is present. He commented this is sound security practice but FSPC policy does not require it. In

told ERAU she does not typically enter cells, but did on this occasion because REYES was struggling¹⁰⁸. She said because she was performing pill pass, not a nursing round, she did not bring the medical segregation bag, but called the clinic to have another nurse bring it to the SMU so she could take REYES's temperature¹⁰⁹. She recorded a temperature of 100 degrees and recalled checking REYES's heart rate and pulse oxygen, but did not enter them in her encounter note. RN (b)(6); (b)(7)(C) said that despite REYES's weakness, she did not do a full set of vital signs because he was alert, oriented and eating at that point. She stated it did not occur to her to check REYES's blood sugar because she did not know REYES was diabetic, noting nurses do not review patients' medical records as part of the pill pass process¹¹⁰. The shift reports for April 1, and 2, 2019 state REYES was in segregation for medical observation due to a fever and that he was on Tamiflu, but do not state he was diabetic¹¹¹.

RN H (b)(6); (b)(7)(C) gave REYES his Tamiflu, which was his only scheduled morning medication. She noted he had a bag with KOP medications, from which she removed a bottle of Tylenol. She encouraged him to take it and to remove his jacket to bring down his temperature. She counseled REYES to stay hydrated and to tell staff if he felt worse during the day.

RN (b)(6); (b)(7)(C) did not take REYES's KOP medications when she exited¹¹². IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units, requires healthcare staff to change KOP medications to directly observed therapy status on pill line. HSA (b)(6); (b)(7)(C) PA (b)(6); (b)(7)(C) CDR (b)(6); (b)(7)(C) and all nurses ERAU interviewed confirmed that FSPC does not allow detainees in segregation to maintain their KOP medications¹¹³. RN (b)(6); (b)(7)(C) acknowledged that he failed to perform medication reconciliation when he processed REYES's assignment to segregation; therefore, he was not aware REYES had KOP metformin, aspirin and Tylenol that needed to be confiscated and changed to pill line¹¹⁴. HSA (b)(6); (b)(7)(C) stated that when security personnel place detainees in segregation cells, they confiscate any medication and turn it over to

documentation and video, ERAU identified numerous occasions where officers opened cell doors while by themselves.

¹⁰⁸ ERAU interview with RN (b)(6); (b)(7)(C).

¹⁰⁹ The medical segregation bag contains supplies necessary to conduct daily nursing rounds, including a portable blood pressure cuff and stethoscope, portable pulse oximeter, thermometer, glucometer and common over-the-counter medication authorized for RN administration per the nursing guidelines.

¹¹⁰ ERAU interview with RN (b)(6); (b)(7)(C).

¹¹¹ See IHSC Daily Assignments and Shift Reports, dated April 1, 2019 and April 2, 2019. Shift reports document patient information passed on to nurses and providers from shift to shift.

¹¹² ERAU interview with RN (b)(6); (b)(7)(C).

¹¹³ ERAU interviews with HSA (b)(6); (b)(7)(C) and RNs

¹¹⁴ ERAU interview with RN (b)(6); (b)(7)(C).

medical¹¹⁵. However, [REDACTED] Chief of Security, stated officers do not take KOP medications from detainees assigned to segregation as a matter of course¹¹⁶.

At 6:00 a.m., RN [REDACTED] sent a Telephone Encounter to PA [REDACTED] reporting her encounter with REYES. She described his generalized weakness and difficulty sitting up in bed, requiring assistance. She stated he was alert and oriented and denied any other complaints, chest pain, shortness of breath, transient vision changes facial weakness or headache¹¹⁷. PA [REDACTED] did not address the Telephone Encounter, but stated to ERAU that he recalled the Charge Nurse relayed the same information during the oncoming shift report¹¹⁸.

Video surveillance footage shows RN [REDACTED] in the SMU at 12:08 p.m.¹¹⁹ He stated to ERAU that when he arrived the officer informed him REYES had been laying in his bunk all morning and did not shower. He had eaten breakfast and lunch. When RN [REDACTED] approached REYES's cell, he was in bed, covered with a blanket. He asked REYES to get up and come to the table in the dayroom, but noting he struggled, RN [REDACTED] entered the cell and helped him out of his bunk and to the table where he proceeded to complete the daily nursing rounds assessment¹²⁰. The video supports that RN [REDACTED] assisted REYES to the table in the dayroom to conduct the assessment¹²¹.

Using the eCW segregation rounds template, RN [REDACTED] entered his encounter note at 2:53 p.m.¹²², explaining to ERAU that this was his first opportunity to document his nursing round after he returned to the clinic. RN [REDACTED] noted that no interpreter was available for the encounter, and commented to ERAU that it is difficult to get an outside telephone line in the SMU. He also noted that the phone is at the officer's desk where patient privacy is not protected, commenting that sufficient privacy for patient assessments is not afforded anywhere in the SMU. RN [REDACTED] stated REYES's English language proficiency was sufficient to conduct the encounter, but also said he was not certain REYES understood everything¹²³.

RN [REDACTED] documented REYES's speech was spontaneous and he answered questions appropriately; his behavior, affect and cognitive function were within normal limits; he was not in acute distress; and did not appear to have any acute or unresolved medical conditions that may

¹¹⁵ ERAU interview with HSA [REDACTED]

¹¹⁶ ERAU interview with Chief [REDACTED]

¹¹⁷ See Telephone Encounter, dated April 2, 2019.

¹¹⁸ ERAU interview with PA [REDACTED]s.

¹¹⁹ See Surveillance Video, Jail Special Housing camera 42.

¹²⁰ ERAU interview with RN [REDACTED]

¹²¹ See Surveillance Video, Jail Special Housing camera 42.

¹²² See Encounter note, dated April 2, 2019.

¹²³ ERAU interview with RN [REDACTED]

worsen in segregation. REYES's general appearance, skin, heart, lungs and extremities were unremarkable. His weight was 143 pounds; his respirations and temperature were within normal limits; his blood pressure was low at 98/62; his heart rate was slightly elevated at 103 beats per minute; and his pulse oxygen was extremely low at 83 percent¹²⁴. RN (b)(6); stated that because of the low pulse oxygen, he planned to check it again after he had REYES walk and breathe deeply¹²⁵. Video supports that he walked with REYES in the dayroom and that although his gait was slow, he needed no assistance¹²⁶. RN (b)(6); reported he re-took REYES's pulse oxygen and recalled only that it did not get above 90 percent¹²⁷. He stated that although concerned about the abnormal vital signs, he did not believe REYES was at imminent risk.

The video shows that while RN (b)(6); was in the dayroom area, he exited REYES's cell with a small bag¹²⁸. He told ERAU it contained five medication bottles, including metformin and aspirin, and said he later turned them in to the pharmacy. He did not document the prescription information on the bottles or count the pills they contained, but recalled at least one may have been approximately half-full¹²⁹. RN (b)(6); (b)(7)(C) stated he did not ask REYES if he had already taken his daily dose of aspirin or morning dose of metformin. Although RN (b)(6); (b)(7)(C) confiscated the bottles and reported he turned them in to the pharmacy, the medical record does not document discontinuation of metformin, aspirin, and Tylenol KOP in favor of pill line prior to REYES's death on April 3, 2019¹³⁰.

RN (b)(6); reported his nursing round assessment findings to PA (b)(6); (b)(7)(C) in a face-to-face encounter¹³¹. PA (b)(6); recalled RN (b)(6); (b)(7)(C) told him REYES's pulse oxygen was 83 percent but his lungs were clear, he had no shortness of breath, spoke in complete sentences, and seemed to be doing better overall. PA (b)(6); (b)(7)(C) commented that the clinical presentation of the patient as described by RN (b)(6); did not correlate with the pulse oxygen reading of 83 percent. He directed the RN to return to the SMU and re-check the pulse oxygen level after REYES took several deep breaths. PA (b)(6); (b)(7)(C) said RN (b)(6); (b)(7)(C) was not pleased with the direction, but he told him to do it anyway. RN (b)(6); stated PA (b)(6); (b)(7)(C) told him how to instruct REYES in raising his

¹²⁴ See Encounter note, dated April 2, 2019.

¹²⁵ ERAU interview with RN (b)(6);

¹²⁶ See Surveillance Video, Jail Special Housing camera 42.

¹²⁷ ERAU interview with RN (b)(6); He did not document a reading above 83 percent during the round.

¹²⁸ See Surveillance Video, Jail Special Housing camera 42.

¹²⁹ Absent details from the prescription bottles, ERAU was not able to determine how REYES came to possess five bottles. His only KOP medications were metformin, aspirin, and Tylenol.

¹³⁰ See Encounter notes, dated April 2 and 3, 2019.

¹³¹ ERAU interviews with PA (b)(6); and RN (b)(6);

pulse oxygen level, which he had already done. He reported the PA did not direct him to return to the SMU to re-take REYES's pulse oxygen.

In his encounter note, RN (b)(6); (b)(7)(C) refers to a Telephone Encounter sent to PA (b)(6); (b)(7)(C) reporting the assessment findings. RN (b)(6); (b)(7)(C) explained to ERAU that he wrote the Telephone Encounter to document his conversation with the PA. The Telephone Encounter, timed 2:56 p.m.¹³², states he notified the PA that REYES's pulse oxygen was 79 to 83 percent¹³³ and his heart rate was 103 to 110 with regular rhythm. He also suggested REYES's possible non-compliance with the medication regimen since "several bottles of old metformin and aspirin were recovered from [segregation] and still have some left in them." Asked whether his concern about possible medication non-compliance prompted RN (b)(6); (b)(7)(C) to consider checking REYES's blood glucose, RN (b)(6); (b)(7)(C) again answered no because a provider had not ordered blood glucose checks¹³⁴. RN (b)(6); (b)(7)(C) further documented in the Telephone Encounter that REYES was ambulatory and denied any pain except in his knees after walking.

At 2:57 p.m., RN (b)(6); (b)(7)(C) entered a chart review note repeating the vital signs entered in his nursing rounds note four minutes earlier¹³⁵ and the same information appearing in the Telephone Encounter to PA (b)(6); (b)(7)(C). He did not document his stated position that PA (b)(6); (b)(7)(C) issued no new direction or orders. PA (b)(6); (b)(7)(C) did not document acknowledgment that he received the Telephone Encounter, and commented to ERAU that RN (b)(6); (b)(7)(C) sent it minutes before the end of his shift. He stated he expected RN (b)(6); (b)(7)(C) to have returned to the SMU to re-check REYES's pulse oxygen per his direction, not to have sent a Telephone Encounter documenting the abnormal vital signs taken hours earlier. He further stated that when RN (b)(6); (b)(7)(C) found REYES's pulse oxygen was 83 percent, he should have at least had him brought to the clinic where his pulse oxygen could be checked using the vital signs machine with an attached pulse oximeter, rather than the small device present in the medical segregation bag.¹³⁶

Video surveillance footage shows RN (b)(6); (b)(7)(C) back in the SMU at 4:42 p.m.¹³⁷ RN (b)(6); (b)(7)(C) stated he returned to the unit to distribute medication and found REYES sitting at the table in the dayroom. RN (b)(6); (b)(7)(C) recalled REYES was in no distress and his condition appeared the same as

¹³² See Telephone Encounter dated April 2, 2019.

¹³³ Except in the Telephone Encounter, RN (b)(6); (b)(7)(C) did not record or report to ERAU that REYES's pulse oxygen was ever as low as 79 percent.

¹³⁴ ERAU interview with RN (b)(6); (b)(7)(C).

¹³⁵ See encounter note, Chart Review, dated April 2, 2019.

¹³⁶ ERAU interview with PA (b)(6); (b)(7)(C).

¹³⁷ See Video Surveillance, Jail Special Housing camera 42, dated April 2, 2019.

earlier¹³⁸. Despite his findings during the earlier nursing round, he did not bring the medical segregation bag to check REYES's vital signs, stating he was in the SMU to complete pill pass, only¹³⁹. REYES took the offered medications, Tamiflu, gabapentin, metformin, and as-needed Tylenol.¹⁴⁰

Officers' entries in the Special Management Unit Housing Record¹⁴¹ date document REYES ate breakfast, lunch, and some of his dinner, went to indoor recreation¹⁴², and showered.

Day of Death

The assigned SMU officer for the overnight shift, from 10:00 p.m. April 2, 2019 to 6:00 a.m. on April 3, 2019, was (b)(6); (b)(7)(C). During his shift, he documented he made security rounds every 15 minutes rather than irregular rounds within a 15 minute timeframe¹⁴⁴.

On April 3, 2019, video surveillance footage shows that (b)(6); (b)(7)(C) RN, entered the SMU at 4:39 a.m.¹⁴⁵ She and Officer (b)(6); (b)(7)(C) then entered REYES's cell. RN (b)(6); (b)(7)(C) explained she was in the SMU for pill pass and that they entered the cell because REYES needed help sitting up¹⁴⁶. Officer (b)(6); (b)(7)(C) stated he assisted RN (b)(6); (b)(7)(C) move REYES to an upright position and had to keep his hand on REYES's back to hold him in position¹⁴⁷. He also commented that REYES was groaning and that he coughed a great deal during his shift. REYES refused his medication, which RN (b)(6); (b)(7)(C) stated did not concern her because he did not look extraordinarily weak or ill. He appeared sleepy but he looked neither flushed nor pale, and drank some water. RN (b)(6); (b)(7)(C) noted no respiratory issues. She documented REYES's temperature was normal at 98.6, his heart rate was at the high end of normal at 100, and his pulse oxygen was 94 percent¹⁴⁸. RN (b)(6); (b)(7)(C) stated she did not take any other vital signs, including blood glucose, because she did not see the need. She documented her intent to complete a

¹³⁸ ERAU interview with RN (b)(6); (b)(7)(C).

¹³⁹ *Id.*

¹⁴⁰ See MAR, April 2, 2019. RN (b)(6); (b)(7)(C) did not document the reason he gave as-needed Tylenol.

¹⁴¹ See Special Management Unit Housing Record, dated April 2, 2019.

¹⁴² Indoor recreation consists out-of-cell time during which detainees access the dayroom and shower area. REYES returned from the shower at 4:33 p.m., prior to RN (b)(6); (b)(7)(C) visit to the SMU for medication distribution.

¹⁴³ See Jail 2 Administrative Segregation Log Book, April 2, 2019.

¹⁴⁴ See SMU Health, Security, Fire Inspection Check Sheet. The check sheet is formatted with printed times in 15-minute and 30-minute time increments. Officer (b)(6); (b)(7)(C) entered times reflecting he made his rounds only one minute different from the times pre-printed on the form.

¹⁴⁵ Video Surveillance, Jail Special Housing camera 42, dated April 3, 2019.

¹⁴⁶ ERAU interview with RN (b)(6); (b)(7)(C).

¹⁴⁷ ERAU interview with Officer (b)(6); (b)(7)(C).

¹⁴⁸ See Encounter note, dated April 3, 2019. RN (b)(6); (b)(7)(C) entered the note at 7:08 a.m., following the medical emergency.

refusal form later¹⁴⁹, informing ERAU that she did not have the opportunity to complete the form before the medical emergency at 6:10 a.m.¹⁵⁰ RN (b)(6); (b)(7)(C) exited the unit at 4:46 a.m.¹⁵¹

At 5:07 a.m., Officer (b)(6); (b)(7)(C) placed a breakfast tray on the food slot of REYES's cell door, then he entered the cell to place the tray on the table¹⁵². He documented he took the tray into the cell after REYES nodded when asked if he wanted the meal¹⁵³. Video next shows Officer (b)(6); (b)(7)(C) walking past the cells at 5:24 a.m.¹⁵⁴ He returned to REYES's cell after picking up food trays from other cells and after encouraging REYES to eat, he tried to sit up¹⁵⁵. He also documented that at 5:52 a.m. he observed REYES was still on his bunk and the meal tray was untouched. Officer (b)(6); (b)(7)(C) noted REYES's torso was moving up and down and that he was looking up at the ceiling¹⁵⁶.

Officer (b)(6); (b)(7)(C) relieved Officer (b)(6); (b)(7)(C) for the day shift starting at 6:00 a.m.¹⁵⁷ Officer (b)(6); (b)(7)(C) advised Officer (b)(6); (b)(7)(C) that REYES was sick and had not eaten his breakfast¹⁵⁸. Video footage shows Officer (b)(6); (b)(7)(C) made a round past the cells at 6:07 a.m., looking quickly into each¹⁵⁹. He documented that REYES was propped on the bed rail on his right side. His eyes were partially open and he appeared to be sleeping¹⁶⁰. He went to the officer's station to start making entries to his logbook, after which Officer (b)(6); (b)(7)(C) entered the range. Officer (b)(6); (b)(7)(C) informed him REYES was sick and had not eaten, to which Officer (b)(6); (b)(7)(C) responded by asking if REYES was breathing. Officer (b)(6); (b)(7)(C) advised Officer (b)(6); (b)(7)(C) he would check and Officer (b)(6); (b)(7)(C) left the immediate area¹⁶².

¹⁴⁹ *Id.*

¹⁵⁰ ERAU interview with R (b)(6); (b)(7)(C)

¹⁵¹ See Video Surveillance, Jail Special Housing Unit camera 42, dated April 3, 2019.

¹⁵² *Id.*

¹⁵³ See Officer (b)(6); (b)(7)(C) written statement, dated April 3, 2019.

¹⁵⁴ See Video Surveillance, Jail Special Housing Unit camera 42, dated April 3, 2019.

¹⁵⁵ See Officer (b)(6); (b)(7)(C) written statement. The video does not support that Officer Lara spent sufficient time at REYES's cell for this to have occurred when in the dayroom at 5:24 a.m.

¹⁵⁶ See Officer (b)(6); (b)(7)(C) written statement. The video does not support that Officer (b)(6); (b)(7)(C) was at or near REYES's cell at 5:52 a.m. He did not record a security round at this time, nor at 5:24 a.m. He entered rounds at 5:01 a.m., 5:14 a.m., 5:29 a.m., and 5:45 a.m. See SMU Health, Security, Fire Inspection Check Sheet.

¹⁵⁷ See Jail 2 Administrative Segregation Log Book, April 3, 2019.

¹⁵⁸ See Officers (b)(6); (b)(7)(C) written statements, dated April 3, 2019.

¹⁵⁹ See Video Surveillance, Jail Special Housing Unit camera 42, dated April 3, 2019.

¹⁶⁰ See Officer (b)(6); (b)(7)(C) statement, dated April 3, 2019

¹⁶¹ Officer (b)(6); (b)(7)(C) was the assigned Jail Wing Officer for the shift.

¹⁶² See Officer (b)(6); (b)(7)(C) statement.

Video shows the next activity at REYES cell was 6:09 a.m. when Officer (b)(6); (b)(7)(C) returned with another officer¹⁶³. (b)(6); (b)(7)(C) reported to ERAU that before this, he had called Lieutenant (b)(6); (b)(7)(C) by phone and advised him that REYES did not look good, but he did not report that REYES was not breathing¹⁶⁴. Lieutenant (b)(6); (b)(7)(C) called the officer assigned to the clinic and directed medical personnel to report to the SMU¹⁶⁵.

(b)(6); (b)(7)(C) was the other officer video shows at REYES's cell at 6:09 a.m.¹⁶⁶ Officer (b)(6); (b)(7)(C) documented Office (b)(6); (b)(7)(C) had instructed Office (b)(6); (b)(7)(C) for him to report to the SMU because something was going on. According to Officer (b)(6); (b)(7)(C) written statement, he issued this instruction at the request of Office (b)(6); (b)(7)(C). When Officer (b)(6); (b)(7)(C) who was on the phone, advised him that REYES was not responsive¹⁶⁹. When the officers entered the cell, Officer (b)(6); (b)(7)(C) shook REYES's right leg while asking if he was OK, commenting to ERAU that REYES was still warm to the touch and his eyes were open¹⁷⁰. He called for Office (b)(6); (b)(7)(C) who immediately responded to the cell, told Officer (b)(6); (b)(7)(C) to call Lieutenant (b)(6); (b)(7)(C) and shook REYES himself¹⁷¹. He stated REYES's eyes were wide open and his chest did not rise and fall¹⁷². The video shows Officer (b)(6); (b)(7)(C) were inside the cell at 6:10 a.m. and outside the cell at 6:11 a.m.¹⁷³ Officers (b)(6); (b)(7)(C) returned to the Jail Housing Control area and Officer (b)(6); (b)(7)(C) informed Office (b)(6); (b)(7)(C) that REYES was unresponsive¹⁷⁴. Officer (b)(6); (b)(7)(C) asked Officer (b)(6); (b)(7)(C) if he called Code 10-10¹⁷⁵, then did so himself over the radio¹⁷⁶. He logged the time of the radio call was 6:14 a.m.¹⁷⁷

¹⁶³ See Video Surveillance Special Housing Unit, camera 42 dated April 3, 2019. Officer (b)(6); (b)(7)(C) statement documents he returned to two additional times between 6:07 a.m. when he first looked in REYES's cell and 6:09 a.m. when he returned with another officer. Officer (b)(6); (b)(7)(C) and other written reports and verbal statements were not consistent concerning events immediately preceding the emergency response. Officer (b)(6); (b)(7)(C) stated during his interview that he had difficulty recalling events because the incident was stressful. ERAU attempted to reconcile the information as best possible.

¹⁶⁴ ERAU interview with Officer (b)(6); (b)(7)(C).

¹⁶⁵ See Lieutenant (b)(6); (b)(7)(C) written statement, dated April 3, 2019.

¹⁶⁶ Officer (b)(6); (b)(7)(C) as the assigned Jail Housing One officer for the shift.

¹⁶⁷ Officer (b)(6); (b)(7)(C) was the assigned Jail Control officer for the shift.

¹⁶⁸ See Officer (b)(6); (b)(7)(C) written statement, dated April 3, 2019. ERAU was unable to determine the time or means by which Officer (b)(6); (b)(7)(C) contacted Officer (b)(6); (b)(7)(C).

¹⁶⁹ See Officer (b)(6); (b)(7)(C) statement.

¹⁷⁰ ERAU interview with Officer (b)(6); (b)(7)(C).

¹⁷¹ ERAU interview with Officer (b)(6); (b)(7)(C).

¹⁷² ERAU interview with Officer (b)(6); (b)(7)(C).

¹⁷³ See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

¹⁷⁴ See Officer (b)(6); (b)(7)(C) statement.

¹⁷⁵ *Id.*

¹⁷⁶ See Officer (b)(6); (b)(7)(C) statement, dated April 3, 2019.

¹⁷⁷ See Jail Control Log, dated April 3, 2019.

Officer (b)(6); (b)(7)(C) stated that he did not call Code 10-10 when he confirmed REYES was unresponsive because he was not certain medical personnel were not already en route. He also stated he considered starting cardio-pulmonary resuscitation (CPR) but did not because he believed REYES was already dead¹⁷⁸. Officer (b)(6); (b)(7)(C) acknowledged he should have called Code 10-10 and started CPR rather than going to Control¹⁷⁹; likewise, Officer (b)(6); (b)(7)(C) acknowledged he should have called Code 10-10 and initiated CPR when he discovered REYES was unresponsive¹⁸⁰. After Officer (b)(6); (b)(7)(C) called the Code 10-10, Officer (b)(6); (b)(7)(C) returned to his post and Officer (b)(6); (b)(7)(C) returned to REYES's cell¹⁸¹.

While these events were underway, medical staff were preparing to respond to Lieutenant (b)(6); (b)(7)(C)'s request for their presence in the SMU. HSA (b)(6); (b)(7)(C) documented the medical officer relayed the request to medical personnel at approximately 6:10 a.m. but did not provide any patient information¹⁸². Two RNs, identified as RN (b)(6); (b)(7)(C) retrieved the medical segregation bag but before they left the clinic, the medical officer received additional information; specifically, REYES's name and that he was having difficulty breathing. RN (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) proceeded to the SMU with the bag, while RN (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) LPN, retrieved the emergency bag and mobile oxygen tank. En route to segregation, they heard the Code 10-10 called on the radio at approximately 6:12 a.m.¹⁸³

The video shows other security personnel arriving within minutes of the 10-10 call, including Officer (b)(6); (b)(7)(C)¹⁸⁴. Officer (b)(6); (b)(7)(C) stated to ERAU that Officers (b)(6); (b)(7)(C) were in the vicinity of the cell and told him REYES had passed¹⁸⁵. He entered the cell, saw no signs of breathing and REYES did not respond to touch or voice commands¹⁸⁶.

At 6:14 a.m., Lieutenant (b)(6); (b)(7)(C) arrived in the SMU¹⁸⁷. She stated to ERAU that she heard the 10-10 call as she arrived at the door, Lieutenant (b)(6); (b)(7)(C) having alerted her moments before that she should respond to the unit because something was going on¹⁸⁸. When she entered

¹⁷⁸ ERAU interview with Officer (b)(6); (b)(7)(C)

¹⁷⁹ ERAU interview with Officer (b)(6); (b)(7)(C)

¹⁸⁰ ERAU interview with Officer (b)(6); (b)(7)(C)

¹⁸¹ ERAU interviews with Officers (b)(6); (b)(7)(C)

¹⁸² See MQMU (acronym unknown) Incident Report, dated April 3, 2019. In the report, HSA (b)(6); (b)(7)(C) summarizes information in the statements of nurses who were involved in the emergency response.

¹⁸³ According to (b)(6); (b)(7)(C), responding medical staff respond to 10-10 calls with the oxygen tank, automated external defibrillator (AED), and emergency bag. Medical responders left the clinic without all equipment because the 10-10 was not called until they were en route.

¹⁸⁴ See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

¹⁸⁵ Interview with Officer (b)(6); (b)(7)(C).

¹⁸⁶ See Officer (b)(6); (b)(7)(C)'s statement, dated April 3, 2019.

¹⁸⁷ See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

¹⁸⁸ ERAU interview with Lieutenant (b)(6); (b)(7)(C), dated May 7, 2019.

the unit, Officer (b)(6); (b)(7)(C) informed her REYES was not breathing¹⁸⁹. She entered the cell and noting there were no signs of life, exited the cell and instructed the officers present, (b)(6); (b)(7)(C) to initiate CPR. Officer (b)(6); (b)(7)(C) was first to perform a round of chest compressions. Lieutenant (b)(6); (b)(7)(C) directed the security surveillance post to activate 911.

The video shows medical personnel entering the SMU and proceeding to REYES's cell at 6:15 a.m. Additional security staff responded as well¹⁹⁰. HSA (b)(6); (b)(7)(C) documented that when the nurses arrived, officers were performing chest compressions while REYES remained on the bed¹⁹¹. They directed security personnel to call 911¹⁹², told officers to move REYES to the floor, and requested an AED¹⁹³. Nurses palpated a weak, thready radial pulse but did not detect a heart rate or pulse oxygen by way of the pulse oximeter applied to the left index finger. REYES's eyes were fixed and open and he was unresponsive to name, touch or pain. A nurse wiped away brown liquid secretion coming from REYES's mouth as chest compressions continued. An RN took over compressions as an officer administered breaths using an ambu-bag.

As requested, Officer (b)(6); (b)(7)(C) retrieved the AED maintained in Jail Control and provided it to the nurses¹⁹⁴. At least twice, the AED did not recommend a shock and compressions continued¹⁹⁵. At 6:18 a.m., the officer in the clinic notified RN (b)(6); (b)(7)(C) RN, that responding staff on scene needed a suction machine. The RNs arrived at the cell at 6:19 a.m. with the suction machine and RN (b)(6); (b)(7)(C) performed oral suction, extracting about five to ten milliliters of fluid while chest compressions continued¹⁹⁶.

Chief (b)(6); (b)(7)(C) responded to the scene and arrived at the cell as medical staff were assessing REYES and Officer (b)(6); (b)(7)(C) was still performing chest compressions¹⁹⁷. He called for staff to

¹⁸⁹ See Lieutenant (b)(6); (b)(7)(C) statement, dated April 3, 2019.

¹⁹⁰ See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

¹⁹¹ See HSA (b)(6); (b)(7)(C) MQMU Incident Report.

¹⁹² ERAU cannot verify whether Lieutenant (b)(6); (b)(7)(C) directed the activation of 911 on her own or pursuant to the direction of medical staff. The Florence Fire Department report documents it received a call from FSPC at 6:17:44 a.m. for "unknown problem/person down" and dispatched Emergency Medical Services (EMS) 13 seconds later.

¹⁹³ See HSA Stephen MQMU Incident Report.

¹⁹⁴ See Officer (b)(6); (b)(7)(C) statement. RN (b)(6); (b)(7)(C) explained that medical personnel typically bring an AED to medical emergencies, but did not in this case because they believed they were responding to a patient with breathing difficulties. According to Chief (b)(6); (b)(7)(C), security personnel did not retrieve the AED when they started CPR because the former ICE Safety Manager prohibited Asset personnel from using the device during emergencies. He said Asset received new direction and officers will retrieve and use AEDs as trained.

¹⁹⁵ See HSA (b)(6); (b)(7)(C) MQMU Incident Report.

¹⁹⁶ *Id.* FSPC responders who performed CPR during the emergency were Officer (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) RNs (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) and LPN (b)(6); (b)(7)(C). See statements. ERAU confirmed their current CPR certification.

¹⁹⁷ See Chief (b)(6); (b)(7)(C) statement, dated April 3, 2019.

retrieve the video camera from Jail Control, but a staff member he could not identify by name informed him the video camera was not functioning. Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) authorized him to use his cell phone to video record the response. He continued filming with his cell phone until Lieutenant (b)(6); (b)(7)(C) arrived with the supervisors' camera and took over recording¹⁹⁸. Chief (b)(6); (b)(7)(C) informed ERAU that security personnel respond to calculated use of force incidents with a video camera, but do not necessarily respond with camera to other emergencies. He acknowledged policies and post orders do not designate responsibility for conducting routine inventories of video cameras and verifying their operability. He said the ICE Compliance Specialist performs this function but does not maintain documentation¹⁹⁹.

EMS personnel arrived on scene at 6:23:58 a.m. and reached REYES at 6:25:01 a.m.²⁰⁰ Responders found the patient supine on the floor inside a cell. CPR was in progress and the AED was in place. FSPC staff reported to EMS that REYES had not been seen walking or talking since last night and would not wake up. The EMS responders confirmed REYES was pulseless, not breathing, and a four-lead EKG showed asystole²⁰¹. His pupils were non-reactive to light and his lung sounds were absent. There were no signs of trauma noted. The patient's right leg was discolored and appeared to have lividity²⁰², and his face was discolored and appeared mottled²⁰³. The responders rolled him to his right side using a three-man log roll and noted what they described as obvious discoloration/lividity to thoracic region.²⁰⁴ Responder (b)(6); (b)(7)(C) contacted the physician overseeing EMS actions, who pronounced REYES's death at 6:33 a.m. Video shows EMS departed at 6:36 a.m.²⁰⁵

After EMS left the scene, RNs (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) examined the body²⁰⁶. RN (b)(6); (b)(7)(C) informed ERAU they found no wounds but observed vomit and diarrhea. She said there was no rigor and that REYES was soft everywhere; also, that there was no lividity or mottling. She was

¹⁹⁸ *Id.* The facility did not provide ERAU with video taken by cell phone or the camera brought to the scene.

¹⁹⁹ ERAU interview with Chief (b)(6); (b)(7)(C).

²⁰⁰ See Florence Fire Department Patient Care Report.

²⁰¹ Asystole means no heart rhythm detected.

²⁰² Lividity is a red to blue/purple discoloration of the skin due to the settling or pooling of blood and fluid under the influence of gravity following death. Lividity can begin about two hours after death.

²⁰³ Mottling occurs when the heart can no longer pump blood effectively and blood flow throughout the body slows. Mottled skin presents as a red or purple marbled appearance and is cool to touch. It usually begins in the feet and legs.

²⁰⁴ The thoracic region refers to the upper part of the body from the neck to the diaphragm.

²⁰⁵ See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

²⁰⁶ See RN (b)(6); (b)(7)(C) statement.

aware EMS responders documented lividity, but said she and RN (b)(6); (b)(7)(C) noted none until the coroner arrived over an hour later²⁰⁷.

Officer (b)(6); (b)(7)(C) stated that after the incident, another officer relieved him in the SMU. He returned later in the shift²⁰⁸. He did not make any log entries documenting the medical emergency or his return to the post. Likewise, the officer who relieved him did not make any entries to the logbook²⁰⁹.

The video shows the Pinal County Coroner entered REYES's cell at approximately 7:43 a.m. RNs (b)(6); (b)(7)(C) remained on scene, and HSA (b)(6); (b)(7)(C) was present²¹⁰. The RNs and AOIC (b)(6); (b)(7)(C) informed ERAU that the coroner took possession of REYES's belongings, including a paper bag on the cell table containing cash and papers²¹¹. At 8:13 a.m., the coroner exited the SMU with REYES's body²¹².

The Pinal County Forensic Examination Report Final Summary signed by (b)(6); (b)(7)(C) MD, Chief Medical Examiner, documents the cause of death as complications of liver cirrhosis²¹³, diabetes mellitus, and hypertensive cardiovascular disease²¹⁴. The manner of death was natural. The report also noted that REYES had a bacterial pneumonia and the influenza PCR²¹⁵ test was negative²¹⁶.

Post-Death Actions

- At the direction of AOIC (b)(6); (b)(7)(C) promptly collected statements from all personnel involved in the emergency response²¹⁷.
- Facility leadership provided ERAU with a sign-in sheet documenting they led a de-briefing of involved staff²¹⁸. They did not produce minutes or a report reflecting the findings of

²⁰⁷ ERAU interview with RN (b)(6); (b)(7)(C)

²⁰⁸ ERAU interview with Officer (b)(6); (b)(7)(C)

²⁰⁹ See Jail 2 Administrative Segregation logbook.

²¹⁰ See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

²¹¹ Interviews with AOIC (b)(6); (b)(7)(C)

²¹² See Video Surveillance, Special Housing Unit camera 42 dated April 3, 2019.

²¹³ Liver cirrhosis is a condition in which the liver does not function properly due to long-term damage.

²¹⁴ Hypertensive cardiovascular disease refers to heart conditions caused by high blood pressure.

²¹⁵ Influenza PCR (polymerase chain reaction) is a rapid laboratory test collected by nasal swab used to the genetic material of influenza viruses.

²¹⁶ See Pinal County Forensic Examination Final Summary, signed by the Medical Examiner on April 25, 2019 and date stamped by the Pinal County Medical Examiner's Office on April 29, 2019.

²¹⁷ See statements.

²¹⁸ See De-Briefing Sign-In Sheet dated April 3, 2019.

the after-action review. Although a report was not produced, Chief (b)(6); (b)(7)(C) informed ERAU Asset initiated the following corrective actions²¹⁹:

- Implemented procedures requiring designated officers to respond to all emergencies with a video camera.²²⁰
- At shift Roll Call, reviewed expectations with respect to officers' response to medical emergencies, including calling 10-10, bringing the AED to the scene, and initiating CPR.
- Chief (b)(6); (b)(7)(C) stated involved officers were made aware of employee assistance services at the de-briefing²²¹.
- AOIC (b)(6); (b)(7)(C) mailed REYES' stored property to the Mexican Consulate²²². He stated the facility did not inventory or receipt the belongings in the cell turned over to the coroner²²³.

CONCLUSIONS

Medical

Compliance Findings

ERAU identified the following deficiency:

(b)(5)

(b)(5)

²¹⁹ ERAU interview with Chief I (b)(6);

²²⁰ See memorandum from Captain (b)(6); (b)(7)(C) dated May 7, 2019.

²²¹ ERAU interview with Chief (b)(6); (b)(7)(C)

²²² See United Parcel Service receipt dated April 17, 2019.

²²³ ERAU interview with AOIC (b)(6);

Areas of Concern

- PA (b)(6); (b)(7)(C) did not mark Telephone Encounters addressed to acknowledge their receipt on March 4, March 17, March 22, April 1, and April 2, 2019. In addition, he did not co-sign a telephone order he issued on February 27, 2019.
- The medical record points to the following concerns with medication administration and related documentation:
 - Healthcare staff speculated expired metformin found by security personnel on March 30, 2019 resulted from REYES's transfer and quick return from LPCC on March 22, 2019. If true, staff did not confiscate the medication during the return intake process.
 - There is no provider order immediately re-starting pill line gabapentin and KOP metformin and aspirin after REYES returned from LPCC, or authorizing him to continue the medications sent back with him. PA Nienhuis re-started the medications on March 25, 2019. Because of the possibility staff did not confiscate REYES's medications when he returned to FSPC, ERAU cannot positively determine whether he did or did not have at least his KOP medications.

- REYES retained his KOP medications when placed in segregation for medical observation. Consistent with policy, all healthcare staff stated detainees are not allowed to retain KOP medications in segregation; however, RN (b)(6); (b)(7)(C) did not complete reconciliation to assure KOPs were confiscated and changed to pill line when REYES was placed in segregation on April 1, 2019. Likewise, RN (b)(6); (b)(7)(C) took no action to confiscate the KOP medications she discovered in REYES's possession during morning pill pass on April 2, 2019. The medications were not confiscated until shortly after noon the same day, during RN (b)(6); (b)(7)(C) nursing round.
- When RN (b)(6); (b)(7)(C) confiscated the KOP medications, he did not ask REYES if he had taken his morning dose of metformin and daily dose of aspirin; consequently, REYES may have missed both. The MAR documents he was given his afternoon dose of metformin and does not document administration of aspirin.
- During afternoon pill pass on April 2, 2019, RN (b)(6); (b)(7)(C) documented he gave REYES as-needed Tylenol without documenting the basis or need.
- Nurses did not check REYES's blood sugar following his placement on medical observation in segregation for flu-like symptoms. When last checked more than a week earlier, his blood sugar was 306 mg/dl. According to the American Diabetes Association, diabetics who develop an illness are at risk for serious complications. Blood glucose levels can increase or decrease to dangerous levels if not monitored closely.
- On April 2, 2019, RN (b)(6); (b)(7)(C) did not take appropriate action by directing REYES's escort from the SMU to the clinic for further assessment when he found his pulse oxygen was 83 percent during his nursing round. He informed PA (b)(6); (b)(7)(C) that despite the low pulse oxygen, REYES appeared to be doing better, but did not return to the SMU to re-check REYES as the PA reported he directed. When back in the SMU for pill pass approximately three hours after his nursing round, RN (b)(6); (b)(7)(C) did not take REYES's vital signs or otherwise assess him.
- RNs (b)(6); (b)(7)(C) both found REYES in an extremely weakened condition during morning pill pass on April 2 and 3, 2019, respectively. They took partial sets of vital signs, but did not exercise prudent nursing judgment by directing his escort to the clinic for further assessment.

Security

Compliance Findings

ERAU identified the following deficiencies in the ICE PBNDS 2011 (revised 2016) governing safety and security.

1. ICE PBNDS 2011 (revised 2016), Emergency Plans, Section (V)(D)(7), which states, “At least one video camera shall be maintained in the control center for use in emergency situations, and the facility administrator shall ensure that it is maintained, tested and supplied as required in ‘K. Maintaining Audiovisual Recording Equipment and Records’ found in standard ‘2.15 Use of Force and Restraints.’”
 - When Chief (b)(6); (b)(7)(C) called for a handheld video camera to be brought to the scene of the medical emergency, staff discovered it was inoperable. Medical emergencies are not included among those addressed in the Emergency Plans standard; however, the unavailability of an operable video camera to record response to emergencies of the nature specifically covered by the standard constitutes a deficiency.
 2. ICE 2011 PBNDS (revised 2016), Special Management Units, section (V)(M), which states, “Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly.”
 - Officer (b)(6); (b)(7)(C) did not make rounds on an irregular schedule on the overnight shift ending April 3, 2019 at 6:00 a.m. He logged rounds every 14 to 16 minutes. During the last hour of his shift, Officer (b)(6); (b)(7)(C) logged rounds 5:01 a.m., 5:14 a.m., 5:29 a.m., and 5:45 a.m. Video surveillance footage does not support that he made these rounds. Officer (b)(6); (b)(7)(C) was last at REYES’s cell at 5:07 a.m. At 5:24 a.m., he walked past but did not look in the cell to observe REYES. Although he documented in his written statement that he observed REYES’s chest moving up and down at 5:52 a.m., the video does not show him at the cell at this time.
- Officer (b)(6); (b)(7)(C) failure to observe REYES directly after 5:07 a.m. also constitutes a violation of the following policies:
- ICE Florence Detention Center (FDC) policy 2.12, Special Management Units, which states, “The Special Housing Officer will personally observe each detainee at least every 30 minutes on an irregular schedule.”
 - ICE FDC policy 2.4, Facility Security and Control/Inspections, which requires that officers “Conduct detainee welfare and security inspections at a minimum of every 15 minutes between the hours of 2200 and 0600.”

ERAU cites the following additional violation of FDC policy.

1. ICE FDC policy 2.4, Facility Security and Control/Inspections, which states, “A log book will be maintained in each housing unit for recording information regarding routine unit operations, as well as unusual and emergency situations.”
 - On April 3, 2019, Officer (b)(6); (b)(7)(C) did not log that REYES was too ill to sit up on his own when the nurse offered him medications. Officer (b)(6); (b)(7)(C) also did not log that he had to keep his hand on REYES’s back to keep him upright while the nurse spoke with him.
 - Officer (b)(6); (b)(7)(C) only entry to the logbook on April 3, 2019 documents he assumed duties for the SMU post at 6:00 a.m. He did not log any events relating to the medical emergency, his departure from the post when relieved by another officer, or his return.

Areas of Concern

- Based on information reported by Officer (b)(6); (b)(7)(C) and his own observation of REYES when he looked in his cell at 6:07 a.m., Officer (b)(6); (b)(7)(C) was concerned enough about his welfare that he called Lieutenant (b)(6); (b)(7)(C). However, he did not enter the cell for another two minutes when joined by Officer (b)(6); (b)(7)(C). Despite determining REYES was unresponsive, the officers did not call a medical emergency or start CPR, nor did Officer (b)(6); (b)(7)(C) when he arrived and confirmed REYES was unresponsive. Officer (b)(6); (b)(7)(C) left the cell area and informed Jail Control officer (b)(6); (b)(7)(C) of REYES’s status, whereupon Officer (b)(6); (b)(7)(C) called Code 10-10. The call was approximately seven minutes after Officer (b)(6); (b)(7)(C) first looked in REYES’s cell, and five minutes after he and Officer (b)(6); (b)(7)(C) confirmed REYES was unresponsive. Had the officers taken appropriate action, the medical emergency response would have been hastened by five to seven minutes.

In addition, the officers who discovered REYES unresponsive did not start CPR until instructed by Lieutenant (b)(6); (b)(7)(C). Due to confusion as to security personnel’s authority to use the AED as part of CPR, officers did not call for the device until directed by medical staff. Responding medical staff did not bring an AED to the scene because they were already responding to a more general call for assistance when they heard the Code 10-10. Following REYES’s death, Asset clarified officers’ responsibilities with respect to medical emergencies, including calling 10-10, initiating CPR, and using AEDs.

- In contradiction with the statements of healthcare staff and IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units, Chief (b)(6); (b)(7)(C) said detainees in the SMU retain their KOP medications. ERAU recommends collaborative review of IHSC

policy, to include clarification of responsibilities with respect to confiscation of the medications.

- As noted in Deficiency 2, officers are required to personally observe detainees in the SMU at least every 30 minutes on an irregular basis. Although officers interviewed stated they understand they are to observe living, breathing flesh by seeing the chest rise and fall, the SMU policy does not address this expectation. To support the effectiveness of rounds as welfare checks, ERAU recommends incorporation of appropriate guidance in the policy and training materials.

Table One: Vital Signs

Date	Time	Blood Pressure ²²⁴	Heart Rate ²²⁵	Respirations ²²⁶	Temperature ²²⁷	Pulse Oximetry ²²⁸	Weight
2/27/19	9:44 am	135/86	91	16	98.9	98%	146.6
2/28/19	8:02 am	128/88	88	20	98.3	97%	148.4
3/04/19	7:46 am	129/81	93	18	98.0	97%	150.8
3/07/19	7:52 am	112/74	90	16	97.9	97%	150.6
3/20/19	1:17 pm	146/91	86	16	97.1		145
3/21/19	10:58 am	121/74	50	16	98.3	97%	169 ²²⁹
3/22/19	3:39 am	126/80	96	16	98.1	98%	149
3/25/19	9:29 am	115/71	105	16	98.3 oral 100.5 tympanic	97%	147.8
3/26/19	8:24 am	107/62	89	20	99.1	97%	149
3/28/19	8:14 am	118/80	98	18	97.6	98%	149
3/30/19	8:27 am	106/69	100	17	97.6	95%	147.8
4/01/19	11:07 am	105/65	114	16	100.1	96%	Not taken
4/02/19	5:44 am	Not taken	Not taken	Not taken	100	Not taken	Not taken
4/02/19	2:53 pm	98/62	103	14	97.3	83%	143
4/03/19	4:36 am	Not taken	100	Not taken	98.6	94%	Not taken

²²⁴ The Federal Bureau of Prisons Clinical Guidance on Diabetes sets the blood pressure treatment goal for older adults with diabetes at <140/90.

²²⁵ A normal heart rate is between 60 and 100 beats per minute.

²²⁶ A normal respiratory rate is between 12 and 20 breaths per minute.

²²⁷ A normal temperature is 98.6 degrees.

²²⁸ A normal pulse oximetry reading is between 95% and 100%.

²²⁹ The outlier weight of 169 pounds was recorded at LPCC.

Table Two: Routine Blood Glucose Readings

Date	Time	Reading (mg/dl)
02/27/19	9:44 a.m. Intake	144
02/28/19	5:00 am	Blank
	3:30 pm	123
03/01/19	5:00 am	97
	3:30 pm	110
03/02/19	5:00 am	96
	3:30 pm	178
03/03/19	5:00 am	90
	3:30 pm	146
03/04/19	5:00 am	Blank
	3:30 pm	165
03/05/19	5:00 am	112
	3:30 pm	156
03/06/19	5:00 am	129
	3:30 pm	179
03/07/19	5:00 am	116
	3:30 pm	137
03/08/19	5:00 am	115
	3:30 pm	233
03/09/19	5:00 am	139
	3:30 pm	160
03/10/19	5:00 am	144
	3:30 pm	204
03/11/19	5:00 am	105
	3:30 pm	209
03/12/19	5:00 am	154
	3:30 pm	204
03/13/19	5:00 am	155
	3:30 pm	217
03/14/19	5:00 am	134
	3:30 pm	220
03/15/19	5:00 am	110
	3:30 pm	148
03/16/19	5:00 am	106
	3:30 pm	127
03/17/19	5:00 am	107
	3:30 pm	Refused
03/18/19	5:00 am	104
	3:30 pm	142
03/19/19	5:00 am	128
	3:30 pm	162
03/20/19	5:00 am	113
	3:30 pm	Routine checks discontinued
3/25/19	9:29 a.m.	306





PINAL COUNTY
WIDE OPEN OPPORTUNITY

FORENSIC EXAMINATION REPORT
EMIGDIO ABEL REYES CLEMENTE
PINAL COUNTY ME CASE #19-197
US IMMIGRATION AND CUSTOMS
CASE #215-881-614

Pinal County

APR 29 2019

Medical Examiner



Report of Examination

ME Case number: 19-197
Agency, number: US Immigration and Customs, 215-881-614
Decedent: Emigdio Abel Reyes Clemente
Date of birth: August 5, 1964
Date of death: April 3, 2019
Date of examination: April 4, 2019
Time of examination: 1100 hours
Investigator: (b)(6); (b)(7)(C)
Forensic Technician:
Present at examination: No agency is present

Cause of Death: Complications of liver cirrhosis, diabetes mellitus, and
hypertensive cardiovascular disease
Manner of Death: Natural

April 25, 2019
Date Signed

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

Chief Medical Examiner

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

REPORTED CIRCUMSTANCES OF DEATH

The decedent was a 54-year-old Mexican immigrant who was being held in the US Immigration and Customs Detention Center in Florence, Arizona. On April 3, 2019, he was found unresponsive in bed in his locked single-man cell within the medical unit by a detention officer. Resuscitation efforts were initiated and Florence Fire Department personnel arrived. They found no signs of life, and the death was pronounced via telemetry at 0633 hours by medical personnel with Mountain Vista Medical Center. The last time it was confirmed that he was alive was at 1730 hours on April 2, 2019.

Past Medical/Surgical History

The decedent had been in the medical until due to fever and possible respiratory infection. He also had a history of diabetes mellitus and restless leg syndrome.

INITIAL EXTERNAL EXAMINATION

The body is received in a zippered body pouch secured by evidence seal number 00003753.

CLOTHING AND PERSONAL EFFECTS

All property is documented on the property sheet that is separate in the file.

EVIDENCE OF MEDICAL INTERVENTION

Two electrocardiographic leads are present on the upper extremities.

EVIDENCE OF TRAUMA

There are faint linear reddish contusions on the anterior medial aspects of the right and left legs.

Injuries consistent with cardiopulmonary resuscitation

There are left second through fifth and eighth rib anterior fractures. There are right second through fourth rib anterior fractures. There is a transverse sternal fracture. There are fractures of the sternal cartilage joints at the anterior rib cage.

These injuries, having been once described, will not be repeated.

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

SCARS, TATTOOS, AND OTHER IDENTIFYING BODY FEATURES

There are faint irregular pigmented scars present on the front of the right and left legs. There is a linear scar present on the posterior aspect of the right forearm. There are no obvious surgical scars or tattoos identified.

GENERAL EXTERNAL EXAMINATION

The preservation is good in the absence of embalming. The body is cold to touch, subsequent to refrigeration. Rigor mortis is fully developed. Posterior red-purple lividity is partially fixed.

The body is that of a normally developed Hispanic male measuring 64 inches in length and weighing 143 pounds. The general appearance is compatible with the reported age of 54 years. The hairline is normal. Scalp hair is black. The irises are brown, and there is no jaundice or lesions of sclera or conjunctivae. The nose is unremarkable. There is facial hair stubble of a beard and mustache. The ears are unremarkable. The mouth is unremarkable. Teeth are natural. The neck is unremarkable. There are no palpable axillary, cervical, abdominal, or inguinal masses. The chest and back are symmetrical and unremarkable.

Body hair is normal in amount and distribution of an average male adult. The abdomen is mildly protuberant. The external genitalia, anus, and perineum are unremarkable. The extremities are symmetrical, without significant clubbing, edema, or deformity. Fingernails are intact.

INTERNAL EXAMINATION

The body is opened by a standard Y-shaped thoracoabdominal incision. All viscera occupy their appropriate anatomic relationships. Subcutaneous adipose tissue ranges up to 2.5 cm in thickness over the abdominal wall. Serous surfaces are smooth and glistening throughout. There are no adhesions or significant free fluid accumulations in the body cavities.

CARDIOVASCULAR SYSTEM

The pericardium is unremarkable. The heart weighs 460 grams. The heart occupies its usual mediastinal site and has a smooth epicardial surface. The external configuration is not remarkable. All major vessels arise in their appropriate anatomic relationships. The coronary ostia are normally placed and are patent. The coronary arteries arise normally, are distributed in a right dominant pattern, and show mild concentric atherosclerosis, with narrowing of the lumen ranging from 20-30%. The atria and ventricles are of normal caliber and are free of gross anomalies and thrombi. The myocardium is red-brown and firm, without focal abnormalities. The ventricular thicknesses are as follows: left ventricle 1.6 cm, interventricular septum 1.6 cm, right ventricle 0.5 cm.

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

The endocardium is unremarkable. The cardiac valve circumferences are appropriate for the caliber of the cardiac chambers. The cardiac valves have thin, pliable leaflets that are free of fusion, vegetations, or significant fenestrations.

The aorta is of normal caliber with all major arterial branches arising in their appropriate anatomic relationship. The intimal surfaces contain mild atherosclerotic changes, but are otherwise smooth, without aneurysm formation or dissection. No systemic venous abnormalities or thrombi are present.

RESPIRATORY SYSTEM

The upper airway, larynx, and trachea are patent with no evidence of edema, ulceration, or obstruction. The right lung weighs 1020 grams and the left lung weighs 1360 grams. There is mild congestion. They are diffusely consolidated, and exude pus or mucus-like material on the cut surfaces. Histologic sections are obtained. The pleural surfaces are smooth and glistening. The parenchyma is well expanded. Sectioning reveals pink to red-purple tissue with no areas of induration, consolidation, hemorrhage, or gross scarring. The bronchi and pulmonary vessels are patent and of normal caliber.

DIGESTIVE SYSTEM

The tongue is unremarkable. The oropharynx is grossly normal and unobstructed. The esophagus is of normal caliber with a smooth, gray-white mucosal lining. The gastroesophageal junction is well defined. The stomach has intact mucosal surfaces. The lumen contains 500 mL of tan liquid with mucoid material, and possibly food material, present. There are no areas of mucosal ulceration, erosion, hemorrhage, or scarring. The small and large intestines are not remarkable. The appendix is present in the right lower quadrant and is unremarkable. The tan-gray, lobular pancreas has no focal abnormalities. The pancreatic ducts are patent and of normal caliber.

HEPATOBIILIARY SYSTEM

The 1700 gram liver has a smooth capsule covering red-brown parenchyma. It displays advanced cirrhosis. The cut surfaces show no diffuse or focal abnormalities. The intrahepatic and extrahepatic biliary ducts are unremarkable. The gallbladder contains viscid olive green bile and is free of calculi. The gallbladder wall appears to be thickened and edematous.

GENITOURINARY SYSTEM

The right kidney weighs 220 grams and the left kidney weighs 230 grams. The kidneys are similar in shape with intact capsules covering smooth, red-brown parenchyma. The cortical surfaces have a coarsely granular appearance. The

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

capsules strip with ease. The cut surfaces show distinct corticomedullary junctions. The calyces, pelves, and ureters are unremarkable. The renal vessels are patent and of normal caliber.

The urinary bladder contains approximately 300 mL of dark yellow urine. The mucosal surfaces are flat and pink-tan. The prostate gland is markedly enlarged.

RETICULOENDOTHELIAL SYSTEM

The 300 gram spleen has an intact, smooth, and glistening capsule covering dark purple, moderately soft parenchyma. Regional lymph nodes have their usual distribution and appearance.

ENDOCRINE SYSTEM

The thyroid and adrenal glands are grossly not remarkable.

NECK

The cervical spine, hyoid bone, and thyroid cartilage are intact and unremarkable. There are no hemorrhages in the strap muscles or soft tissues of the neck.

MUSCULOSKELETAL SYSTEM

The bony framework, supporting musculature, and soft tissues are grossly normal, except the rib fractures as described above.

NERVOUS SYSTEM

The scalp is reflected in the usual fashion. There are no contusions, lacerations, or abrasions of the scalp or subscalpular structures. There are no skull fractures. The pituitary gland is unremarkable. The cerebral vessels are intact with no malformation, aneurysm, thrombosis, or significant atherosclerotic narrowing. The cranial nerves are grossly normal.

The dura and dural sinuses are unremarkable. There are no epidural, subdural, or subarachnoid hemorrhages. The brain weighs 1020 grams. The leptomeninges are thin and clear. The cerebral hemispheres are symmetrical with normal external landmarks and an unremarkable convolution pattern. There are no uncus, subfalcine, transtentorial, or tonsillar herniations. Multiple sections of cerebrum, cerebellum, and brain stem are unremarkable. The ventricular system is symmetrical and filled with clear fluid.

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

TOXICOLOGY SPECIMENS

Samples of the following are collected and some are submitted for toxicological testing.

- Vitreous fluid.
- Blood.
- Urine.

The toxicology report is separate in the file.

A urine drug screen is performed with CLIA waived Inc. Rapid Dip Drug Test strip (9 panel). The result is negative for cocaine metabolites, opiates, methamphetamine, amphetamines, benzodiazepines, barbiturates, oxycodone, methadone, and marijuana.

MICROSCOPIC EXAMINATION / DIAGNOSES

Lungs: Pneumonia

Heart: Myocyte hypertrophy

FINAL SUMMARY

Based on the forensic examination findings and investigative history as available to me, it is my opinion that Emigdio Abel Reyes Clemente, a 54-year-old Hispanic male, died as a result of complications of liver cirrhosis, diabetes mellitus, and hypertensive cardiovascular disease.

The manner of death is natural.

As with all death investigations, opinions expressed herein are amenable to change should new, reliable, and pertinent information come to light.

The Pinal County Medical Examiner's Office is required by statute (A.R.S. § 11-594(A) (2) and (4)) to certify the cause and manner of death following completion of the death investigation of each case over which it assumes jurisdiction, and to promptly execute a death certificate, on a form provided by the state registrar of vital statistics, indicating the cause and manner of death. The form provided by the state registrar of vital statistics includes five manners of death: homicide, suicide, accident, natural, and undetermined. The determination of manner of death is a forensic determination by the pathologist predicated upon the totality of all then-known forensic evidence and other circumstances surrounding the cause of death; it is not a legal determination of criminal or civil responsibility of any person(s) for the death. The significant findings below may not be a complete list of the decedent's medical history. This report was partially generated using dragon automated dictation software and may contain minor transcription errors.

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

Significant findings

- I. Liver cirrhosis of unknown etiology
 - a. Splenomegaly
- II. Diabetes mellitus
- III. Hypertensive cardiovascular disease
 - a. Left ventricular hypertrophy
 - b. Benign nephrosclerosis
- IV. Respiratory infection
 - a. Bacteria pneumonia
 - b. Nasal swabs negative for influenza PCR
- V. Marked benign prostate hyperplasia
- VI. Multiple injuries from cardiopulmonary resuscitation
- VII. No other evidence of acute trauma
- VIII. Urine drug screen negative
- IX. Blood toxicology negative
- X. Vitreous electrolytes insignificant
 - a. Sodium 150 MMOL/L
 - b. Potassium 6.2 MMOL/L
 - c. Chloride 121 MMOL/L
 - d. Glucose <2 mg/dL
 - e. Urea Nitrogen 42 mg/dL
 - f. Creatinine 0.7 mg/dL

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

Laboratory Case Number: 3168161	Subject's Name: REYES-CLEMENTE, ABEL
Client Account: 14185 / PCME01 Physician: Report To: Pinal County AZ Med Exam Offic ATTN: Pinal County 570 W. Adamsville Road Florence, AZ 85132 FX: 520-866-7296	Agency Case #: 19-197 Date of Death: 04/03/2019 Test Reason: Other Investigator: (b)(6) Date Received: 04/08/2019 Date Reported: 04/15/2019

Laboratory Specimen No: 40783173	Date Collected: 04/04/2019 12:00
Container(s): 01:RTB Blood, ILIAC	Test(s): 70090 Pinal County Custom Panel, Blood

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
AMPHETAMINES	Negative				
COCAINE/METABOLITES	Negative				
OPIATES	Negative				
OXYCODONE/METABOLITE	Negative				
ALCOHOL	Negative				
Methanol	Negative				
Ethanol	Negative				
Acetone	Negative				
Isopropanol	Negative				

Specimens will be kept for at least one year from the date of initial report.

REYES-CLEMENTE, ABEL

Laboratory Case #: 3168161

Printed Date/Time: 04/15/2019, 12:58

Page: 1 of 2

DHS-20-0638-C-000076

2020-ICLI-00057 222

Laboratory Specimen No: 40783174
Container(s): 01:VIT_CON Vitreous,EYE

Date Collected: 04/03/2019 10:00
Test(s): 49901 Volatiles Not Performed
32400 Electrolyte Panel, Vitreous

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
Sodium		150	MMOL/L		(1)
Potassium		6.2	MMOL/L		(1)
Chloride		121	MMOL/L		(1)
Glucose		<2	mg/dL		(1)
Urea Nitrogen		42	mg/dL		(1)
Creatinine		0.7	mg/dL		(1)
< Volatile Testing Not Performed >					

Due to negative blood, tissue, and/or urine volatile (Acetone, Ethanol, Isopropanol, and Methanol) results, volatile testing was not performed on the vitreous specimen.

Performing Location(s):

(1) LabCorp Dublin
6370 Wilcox Road , Dublin, OH 43016-1296
Medical Director: (b)(6); (b)(7)(C) PhD

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

REYES-CLEMENTE, ABEL

Case Reviewer

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

F-ABFT

Laboratory Case #:3168161

Print Date/Time:04/15/2019, 12:58

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

Page: 2 of 2



U.S. Immigration
and Customs
Enforcement

AUG 13 2019

MEMORANDUM FOR: Timothy S. Robbins
Acting Executive Associate Director
Office of Enforcement and Removal Operations

THROUGH: (b)(6); (b)(7)(C)
Associate Director
Office of Professional

FROM: (b)(6); (b)(7)(C)
Acting Assistant Director

SUBJECT: Findings for the Death of ICE Detainee
Agustina RAMIREZ-Arreola (b)(7)(E)

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), has completed its review of the death of ICE detainee Agustina RAMIREZ-Arreola. RAMIREZ died on July 25, 2018, while in ICE custody at the Alvarado Hospital Medical Center (AHMC) in San Diego, California (CA). The San Diego County Medical Examiner documented RAMIREZ's cause of death as complications of aortic valve replacement, due to rheumatic heart disease,¹ with coronary artery disease,² pneumonia,³ and tuberculosis (TB)⁴ as contributing.

On November 20, 2013, RAMIREZ applied for admission into the United States at the Port of Entry (POE) located in San Ysidro, CA, seeking political asylum. After a United States Customs and Border Protection (CBP) officer conducted an interview, it was determined RAMIREZ was inadmissible to the United States pursuant to section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA). CBP served RAMIREZ with a Notice to Alien Ordered Removed/Departure Verification and Notice and Order of Expedited Removal and removed her from the United States to Mexico for a period of five years. On May 21, 2018, RAMIREZ again applied for admission into the United

¹ Rheumatic heart disease is a condition where the heart valves have been permanently damaged by rheumatic fever, an inflammatory disease that can develop as a complication of inadequately treated strep throat or scarlet fever.

² Coronary artery disease is the narrowing or blockage of the coronary arteries, usually caused by atherosclerosis, which is a buildup of cholesterol and fatty deposits on the inner walls of the arteries.

³ Pneumonia is an infection in one or both of the lungs.

⁴ TB is a potentially serious infectious bacterial disease that mainly affects the lungs. Symptoms include chest pain, pain while breathing, cough, fever, loss of appetite, and night sweats.

States at the San Ysidro POE, claiming fear of returning to Mexico. A CBP officer interviewed RAMIREZ and determined she was inadmissible to the United States pursuant to section 212(a)(7)(A)(i)(I) of the INA and RAMIREZ was processed for expedited removal pending review of credible fear claim. On May 24, 2018, CBP determined RAMIREZ would remain in CBP custody at the San Ysidro POE until bed space became available with ICE. On June 3, 2018, RAMIREZ was transferred to Otay Mesa Detention Center (OMDC).

On June 3, 2018, at 5:48 p.m., RAMIREZ arrived to OMDC and a Registered Nurse (RN) completed a timely medical pre-screening. At 7:55 p.m., a RN conducted a medical and mental health screening and documented that RAMIREZ's vital signs were within normal limits, except for an elevated blood pressure and elevated heart rate. RAMIREZ denied pain or taking medication but admitted to a cough and sore throat present for three days. The RN further documented RAMIREZ's TB symptom screening was negative. The RN designated RAMIREZ's medical screening as normal and cleared her for custody. OMDC staff processed RAMIREZ into the facility and appropriately classified her as low custody.⁵

On June 4, 2018 at 3:37 a.m., OMDC officers moved RAMIREZ to a general population housing unit. At 8:24 p.m., the OMDC radiology technician performed RAMIREZ's first TB chest X-ray. The TB chest X-ray determined active tuberculosis could not be ruled out and a provider documented RAMIREZ was not cleared for general population. At 8:43 p.m., a second TB chest X-ray was performed. At 8:45 p.m., although RAMIREZ was not cleared for general population, she returned to the general population housing unit.

At 11:06 p.m., an RN notified a Physician Assistant (PA) of the second TB chest X-ray results, which were positive for TB. The PA subsequently ordered RAMIREZ's transport to the emergency room by facility van, as all of OMDC's Medical Housing Unit (MHU) negative pressure rooms were occupied.

On June 5, 2018 at 1:52 a.m., AHMC admitted RAMIREZ. While hospitalized, AHMC treated RAMIREZ for TB through rifampin, isoniazid (INH), pyrazinamide, and ethambutol (RIPE) therapy⁶ and further determined RAMIREZ needed aortic stenosis⁷ correction surgery.

On July 4, 2018, at 9:42 p.m., RAMIREZ returned to OMDC. An RN immediately assessed RAMIREZ, documented that vital signs were within normal limits, and admitted her for housing in an MHU negative pressure cell until a provider could evaluate her the following day.

⁵ ERAU notes RAMIREZ did not receive chest x-ray or a TB test because the TB symptom screening was negative, and the radiology technician works from Monday through Friday from 3:00 p.m. to 11:30 p.m. RAMIREZ arrived on a Sunday.

⁶ RIPE therapy is the administration of the four antibiotic drugs used in combination to treat TB.

⁷ Aortic stenosis is a condition in which the valve in the large blood vessels branching off the heart (aorta) is abnormally narrowed, preventing the heart valve from fully opening and causing inability of the blood to flow from the heart to the rest of the body.

On July 5, 2018, at 2:26 p.m., an OMDC provider conducted a hospital discharge exam and an initial health assessment and noted RAMIREZ's vital signs were all within normal limits. The provider documented that an AHMC infectious disease specialist had cleared RAMIREZ for discharge and travel back to the facility but recommended continuation of RIPE therapy.⁸ Furthermore, the provider detailed that while RAMIREZ was at AHMC, he gave verbal approval to complete RAMIREZ's aortic valve replacement; however, an AHMC cardiologist ultimately recommended follow-up with a cardiac surgeon to consider outpatient surgery. The OMDC provider noted during the assessment a normal cardiac exam except for a heart murmur. The provider ordered an urgent referral to a cardiac surgeon and a chronic care follow-up with a PA on July 9, 2018.⁹

On July 7, 2018, an RN assessed RAMIREZ for a complaint of itching skin. The RN prescribed her diphenhydramine HCL¹⁰ (25 mg), orally every six hours, as needed, for three days.

On July 10, 2018, a cardiac surgeon completed an offsite consultation and recommended RAMIREZ receive aortic valve replacement surgery. An RN assessed RAMIREZ following the consultation and scheduled a provider follow-up with a PA for July 11, 2018.

On July 12, 2018, an OMDC provider received the cardiac surgeon's consult report, which documented that RAMIREZ had no knowledge of cardiovascular disease or a heart murmur prior to the recent hospitalization. The report further documented that RAMIREZ was a suitable candidate for surgical valve replacement with low surgical risk and that RAMIREZ had indicated her consent through a translator. On July 17, 2018, the OMDC provider made a referral for surgery.

On July 18, 2018, RAMIREZ was seen a second time for a complaint of itchiness. The RN prescribed her with diphenhydramine HCL (25 mg), orally every six hours, as needed, for three days.

On July 19, 2018, a PA assessed RAMIREZ for a post-cardiology consultation follow-up. The PA documented that RAMIREZ's vital signs were all within normal limits except for an elevated blood pressure and that her most bothersome symptom was itchiness. The PA diagnosed her with nonrheumatic aortic stenosis and pruritus.¹¹ The treatment plan included a change to the diphenhydramine HCL (25 mg) to orally three times daily, as needed, for 30 days, approved as a "keep on person" medication and noted that aortic valve stenosis surgery was scheduled for July 25, 2018.

⁸ Specifically, the infectious disease specialist suggested continuation of RIPE therapy, avoiding pyrazinamide due to a reaction RAMIREZ had to the medication, in the event that latent TB became active again and resulted in infectious pulmonary disease.

⁹ ERAU notes the PA never conducted the chronic care follow-up.

¹⁰ Diphenhydramine HCL is the generic name for Benadryl, an antihistamine used to treat allergy, hay fever, and common cold symptoms.

¹¹ Pruritis is the medical term for itchiness.

On July 24, 2018, at 9:53 a.m., OMDC transported RAMIREZ to AHMC for surgery.

On July 25, 2018, RAMIREZ underwent cardiopulmonary bypass surgery and AVR surgery. During the surgery RAMIREZ's blood pressure began to drop and while AHMC medical staff made several intervention attempts, she was ultimately placed on extracorporeal membrane oxygenation (ECMO)¹² in the intensive care unit. Over the next several hours RAMIREZ experienced significant internal bleeding and doctors attempted to keep up with the transfusion demand. Despite additional interventions to increase RAMIREZ's cardiac index,¹³ the surgeon decided to return RAMIREZ to the operating room. The surgeon documented that following further interventions during surgery, RAMIREZ initially appeared stable but quickly began to deteriorate. At 10:45 p.m., the surgeon pronounced RAMIREZ dead. The surgeon documented the preliminary cause of death as cardiogenic shock,¹⁴ with possible contributing factors of an allergic reaction to protamine¹⁵ following the first operation and a hypertrophied¹⁶ noncompliant left ventricle.¹⁷

On August 21, 2018, 27 days after RAMIREZ's death, ERO mailed RAMIREZ's property and funds to her family.

On September 20, 2018, the San Diego County Medical Examiner completed RAMIREZ's autopsy and documented the cause of death as rheumatic heart disease, with coronary artery disease, pneumonia, and TB as contributing.

ERAU reviewed the medical care RAMIREZ received while at OMDC, as well as the facility's efforts to ensure that she was safe and secure while detained at the facility. ERAU found OMDC failed to comply with the following requirements of the ICE Performance Based National Detention Standards (PBNDS) 2011:

1. ICE PBNDS 2011, *Medical Care*, Section (V)(C)(2) states, "Detainees with symptoms suggestive of TB, or with suspected or confirmed active TB disease based on clinical and/or laboratory findings, shall be placed in a functional airborne infection isolation room with negative pressure ventilation and be promptly evaluated for TB disease. Patients with suspected active TB shall remain in airborne infection isolation until determined by a qualified provider to be noncontagious in accordance with CDC guidelines." On June 4, 2018, although RAMIREZ's initial chest X-ray identified possible TB, OMDC allowed RAMIREZ to return to general population. RAMIREZ was in the unit for approximately two and one-half hours before results

¹² ECMO is a technique of providing prolonged cardiac and respiratory support, outside the body, to persons whose heart and lungs are inefficient.

¹³ Cardiac index is a measurement of the amount of blood being pumped out of the heart to the body.

¹⁴ Cardiogenic shock is a fatal condition in which the heart is suddenly unable to pump enough blood to meet the body's needs.

¹⁵ Protamine is a medication used to reverse the effect of heparin (an anticoagulant used to prevent blood clotting) during surgery.

¹⁶ Hypertrophied means an abnormal enlargement of an organ or tissue.

¹⁷ The left ventricle is one of four chambers in the heart, separated by the aortic valve, which pumps blood from the heart to the rest of the body.

of a second chest X-ray were available. The second chest X-ray confirmed results of the first, and after notification to a provider, the provider ordered RAMIREZ's transfer to the hospital for isolation, testing, and treatment.

2. ICE PBNDS 2011, *Terminal Illness, Advanced Directives and Death*, Section (III)(V)(F) states, "Facilities shall turn over the property of the decedent to ICE/ERO within one week for processing and disposition. Unless property of a decedent is being held as part of an investigation into the circumstances of death, that property should be returned to the decedent's next of kin, if known, within two weeks." OMDC processed RAMIREZ's property on July 31, 2018. ERO did not take possession of the property until August 21, 2018, 27 days after her death. ERO shipped the property and funds to RAMIREZ's family on the same date.

ERAU also noted two areas of concern, which are discussed in the attached report. If you have any questions, please contact me or have a member of your staff contact Acting Unit Chief (b)(6); (b)(7)(C) at (202) 73 (b)(6);

Attachment

cc: Derek Benner
Tae Johnson

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

SYNOPSIS

On July 25, 2018, Agustina RAMIREZ-Arreola, a sixty-two-year-old citizen of Mexico, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at the Alvarado Hospital Medical Center (AHMC), in San Diego, California (CA). The San Diego County Medical Examiner documented RAMIREZ's cause of death as complications of aortic valve replacement (AVR),¹ due to rheumatic heart disease,² with coronary artery disease,³ pneumonia,⁴ and tuberculosis⁵ (TB) as contributing factors.⁶

RAMIREZ was detained at the Otay Mesa Detention Center (OMDC) in San Diego, CA, from June 3, 2018, until July 24, 2018. OMDC is owned and managed by CoreCivic. OMDC is required to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. Medical care at OMDC is provided by the ICE Health Service Corps (IHSC), with support from STG International (STG) and Akahi Associates contract companies. At the time of RAMIREZ's death, OMDC housed approximately 832 male and 142 female detainees for periods in excess of 72 hours.

DETAILS OF REVIEW

From August 28 to 30, 2018, the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited OMDC to review the circumstances surrounding RAMIREZ's death. ERAU was assisted in its review by contract subject matter experts in correctional healthcare and security who are employed by Creative Corrections, a national management and consulting firm.⁷ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to RAMIREZ, in addition to conducting in-person interviews of individuals employed by IHSC, CoreCivic, and STG.

During the review, ERAU took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in this report should not be construed in any way as indicating the deficiencies identified contributed to the detainee's death. ERAU determined the following timeline of events, from the time of RAMIREZ's apprehension by U.S. Customs and Border Protection (CBP), through her detention at OMDC, and eventual death at AHMC.

¹ AVR is a type of open-heart surgery used to treat problems with the heart's aortic valve. The aortic valve controls the flow of blood out from the heart to the rest of the body.

² Rheumatic heart disease is a condition where the heart valves have been permanently damaged by rheumatic fever, an inflammatory disease that can develop as a complication of inadequately treated strep throat or scarlet fever.

³ Coronary artery disease is the narrowing or blockage of the coronary arteries, usually caused by atherosclerosis, which is a buildup of cholesterol and fatty deposits on the inner walls of the arteries.

⁴ Pneumonia is an infection in one or both of the lungs.

⁵ TB is a potentially serious infectious bacterial disease that mainly affects the lungs. Symptoms include chest pain, pain while breathing, cough, fever, loss of appetite, and night sweats.

⁶ See Exhibit 1: San Diego County Medical Examiner Department, dated September 20, 2018.

⁷ See Exhibit 2: Creative Corrections Healthcare and Security Compliance Analysis.

IMMIGRATION AND CRIMINAL HISTORY

On November 20, 2013, RAMIREZ applied for admission into the United States at the San Ysidro Port of Entry (POE) located in San Ysidro, CA, seeking political asylum.⁸ After a CBP officer conducted an interview and took a sworn statement, it was determined RAMIREZ was inadmissible to the United States pursuant to section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an immigrant without an immigrant visa.

On November 22, 2013, CBP served RAMIREZ with a Notice to Alien Ordered Removed/Departure Verification (Form I-296)⁹ and Notice and Order of Expedited Removal (Form I-860).¹⁰ CBP removed RAMIREZ from the United States to Mexico for a period of five years.¹¹

On May 21, 2018, RAMIREZ applied for admission into the United States at the San Ysidro POE. RAMIREZ claimed fear of returning to Mexico and was processed as an expedited removal with credible fear.¹²

On May 22, 2018, a CBP officer interviewed RAMIREZ and it was determined she was inadmissible to the United States pursuant to section 212(a)(7)(A)(i)(I) of the INA.¹³

On May 24, 2018, CBP determined RAMIREZ would remain in CBP custody at the San Ysidro POE until bed space became available with ICE.¹⁴

On June 3, 2018, RAMIREZ was transferred to OMD, pending (b)(7)(E); (b)(3):Unspecified Statute

On July 9, 2018, Supervisory Asylum Officer (b)(6); (b)(7)(C) completed (b)(7)(E); (b)(3):Unspecified Statute with RAMIREZ.¹⁶

On July 17, 2018, RAMIREZ was found to have negative credible fear and she requested review by an immigration judge (IJ).¹⁷

On July 23, 2018, an IJ issued an order of removal for RAMIREZ.¹⁸

⁸ See Form I-213 Narrative, dated November 22, 2013.

⁹ See Form I-296, dated November 22, 2013.

¹⁰ See Form I-860, dated November 22, 2013.

¹¹ See Form I-296, dated November 22, 2013.

¹² See Record of Deportable/Inadmissible Alien (Form I-213), dated May 22, 2018.

¹³ *Id.*

¹⁴ See Enforce Alien Removal Module (EARM) Comments section, dated May 24, 2018.

¹⁵ See EARM Comments section, dated June 3, 2018.

¹⁶ See Credible Fear Interview, dated July 9, 2018.

¹⁷ See Record of (b)(7)(E); (b)(3):Unspecified Statute and Request for Review by IJ (Form I-869), dated July 17, 2018.

¹⁸ See Order of the IJ, dated July 23, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

NARRATIVE

On June 3, 2018, at approximately 5:48 p.m., RAMIREZ arrived at OMD and Lieutenant (Lt.) (b)(6); (b)(7)(C) Registered Nurse (RN), medically pre-screened RAMIREZ. (b)(6); (b)(7)(C) documented that RAMIREZ acknowledged a current illness or health problem but denied being on medication. (b)(6); (b)(7)(C) also documented that RAMIREZ's appearance, behavior, skin and breathing were all described as normal and that RAMIREZ was alert and there were no noticeable restrictions or difficulties in her ease of movement.

At approximately 5:55 p.m., OMD staff booked RAMIREZ into the facility and appropriately classified her as low custody.²⁰ A supervisor approved the rating on June 5, 2018.²¹

At approximately 7:55 p.m.,²² RN (b)(6); (b)(7)(C) conducted a medical and mental health intake screening and documented the following:²³

- Vital signs (VS) were all within normal limits except for an elevated blood pressure (BP) of 130/85 and an elevated heart rate of 126 beats per minute (bpm).²⁴ Ten minutes later, RN (b)(6); (b)(7)(C) took RAMIREZ's pulse again and found it to be slightly lower at 116 bpm; she scheduled RAMIREZ for two additional pulse checks.²⁵
- RAMIREZ denied taking medication on a regular basis.
- RAMIREZ stated she had eye surgery ten years earlier to remove a piece of flesh.
- RAMIREZ denied pain or medical problems except for having a cough and sore throat for three days.
- RAMIREZ's TB symptom screening was negative and she denied a history of TB infection.

During her interview (b)(6); (b)(7)(C) stated that because RAMIREZ's cough was only three days in duration, she did not consider it prolonged; therefore, the reported cough was determined not to be a symptom of TB.²⁶ (b)(6); (b)(7)(C) designated RAMIREZ's intake screening as normal and medically cleared her for custody. RAMIREZ signed a consent for medical treatment form.²⁷

¹⁹ See eClinicalWorks (eCW) Pre-Screen Progress Note by (b)(6); (b)(7)(C) dated June 3, 2018. (b)(6); (b)(7)(C) did not utilize interpretation services as she is fluent in Spanish.

²⁰ See ICE Custody Classification Worksheet and Inmate/Detainee Commitment Summary, both dated June 3, 2018.

²¹ See ICE Custody Classification Worksheet, dated June 3, 2018.

²² ERAU notes all progress note times are based on the VS times entered within the note, unless otherwise stated.

²³ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated June 3, 2018. RN (b)(6); (b)(7)(C) utilized Spanish interpretation services.

²⁴ Normal temperature is 98.6; normal range for pulse is 60 to 100 bpm; normal range for respirations is 12 to 20 breaths per minute; and normal blood pressure is 120/80 or less. According to the American Heart Association, this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic reading of 80 to 89.

²⁵ See eCW Follow Up Pulse Check, dated June 6, 2018, June 16, 2018, and June 18, 2018. Although (b)(6); (b)(7)(C) noted she scheduled RAMIREZ for two additional pulse checks on June 6 and 16, and a third was scheduled for June 18, 2018. None of the pulse checks were completed due to RAMIREZ being in the hospital on those dates. The appointments are recorded in eCW with no comments.

²⁶ ERAU interview with RN (b)(6); (b)(7)(C) dated August 28, 2018.

²⁷ See IHSC Medical Consent Form, dated June 3, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

On June 4, 2018, at approximately 3:37 a.m., RAMIREZ entered Alpha Unit.²⁸ OMDC staff assigned RAMIREZ to cell 106, bed E.²⁹

At 8:24 p.m., the OMDC radiology technician completed RAMIREZ's initial TB screening X-ray in the Intake X-ray room.³⁰ Captain (b)(6); (b)(7)(C) OMDC Health Services Administrator (HSA), stated that chest X-rays are the primary TB testing method at OMDC. As there is only one full-time radiology technician, who works Monday through Friday during the evening shift, 3:00 p.m. to 11:30 p.m., detainees that arrive outside this timeframe receive a TB symptom screening only and a follow-up TB screening X-ray when the radiology technician returns.³¹ (b)(6); (b)(7)(C) explained that because RAMIREZ arrived on Sunday, the radiology technician did not complete her chest X-ray until Monday evening. Furthermore, as her intake TB symptom screening was negative, isolation pending a chest X-ray was not deemed necessary.³²

At 8:29 p.m., (b)(6); (b)(7)(C) documented active TB could not be ruled out and did not clear RAMIREZ for general population.³³ At 8:43 p.m., a second chest X-ray was performed.³⁴

At 8:45 p.m., although RAMIREZ was not cleared for general population and the results of her second X-ray were not yet available, she returned to Alpha Unit.³⁵

At 11:06 p.m., RN (b)(6); (b)(7)(C) notified Physician Assistant (PA) (b)(6); (b)(7)(C) of the two chest X-ray findings, both of which confirmed active TB could not be ruled out.³⁶ As OMDC's negative pressure rooms in the Medical Housing Unit (MHU) were full, PA (b)(6); (b)(7)(C) ordered RAMIREZ's transport to the emergency room by facility van.³⁷

At 11:19 p.m., RAMIREZ, wearing a mask, left Alpha Unit; she entered Intake at 11:22 p.m.³⁸

²⁸ See surveillance video screenshot, Alpha Corridor Camera, dated June 4, 2018.

²⁹ See OMDC Cellmate History, dated August 3, 2018.

³⁰ See Shina Systems Configuration Management screen print, dated June 4, 2018.

³¹ ERAU interview with HSA (b)(6); (b)(7)(C) August 28, 2018.

³² The TB symptom screening consists of asking detainees whether s/he has experienced any of the following symptoms in the last two months for more than two weeks: a cough, coughing up blood, chest pain, fever, chills, or night sweats for an unknown reason, loss of appetite, unexplained weight loss, previous history of TB. ERAU notes RAMIREZ answered no to each question.

³³ See X-Ray Exam Report, dated June 4, 2018.

³⁴ See Shina Systems Configuration Management screen print, dated June 4, 2018.

³⁵ See Alpha Unit Logbook, dated June 4, 2018. ERAU notes that per the PBNDS 2011, *Medical Care*, Section (V)(C)(2), "detainees...with suspected or confirmed active TB disease based on clinical and/or laboratory findings, shall be placed in a functional airborne infection isolation room with negative pressure ventilation and be promptly evaluated for TB disease."

³⁶ See Telephone Encounter by RN (b)(6); (b)(7)(C) dated June 4, 2018. See also Second X-Ray Exam Report, dated June 4, 2018.

³⁷ *Id.*

³⁸ See surveillance video screenshot, (b)(6); (b)(7)(C)

DETAINEE DEATH REVIEW – ~~Augustina~~ RAMIREZ-Arreola JICMS

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

On June 5, 2018, at 12:52 a.m., RAMIREZ boarded an OMDC van en route to the hospital.³⁹ At 1:52 a.m., AHMC admitted RAMIREZ into the care of attending physician (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) RAMIREZ remained in the care of AHMC from June 5, 2018 to July 4, 2018, during which time OMDC nurses obtained 12 hospital updates from AHMC.⁴¹ Notable events during RAMIREZ's hospitalization are summarized below.

- On June 6, 2018, AHMC collected three mucous samples and administered a purified protein derivative (PPD) skin test.⁴²
- On June 8, 2018, the PPD skin test and mucous samples were negative for TB, but positive for extended spectrum beta-lactamase (ESBL).⁴³ A chest CT scan showed pneumonia in the bilateral lobes and left upper lobe.
- On June 14, 2018, AHMC initiated rifampin, isoniazid (INH), pyrazinamide, and ethambutol (RIPE) therapy.⁴⁴
- On June 19, 2018, AHMC stopped RIPE therapy due to elevated liver enzymes.
- On June 21, 2018, AHMC re-initiated RIPE therapy with ethambutol only, and initiated intravenous hydration with normal saline⁴⁵ and potassium. Liver enzyme and ova and parasites testing were pending.⁴⁶ AHMC gave (b)(6); (b)(7)(C) to relieve nausea and Benadryl to treat insomnia.
- On June 26, 2018, AHMC ordered a cardiology evaluation and cardiac catheterization⁴⁷ after the echocardiogram (ECG)⁴⁸ revealed aortic stenosis.⁴⁹ AHMC gave RAMIREZ Benadryl and Vistaril⁵⁰ to relieve itching.
- On June 27, 2018, AHMC re-initiated RIPE therapy.
- On July 3, 2018, AHMC released RAMIREZ from respiratory isolation and planned to discharge her after completing five days of RIPE therapy. A cardiology evaluation and cardiac catheterization were pending as a possible outpatient procedure.

³⁹ See surveillance video screenshot, Inner Bus Sally Port East, dated June 5, 2018.

⁴⁰ See AHMC Hospital Records, dated June 5, 2018.

⁴¹ During interview with ERAU on August 28, 2018, HSA (b)(6); (b)(7)(C) informed the review team that IHSC expects that when detainees are stable, facility medical staff obtain hospital updates daily and document those results.

⁴² A PPD skin test is a solution injected into the skin to determine whether a person has been infected with TB.

⁴³ ESBL is a bacterium that produces an enzyme, beta lactamase, which can break down commonly used antibiotics and render them noneffective for treatment.

⁴⁴ RIPE therapy is the administration of the four antibiotic drugs used in combination to treat TB. The vitamin pyridoxine (B6) is always included with INH dosing.

⁴⁵ Normal saline is a mixture of sodium chloride (salt) and water, often used as an intravenous solution to keep the intravenous catheter cleared of blockage and bacteria.

⁴⁶ See AHMC Microbiology reports, dated July 4, 2018. A parasite is an organism that lives in or on another organism (host) and benefits by deriving nutrients at the host's expense. Ova are eggs of the parasite. An AHMC laboratory report documented the tests were negative.

⁴⁷ Cardiac catheterization is the insertion of a catheter into a chamber or vessel of the heart for diagnostic and interventional purposes.

⁴⁸ An ECG is a test using ultrasound to make pictures of the heart.

⁴⁹ Aortic stenosis is a condition in which the valve in the large blood vessels branching off the heart (aorta) is abnormally narrowed, preventing the heart valve from fully opening and causing inability of the blood to flow from the heart to the rest of the body.

⁵⁰ Vistaril is a sedative used to treat anxiety, tension, and allergic skin reactions.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

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

On July 4, 2018, at 8:59 a.m.,⁵¹ (b)(6); (b)(7)(C) infectious disease specialist at AHMC, documented an assessment finding of latent TB infection.⁵² (b)(6); (b)(7)(C) noted RAMIREZ was negative on all MTB PCR tests and TB smears. The negative tests indicated tuberculosis bacteria was absent in the lungs, meaning the detainee was not infectious by airborne transmission. Dr. (b)(6); (b)(7)(C) discontinued TB isolation on July 3, 2018 and cleared RAMIREZ for aortic stenosis surgery from an infectious disease standpoint.

At 9:42 p.m., RAMIREZ returned to OMDC from AHMC and went directly to medical.⁵³

At approximately 10:07 p.m.,⁵⁴ (b)(6); (b)(7)(C) assessed RAMIREZ and documented RAMIREZ's VS were within normal limits.⁵⁵ OMDC medical staff admitted RAMIREZ to the MHU pending evaluation by the primary care provider the following day.

On July 5, 2018, at approximately 2:26 p.m., (b)(6); (b)(7)(C) conducted RAMIREZ's hospital discharge exam and initial health assessment. (b)(6); (b)(7)(C) documented the following:⁵⁶

- RAMIREZ's VS were within normal limits.
- RAMIREZ's cardiac examination was normal except for a heart murmur of 3/6,⁵⁷ heard at the upper sternal border.⁵⁸ The pulse rate and rhythm were normal.
- While RAMIREZ underwent a TB workup and infectious disease consultation at the hospital, a heart murmur was noted. An ECG showed aortic stenosis, found severe by way of cardiac catheterization.
- On July 3, 2018, an AHMC charge nurse called to request urgent AVR per recommendation of cardiology, for which (b)(6); (b)(7)(C) gave verbal approval.⁵⁹ Upon RAMIREZ's return, given the previous urgent request, (b)(6); (b)(7)(C) contacted AHMC and determined that the cardiologist decided the AVR procedure was not emergent and could be arranged on an outpatient basis. (b)(6); (b)(7)(C) further noted RAMIREZ was cleared for surgery, general anesthesia, and proposed cardiac operation; he recommended follow-up with cardiac surgeon, I (b)(6); (b)(7)(C) to consider outpatient surgery.
- (b)(6); (b)(7)(C) addressed the aortic stenosis diagnosis, as well as TB testing and treatment.

⁵¹ See AHMC Progress Note by (b)(6); (b)(7)(C) dated July 4, 2018.

⁵² Latent TB means there was past disease and that bacteria in the lungs was inactive. Latent TB may become active again and result in infectious pulmonary disease.

⁵³ See surveillance video screenshot, Receiving Sally Port, dated July 4, 2018.

⁵⁴ See surveillance video screenshot, Medical Nurse Station 1, dated July 4, 2018.

⁵⁵ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 4, 2018. ERAU notes RN (b)(6); (b)(7)(C) did not sign off on the progress note or enter the associated VS until July 6, 2018. Furthermore, as RN (b)(6); (b)(7)(C) is fluent in Spanish, the use of interpretation services was not necessary.

⁵⁶ See eCW Progress Notes by (b)(6); (b)(7)(C), dated July 5, 2018. As (b)(6); (b)(7)(C) is fluent in Spanish, the use of interpretation services was not necessary.

⁵⁷ Heart murmurs are classified according to how loud the sound is with a stethoscope. A 3/6 murmur means the loudness was on a level three on a scale of one to six.

⁵⁸ Upper sternal border is the area in the middle of the chest, under the collar bone.

⁵⁹ ERAU notes RAMIREZ's medical record did not contain a hospital update on July 3, 2018 from (b)(6); (b)(7)(C) regarding this request.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

- RAMIREZ's three sputum smears were negative for TB.⁶⁰
- (b)(6); (b)(7)(C) noted the infectious disease specialist determined RAMIREZ was stable for discharge and clear for travel but recommended continuation of three-drug TB treatment, avoiding pyrazinamide, following up on smear cultures, and retesting liver enzymes.

(b)(6); (b)(7)(C) documented the following assessment findings:⁶¹

- The general adult medical examination was abnormal.
- Encounter for observation for other suspected diseases and conditions was ruled out.
- Non-rheumatic aortic valve stenosis.⁶²
- Pneumonia due to Escherichia coli.⁶³

(b)(6); (b)(7)(C) ordered: RIPE medications, except pyrazinamide, and omeprazole as needed for heartburn; an urgent referral for follow-up with (b)(6); (b)(7)(C) and chronic care follow-up on July 9, 2018,⁶⁴ with OMDC PA (b)(6); (b)(7)(C). Additional treatment orders included Snellen⁶⁶ and Ishihara vision testing⁶⁷ and laboratory tests for human immunodeficiency virus (HIV),⁶⁸ comprehensive metabolic panel (CMP),⁶⁹ thyroid cascade profile,⁷⁰ urinalysis with microscopic examination with reflex culture,⁷¹ and QuantiFERON TB Gold.⁷² Although (b)(6); (b)(7)(C) documented the labs and vision testing were completed on July 6, 2018,⁷³ the labs were not completed until July 18, 2018 and (b)(6); (b)(7)(C) medically cleared RAMIREZ for general population

⁶⁰ See AHMC Microbiology report, dated July 4, 2018. According to the AHMC Microbiology report, AHMC conducted four sputum smears, one of which was still processing at the time of RAMIREZ's hospital discharge.

⁶¹ See eCW Progress Notes by (b)(6); (b)(7)(C) dated July 5, 2018.

⁶² Nonrheumatic aortic valve stenosis means the condition is not caused by a history of rheumatic fever.

⁶³ Escherichia coli (E. Coli) is a type of bacteria that normally lives in the intestines. While E. coli is most often associated with food poisoning, the bacteria can cause pneumonia and urinary tract infections from different strains.

⁶⁴ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 9, 2018. A blank follow-up encounter note by R (b)(6); (b)(7)(C) was present in the medical record for this date but PA (b)(6); (b)(7)(C) did not see RAMIREZ until July 19, 2018. The July 19, 2018, appointment was a follow-up to RAMIREZ's July 10, 2018, appointment with the cardiac surgeon, not for the reason (b)(6); (b)(7)(C) originally scheduled the appointment. PA (b)(6); (b)(7)(C) stated during the interview with ERAU on August 28, 2018, that she did not know why she did not see RAMIREZ as ordered by (b)(6); (b)(7)(C).

⁶⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 5, 2018.

⁶⁶ A Snellen test is a test to determine visual acuity, using an eye chart.

⁶⁷ The Ishihara test is a color perception test for red-green color deficiencies.

⁶⁸ HIV is a virus that attacks cells that helps the body fight infection.

⁶⁹ A CMP is a series of blood test that provide a snapshot of the body's chemistry and the way it uses energy through metabolism.

⁷⁰ A thyroid cascade profile is a test used to diagnose common thyroid disorders. If the initial test result is normal, further testing (cascading) is deemed unnecessary.

⁷¹ A urinalysis with microscopic examination with reflex culture involves a dipstick urine test to determine the chemical constituents in the urine, a microscopic examination to detect the presence of abnormal urine cells, and culture to identify the organisms causing infection.

⁷² QuantiFERON TB Gold is a whole-blood test for use as an aid in diagnosing Mycobacterium TB infection, including latent TB infection and TB disease.

⁷³ ERAU notes the labs were not drawn until July 18, 2018, and there is no documentation vision testing was completed.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

with no respiratory isolation needed.⁷⁴ ERAU notes there is no documentation vision testing was completed.

At approximately 3:29 p.m., RN (b)(6) signed off on an initial TB monitoring report and documented that they submitted a referral to Cure TB,⁷⁵ placed RAMIREZ on a medical hold, and reported the TB case to the California Health Department in San Diego.⁷⁶

On this same date, RAMIREZ submitted a request in Spanish requesting access to her property so she could retrieve phone numbers for her lawyer and family.⁷⁷ An OMDC staff member⁷⁸ responded on July 11, 2018, documenting that RAMIREZ was given an opportunity to access her property for phone numbers and other items but RAMIREZ refused and stated she only wanted to have her voice reset.⁷⁹ The OMDC staff member further noted that RAMIREZ's voice was reset per her request.

On July 6, 2018, at 11:57 a.m., RN (b)(6); (b)(7)(C) documented an update to the initial TB monitoring report,⁸⁰ adding the results of the tests completed at the hospital, which stated RAMIREZ was positive for Interferon Gamma Release Assay (IGRA)⁸¹ and HIV negative.

At 9:18 p.m., OMDC staff reassigned RAMIREZ to cell 101,⁸² bed H, a lower bunk on the lower level.⁸³

On July 7, 2018, at 2:49 p.m., RN (b)(6); (b)(7)(C) assessed RAMIREZ and documented the following:⁸⁴

- RAMIREZ's VS were within normal limits.
- RAMIREZ denied pain but complained of itchiness on her arms and legs.
- RAMIREZ was prescribed diphenhydramine HCL⁸⁵ (25 mg), orally every six hours, as needed, for three days.

⁷⁴ See eCW Progress Note by (b)(6); (b)(7)(C) dated July 5, 2018.

⁷⁵ Cure TB is a program promoted by the Center for Disease Control that works to prevent the spread of TB among people who cross international borders.

⁷⁶ See eCW TB Suspect Initial by RN (b)(6); (b)(7)(C) dated July 5, 2018.

⁷⁷ See Request for Assistance, dated July 5, 2018.

⁷⁸ ERAU was unable to identify the OMDC staff member as the signature was illegible.

⁷⁹ ERAU could not confirm the meaning of voice reset; however, it is believed this meant RAMIREZ needed to reset her pin.

⁸⁰ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 6, 2018.

⁸¹ An IGRA is a whole blood test used to aid in the diagnosis of TB infection. It does not differentiate latent TB from active TB disease. QuantiFERON-TB Gold is a commonly used IGRA.

⁸² See OMDC Cellmate Housing History, dated August 3, 2018.

⁸³ During ERAU's tour of the facility, a Unit Counselor (name unknown), stated RAMIREZ was reassigned to a lower bunk on a lower level at her request citing difficulty climbing the stairs and accessing upper bunks.

⁸⁴ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 7, 2018. RN (b)(6); (b)(7)(C) utilized Spanish interpretation services.

⁸⁵ Diphenhydramine HCL is the generic name for Benadryl, an antihistamine used to treat allergy, hay fever, and common cold symptoms.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

On July 9, 2018, at 11:14 a.m., RN (b)(6); (b)(7)(C) signed off on the TB monitoring report from July 5, 2018, requesting updates with final culture results and a follow-up comparison chest X-ray after six to eight weeks of TB treatment.⁸⁶

On July 10, 2018, at 2:25 p.m., (b)(6); (b)(7)(C) completed an offsite consultation with RAMIREZ.⁸⁷

At 2:34 p.m., RN (b)(6); (b)(7)(C) assessed RAMIREZ and documented the following:⁸⁸

- RAMIREZ's VS were within normal limits.
- An off-site provider discharge note recommended AVR surgery, which she notified PA Rosenblatt of.
- RN (b)(6); (b)(7)(C) scheduled RAMIREZ for a follow-up appointment with a provider on July 11, 2018.⁸⁹
- RAMIREZ was returned to general population in stable condition.

On July 12, 2018, at 9:45 a.m., (b)(6); (b)(7)(C)'s office faxed a consult report to (b)(6); (b)(7)(C) which indicated that RAMIREZ had no knowledge of cardiovascular disease or a heart murmur prior to the recent hospitalization. (b)(6); (b)(7)(C) detailed events at AHMC, including three negative sputum tests, initiation of RIPE therapy, discontinuation of pyrazinamide upon development of symptoms of pancreatitis, and treatment for pneumonia. (b)(6); (b)(7)(C) detailed identification of the cardiac murmur and diagnosis of rheumatic valvular disease with severe aortic stenosis.⁹¹ (b)(6); (b)(7)(C) determined RAMIREZ was a suitable candidate for surgical valve replacement with low surgical risk and recommended RAMIREZ for AVR. (b)(6); (b)(7)(C) documented that through a translator, the indications, risks and alternatives were explained to RAMIREZ and that she indicated her consent.

On July 17, 2018, at 4:38 p.m., (b)(6); (b)(7)(C) documented he submitted a referral for surgery pursuant to (b)(6); (b)(7)(C) recommendation.⁹²

On July 18, 2018, at 11:39 a.m., RN (b)(6); (b)(7)(C) saw RAMIREZ pursuant to her complaint of itchy skin and documented the following:⁹³

⁸⁶ See eCW TB Suspect Initial by RN (b)(6); (b)(7)(C) dated July 5, 2018.

⁸⁷ See "Memorandum re: RAMIREZ ARREOLA, (b)(6); (b)(7)(C)" dated July 10, 2018.

⁸⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 10, 2018. As RN (b)(6); (b)(7)(C) fluent in Spanish, the use of interpretation services was not necessary.

⁸⁹ Although RN (b)(6); (b)(7)(C) scheduled a follow-up for July 11, 2018, PA (b)(6); (b)(7)(C) did not see RAMIREZ until July 19, 2018. During her interview with ERAU on August 30, 2018, PA (b)(6); (b)(7)(C) could not recall the reason for the delay.

⁹⁰ See "Memorandum re: RAMIREZ ARREOLA, (b)(6); (b)(7)(C)" by Dr. (b)(6); (b)(7)(C) dated July 10, 2018. There is no progress note from (b)(6); (b)(7)(C) detailing receipt of this report; however, (b)(6); (b)(7)(C) signed the bottom of the fax coversheet on July 13, 2018.

⁹¹ Rheumatic valvular disease describes a group of short-term and long-term heart disorders that can occur as a result of rheumatic fever. One common result of rheumatic fever is heart valve damage. The damage may lead to a valve disorder such as aortic valve stenosis.

⁹² See eCW Telephone encounter by (b)(6); (b)(7)(C) dated July 17, 2018.

⁹³ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 18, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

- RAMIREZ's VS were within normal limits except for an elevated BP of 137/84.
- RAMIREZ's skin was very dry, with a red rash over her left forearm and right upper arm.
- RAMIREZ complained of recurring itchiness all over.

RN (b)(6); (b)(7)(C) noted a diagnosis of risk for impaired skin integrity and started RAMIREZ on diphenhydramine HCL (25 mg) orally every six hours, as needed, for three days.

At 4:25 p.m., RN (b)(6); (b)(7)(C) signed off on a progress note documenting completion of RAMIREZ's blood work pursuant to the lab tests ordered on July 5, 2018.⁹⁴

On July 19, 2018, at 2:08 p.m., PA (b)(6); (b)(7)(C) saw RAMIREZ for a post-cardiology consultation follow-up and documented the following:⁹⁵

- RAMIREZ's VS were within normal limits except for an elevated BP of 134/80.
- RAMIREZ reported that prior to arrival, she had no idea she had the heart problem and that she does get tired easily.
- RAMIREZ indicated that the itching was the most bothersome symptom, possibly from one of her current medications. The general examination found no obvious rash, although RAMIREZ had scratched her skin, which caused welts and erythema.⁹⁶
- PA Rosenblatt heard the systolic murmur.⁹⁷
- RAMIREZ became tearful and was concerned about being alone for surgery.

PA (b)(6); (b)(7)(C) diagnosed RAMIREZ with nonrheumatic aortic stenosis and pruritus,⁹⁸ unspecified. Per the direction of (b)(6); (b)(7)(C) IHSC Infection Control Specialist, RAMIREZ was started on diphenhydramine HCL (25 mg) orally three times daily, as needed for 30 days, approved as a "keep on person" medication. PA (b)(6); (b)(7)(C) noted surgery for aortic valve stenosis was scheduled for July 25, 2018. PA (b)(6); (b)(7)(C) scheduled a provider follow-up for one week as needed post-surgery.

⁹⁴ See eCW Progress Note by RN (b)(6); (b)(7)(C), dated July 18, 2018. During the interview with ERAU on August 28, 2018, (b)(6); (b)(7)(C) stated he ordered the labs drawn on July 6, 2018, so the results would be available prior to the cardiology consultation; although the labs were drawn later than ordered, the tests were done in time for RAMIREZ's surgery.

⁹⁵ See eCW Progress Note by PA (b)(6); (b)(7)(C), dated July 19, 2018.

⁹⁶ Erythema is superficial reddening of the skin, usually in patches, as a result of injury or irritation causing dilatation of the blood capillaries.

⁹⁷ A systolic murmur is a heart murmur that begins during or after the first heart sound and ends before or during the second heart sound.

⁹⁸ Pruritis is the medical term for itchiness.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

On July 20, 2018, at an unknown time, (b)(6); (b)(7)(C) received the results of RAMIREZ's laboratory work.⁹⁹ (b)(6); (b)(7)(C) noted the results were normal except for elevated liver enzymes and low blood urea nitrogen (BUN),¹⁰⁰ creatinine,¹⁰¹ BUN/creatinine ratio,¹⁰² and Albumin/Globulin ratio.¹⁰³

On July 24, 2018, at 9:53 a.m., OMDC transferred RAMIREZ to AHMC to prepare RAMIREZ for her surgery; RAMIREZ arrived at the hospital at 10:15 a.m.¹⁰⁴ Officer (b)(6); (b)(7)(C), assigned to hospital detail from 2:00 p.m. to 10:00 p.m., stated RAMIREZ was nervous, emotional, and crying during the shift.¹⁰⁵

At 2:03 p.m., RN (b)(6); (b)(7)(C) documented that AHMC medical staff had prepared RAMIREZ for repair of the aortic stenosis and coronary artery bypass graft (CABG),¹⁰⁶ scheduled for the following day, and that RAMIREZ was currently stable.¹⁰⁷

Day of Death

On July 25, 2018, at 6:38 a.m., RN (b)(6); (b)(7)(C) documented that RAMIREZ had been anxious and crying the evening before but was better at the time of the update.¹⁰⁸

During the morning hours, RAMIREZ underwent cardiopulmonary bypass (CPB)¹⁰⁹ and AVR surgery.¹¹⁰ Per the Postoperative Report completed by (b)(6); (b)(7)(C), initially, the surgery was completed without trouble but as the right atrium was being repaired, RAMIREZ's BP began to drop. Surgical staff ultimately placed RAMIREZ on extracorporeal membrane oxygenation (ECMO).¹¹¹ RAMIREZ's chest was left open and she was taken to the intensive care unit (ICU). The postoperative report indicates RAMIREZ had significant bleeding over the next several hours which required repeated blood transfusions. Despite the various interventions, which failed to

⁹⁹ See Lab Result Printout, dated August 1, 2018.

¹⁰⁰ BUN is a medical test that measures the amount of urea nitrogen found in blood. The liver produces urea in the urea cycle as a waste product of the digestion of protein.

¹⁰¹ Creatinine is a chemical waste molecule that is generated from muscle metabolism. Creatinine is produced from creatine, a molecule of major importance for energy production in muscles.

¹⁰² BUN/creatinine ratio test is used to detect conditions such as congestive heart failure, gastrointestinal bleeding or severe dehydration in high results, and liver disease or malnutrition in low results.

¹⁰³ A/G ratio is a test used to determine overproduction of globulins, seen in cases of multiple myeloma or autoimmune diseases, or underproduction of albumin, which is seen in cirrhosis, or selective loss of albumin from the circulation, as seen with kidney disease.

¹⁰⁴ See Transportation Trip Ticket, OMDC, dated July 24, 2018.

¹⁰⁵ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 29, 2018.

¹⁰⁶ CABG is a form of bypass surgery to create new routes around the narrowed and blocked coronary arteries, permitting increased blood flow to deliver oxygen and nutrients to the heart muscle.

¹⁰⁷ See eCW Telephone encounter by (b)(6); (b)(7)(C) dated July 24, 2018.

¹⁰⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 25, 2018.

¹⁰⁹ CPB is a technique in which a machine temporarily takes over function of the heart and lungs during surgery, maintaining the circulation of blood and the oxygen content of the patient's body.

¹¹⁰ See Postoperative Report by (b)(6); (b)(7)(C), dated July 25, 2018.

¹¹¹ ECMO is a technique of providing prolonged cardiac and respiratory support, outside the body, to persons whose heart and lungs are inefficient.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

increase RAMIREZ's cardiac index,¹¹² AHMC medical staff decided to return RAMIREZ to the operating room. (b)(6); (b)(7)(C) documented that following further interventions during the surgery, RAMIREZ initially looked good, but her condition quickly deteriorated. Despite all efforts, AHMC medical staff could not maintain adequate cardiac output, and (b)(6); (b)(7)(C) made the decision to stop all treatments. RAMIREZ sustained a cardiac rhythm¹¹³ but her BP could not be sustained.

At 10:45 p.m. (b)(6); (b)(7)(C) pronounced RAMIREZ dead.¹¹⁴ (b)(6); (b)(7)(C) recorded RAMIREZ's preliminary cause of death as cardiogenic shock,¹¹⁵ with possible contributing factors of an allergic reaction to protamine¹¹⁶ following the first operation, and a hypertrophied¹¹⁷ noncompliant left ventricle.¹¹⁸

Officer (b)(6); (b)(7)(C) stated she notified L (b)(6); (b)(7)(C) of RAMIREZ's death.¹¹⁹ (b)(6); (b)(7)(C) documented he immediately notified Deportation Officer (DO) (b)(6); (b)(7)(C).¹²⁰

Post-Death Events

On July 26, 2018, at 2:50 a.m., after RAMIREZ's body had been transferred to the hospital morgue (b)(6); (b)(7)(C) relieved Officers (b)(6); (b)(7)(C) and Stephens of hospital detail duty.¹²¹

At 6:37 a.m., RN (b)(6); (b)(7)(C) documented the aortic replacement procedure from the previous day, RAMIREZ's death at 10:45 p.m., and that OMDC staff had notified ICE.¹²²

On July 31, 2018, OMDC security staff processed RAMIREZ's property and funds for release to ICE.¹²³

¹¹² Cardiac index is a measurement of the amount of blood being pumped out of the heart to the body.

¹¹³ A cardiac rhythm refers to the transmission of electrical signals that normally control the heart rate and regularity of beats.

¹¹⁴ See County of San Diego Medical Examiner's Report, dated October 15, 2018.

¹¹⁵ Cardiogenic shock is a fatal condition in which the heart is suddenly unable to pump enough blood to meet the body's needs.

¹¹⁶ Protamine is a medication used to reverse the effect of heparin (an anticoagulant used to prevent blood clotting) during surgery.

¹¹⁷ Hypertrophied means an abnormal enlargement of an organ or tissue.

¹¹⁸ The left ventricle is one of four chambers in the heart, separated by the aortic valve, which pumps blood from the heart to the rest of the body. See Death Summary by (b)(6); (b)(7)(C) dated July 31, 2018.

¹¹⁹ See Incident Report by Officer (b)(6); (b)(7)(C) dated July 26, 2018.

¹²⁰ See Incident Report by (b)(6); (b)(7)(C) dated July 26, 2018.

¹²¹ See Incident Reports by Officer (b)(6); (b)(7)(C) dated July 26, 2018.

¹²² See eCW Progress Note by RN (b)(6); (b)(7)(C) dated July 26, 2018.

¹²³ See OMDC Trust Account Closing Receipt, dated August 21, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

On August 21, 2018, DO (b)(6); (b)(7)(C) inventoried and proceeded RAMIREZ's property and funds at the facility.¹²⁴ ICE shipped the property and funds to RAMIREZ's family on this same date.¹²⁵ The package was delivered on August 24, 2018.¹²⁶

On September 20, 2018, the San Diego County Medical Examiner completed RAMIREZ's autopsy and documented an official cause of death of rheumatic heart disease, with coronary artery disease, pneumonia, and tuberculosis as contributing.¹²⁷

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care OMDC provided RAMIREZ, as well as the facility's efforts to ensure that she was safe and secure while detained at the facility. ERAU found deficiencies in OMDC's compliance with certain requirements of the ICE PBNDS 2011.

1. ICE PBNDS 2011, *Medical Care*, Section (V)(C)(2) states, "Detainees with symptoms suggestive of TB, or with suspected or confirmed active TB disease based on clinical and/or laboratory findings, shall be placed in a functional airborne infection isolation room with negative pressure ventilation and be promptly evaluated for TB disease. Patients with suspected active TB shall remain in airborne infection isolation until determined by a qualified provider to be noncontagious in accordance with CDC guidelines." The CDC TB Guidelines, *Prevention and Control of Tuberculosis in Correctional and Detention Facilities*, further state, "Persons who have radiographs suggestive of TB should be isolated immediately and evaluated further."
 - On June 4, 2018, although RAMIREZ's initial chest X-ray identified possible TB, OMDC allowed RAMIREZ to return to general population. RAMIREZ was in the unit for approximately two and one-half hours before results of a second chest X-ray were available. The second chest X-ray confirmed results of the first and, after notification to a provider, the provider ordered RAMIREZ's transfer to the hospital for isolation, testing, and treatment.
2. ICE PBNDS 2011, *Terminal Illness, Advanced Directives and Death*, Section (III)(V)(F) states, "Facilities shall turn over the property of the decedent to ICE/ERO within one week for processing and disposition. Unless property of a decedent is being held as part of an investigation into the circumstances of death, that property should be returned to the decedent's next of kin, if known, within two weeks."
 - OMDC processed RAMIREZ's property on July 31, 2018, 5 days after her death; however, ERO did not retrieve the property or funds from OMDC until August 21, 2018, 27 days after her death. ERO shipped the property and funds to RAMIREZ's family on that same date.

¹²⁴ *Id.*

¹²⁵ See Property Tracking, dated August 21, 2018.

¹²⁶ See Proof of Delivery, dated August 29, 2018.

¹²⁷ See Exhibit 1: San Diego County Medical Examiner Department, dated September 20, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

Areas of Concern

Although not reflective of any violation of the requirements of the detention standards, ERAU noted the following general concerns regarding RAMIREZ's medical care:

- On July 5, 2018, (b)(6); (b)(7)(C) ordered laboratory samples and vision testing for July 6, 2018. Nurses did not draw the laboratory samples until July 18, 2018, and there is no documentation vision testing was ever completed.
- On July 5, 2018, (b)(6); (b)(7)(C) orders included direction for a chronic care follow-up assessment by (b)(6); (b)(7)(C) on July 9, 2018. (b)(6); (b)(7)(C) did not see RAMIREZ on this date or at any other time for a chronic care follow-up. Also, on July 10, 2018, RN (b)(6); (b)(7)(C) noted she scheduled a cardiology consultation follow-up with (b)(6); (b)(7)(C) for July 11, 2018. (b)(6); (b)(7)(C) did not assess RAMIREZ for the cardiology consultation follow-up until July 19, 2018.

DETAINEE DEATH REVIEW – Agustina RAMIREZ-Arreola JICMS

(b)(7)(E)

EXHIBITS

1. San Diego County Medical Examiner Department, dated September 20, 2018.
2. Creative Corrections Healthcare and Security Compliance Analysis.



County of San Diego

GLENN N. WAGNER, D.O.
CHIEF MEDICAL EXAMINER
(858) 694-2895

MEDICAL EXAMINER'S DEPARTMENT
5570 OVERLAND AVE, STE 101, SAN DIEGO, CA 92123-1215
<http://www.sandiegocounty.gov/me>

STEVEN C. CAMPMAN, M.D.
CHIEF DEPUTY MEDICAL EXAMINER
(858) 694-2895

CALL INFO	NAME OF DECEASED RAMIREZ-ARREOLA, Agustina		AKA	HIO ☐	CASE NUMBER (b)(6); (b)(7)(C)
	INVESTIGATOR (b)(6); (b)(7)(C)	REPORTED BY Alvarado OR	REPORT NG AGENCY Alvarado Hospital		PREVIOUS WAIVE #
	CALL DATE AND TIME 7/25/2018 2255	ARRIVAL DATE AND TIME		RETURN DATE AND TIME	
DECEDENT	DATE AND TIME OF DEATH 7/25/2018 2245		DATE OF BIRTH 5/30/1956	AGE 62 Years	GENDER Female
	RACE Hispanic Mexican		RESIDENCE (STREET, CITY, STATE, ZIP) [REDACTED] San Diego, California, 92101		COUNTY San Diego
	LAST SEEN ALIVE		COUNTRY OF RESIDENCE San Diego		OCCUPATION Homemaker
	PAID AUTOPSY ☐				
DEATH	LOCATION OF DEATH Alvarado Hospital		TYPE OF PLACE Hospital		
	ADDRESS (STREET, CITY, STATE, ZIP) 6655 Alvarado Road, San Diego, CA, 92120				
	SUMMARY The decedent was a married, 62 year old Hispanic female who was currently in custody with the Immigration and Customs Enforcement (ICE). After developing sudden weakness, she was sent to Alvarado Hospital on June 08, 2018 and was found to have significant cardiac disease. On July 04, 2018, she underwent a cardiac catheterization and was released back into custody. On July 24, 2018 she was re-admitted to undergo a cardiac valve replacement. On the morning of July 25, 2018, her surgery began and was completed without any known complications. While in the recovery room, staff were unable to stabilize her vital signs and she was taken back to the operating room where she continued to decline. Despite aggressive efforts, staff were unable to regain a spontaneous heart rate and her death was pronounced. Medical Examiner's jurisdiction invoked according to the California Government Code 27491: Deaths in prison or while under sentence.				
INCIDENT	LOCATION OF INCIDENT		INCIDENT PLACE TYPE AT WORK ☐ AT RESIDENCE ☐		
	ADDRESS (STREET, CITY, STATE, ZIP) COUNTY				
	DATE AND TIME OF INCIDENT		INVESTIGATING AGENCY	OFFICER	BADGE #
	REPORT #				
	DECEASED WAS	BELTED No	HELMETED ☐ YES ☒ NO	POSITION	ON PRIVATE PROPERTY ☐ YES ☐ NO
NOTIFICATION	VEHICLE		LICENSE NUMBER		STATE
	IDENTIFIED BY		METHOD Hospital Identification		DATE AND TIME 07/25/2018 2331
	FUNERAL HOME		PROPERTY ☐ YES ☒ NO	PUBLIC ADMINISTRATOR ☐ YES ☒ NO	TYPE OF EXAM External Exam
	NAME OF NOK OR OTHER Homeland Security		RELATIONSHIP Legal	DATE NOTIFIED 7/25/2018	NOTIFIED BY Hospital Staff

DHS-20-0638-C-000098

INVESTIGATIVE NARRATIVE

Decedent: RAMIREZ-ARREOLA, Agustina

Antemortem Events:

On July 25, 2018 I learned the following information through medical staff from Alvarado Hospital and supplemented with medical records. The decedent had been a detainee in custody of the Immigration and Customs Enforcement (ICE) at their downtown San Diego facility. While in custody, in June of 2018, she began to develop weakness and was taken to Alvarado Hospital for an evaluation. At the time, tests showed that she had significant pre-existing cardiac disease and was admitted. On July 03, 2018, she was scheduled for and underwent a cardiac catheterization and was released back to the facility the following day pending follow up surgery at a later date.

On July 24, 2018, she was brought back to Alvarado Hospital to undergo the surgery, which was relayed as a valve replacement procedure. On the morning of July 25, 2018, the surgery began and was completed without reported complications and she was brought into the recovery room to stabilize her. During this time, medical personnel were unable to normalize her vital signs and she was ultimately taken back to the operating room in an attempt to find the reason. Despite lengthy efforts by staff to regain spontaneous heart rate, they were unable to and on July 25, 2018 at 2045 hours, her death was pronounced. At 2255 hours, hospital staff called the San Diego County Medical Examiner's Office to report the death and secured her body for transportation.

Past Medical, Surgical, and Social History:

According to medical records from Alvarado Hospital, the decedent was described as a poor historian and her past medical history prior to being detained was unknown. While in custody, she was diagnosed with coronary artery disease, pneumonia and tuberculosis.

Scene Description:

The decedent was pronounced dead while in the operating room of Alvarado Hospital located at 6655 Alvarado Road in the city of San Diego. On July 25, 2018 at 2331 hours, I arrived at the facility where I found the decedent atop a gurney in a hallway of the OR. There was nothing remarkable regarding the scene.

Body Description:

The body was only briefly viewed lying supine inside a hospital issued pouch. Blue tamper-evident seal number 0071325, along with an identification band was placed on top of the decedent's body for the transportation company.

Special Requests:

None.

Identification:

The decedent was visually identified to me upon my arrival by Alvarado Hospital staff.

Antemortem Specimens:

I did not collect antemortem samples.

Public Administrator:

No referral is needed as the decedent's next of kin are aware of her death.

Other Important Factors:

None.

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

Signed

September 20, 2018

Medical Examiner Investigator

Approved by:

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

CAUSE OF DEATH WORKSHEET

San Diego County Medical Examiner Department

☐ Autopsy

☐ Fetal death

San Diego County Medical Examiner

2018-01819

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

7/27/2018

RAMIREZ-ARREOLA, Agustina

☒ External

☐ Possible SIDS

☒ Not Dictated

☐ Family Paid

☐ Body not coming to office

CAUSE OF DEATH: (PENDING)

Time interval

Complications of aortic valve replacement hours

Due To: Rheumatic Heart Disease years

Due To: _____

Due To: _____

CONTRIBUTING: Coronary artery Disease, Pneumonia;
Tuberculosis (TB).

MANNER: () Pending (☒) Natural () Accident () Suicide () Homicide () Undetermined

****Use reverse side for manner type in non-pending cases**

HOW OCCURRED: _____

DATE and TIME of INJURY:

LOCATION:

SURGERIES and DATES:

Aortic valve replacement, 7/25/18.

7/29/18

If FEMALE, pregnant within the last year? () Yes (☒) No (☒) Unknown

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

Supervising Pathologist

Date

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

06/15

AMERICAN
OVERSIGHT

Manner Types and SubTypes

(check one)

NATURAL

- ☐ AIDS Related
- ☐ Alcohol Related
- ☐ Anaphylactic Reaction
- ☐ Autoimmune/Systemic
- ☐ Cancer
- ☒ Cardiovascular
- ☐ Central Nervous System
- ☐ Chronic Drug Abuse
- ☐ Diabetes Related
- ☐ Endocrine
- ☐ Family Paid
- ☐ Gastrointestinal
- ☐ Hematologic
- ☐ Infant/Perinatal (not SIDS)
- ☐ Infectious
 - ☐ Viral
 - ☐ Bacterial
 - ☐ Other
- ☐ Intrauterine/Stillborn
- ☐ Liver disease
- ☐ Obesity Related
- ☐ Other
- ☐ Pregnancy Related
- ☐ Psychiatric Related
- ☐ Pulmonary
- ☐ Renal
- ☐ Seizures
- ☐ SIDS
- ☐ Undetermined

ACCIDENT

- ☐ Aircraft
- ☐ Alcohol Related
- ☐ Anaphylactic Reaction
- ☐ Animal Related
- ☐ Asphyxia
 - ☐ Airway Obstruction
 - ☐ Autoerotic
 - ☐ Other
 - ☐ Positional
 - ☐ Strangulation
 - ☐ Suffocation
 - ☐ Traumatic
- ☐ Bicycle
- ☐ Blunt Force (other)
- ☐ Boating
- ☐ Carbon Monoxide
- ☐ Chemical/Poison
- ☐ Cutting/Stabbing
- ☐ Drowning
- ☐ Drug – Medication
 - ☐ Drug and Alcohol
 - ☐ Drug and Meds
 - ☐ Drug, meds & alcohol
 - ☐ Drugs of Abuse
 - ☐ Medication
 - ☐ Meds & Alcohol

ACCIDENT (cont.)

- ☐ Electrocution
- ☐ Explosion
- ☐ Exposure
- ☐ Fall
 - ☐ Blunt head trauma
 - ☐ Fracture, other
 - ☐ Hip/Femur fracture
 - ☐ Multiple injuries
 - ☐ Other
 - ☐ Spinal fracture
 - ☐ Subdural hematoma
- ☐ Fire
- ☐ Firearm
- ☐ Hanging
- ☐ Industrial
- ☐ Ingested Foreign Object(s)
- ☐ Inhalation
- ☐ Medical/Therapeutic
- ☐ Motor Vehicle
 - ☐ Auto Rollover (solo)
 - ☐ Auto vs Auto
 - ☐ Auto vs Bicycle
 - ☐ Auto vs Fixed Object
 - ☐ Auto vs Motorcycle
 - ☐ Auto vs Pedestrian
 - ☐ Hit and Run
 - ☐ Motorcycle
 - ☐ Off Road
 - ☐ Other
 - ☐ Unknown
- ☐ Other
- ☐ Restraint Related
- ☐ Scalding
- ☐ Scuba - Diving
- ☐ Spear gun
- ☐ Train
- ☐ Undetermined

SUICIDE

- ☐ Alcohol Related
- ☐ Asphyxia
 - ☐ Strangulation
 - ☐ Suffocation
 - ☐ Other
- ☐ Blunt Force (other)
- ☐ Carbon Monoxide
- ☐ Chemical/Poison
- ☐ Cutting/Stabbing
- ☐ Drowning
- ☐ Drug – Medication
 - ☐ Drug & Alcohol
 - ☐ Drug and Meds
 - ☐ Drug, meds & alcohol
 - ☐ Drugs of Abuse
 - ☐ Medication
 - ☐ Meds & Alcohol
- ☐ Electrocution

SUICIDE (cont.)

- ☐ Explosion
- ☐ Fire
- ☐ Firearm
- ☐ Hanging
- ☐ Inhalation
- ☐ Jumping
- ☐ Motor Vehicle
 - ☐ Auto Rollover (solo)
 - ☐ Auto vs. Fixed Object
 - ☐ Auto vs. Pedestrian
 - ☐ Motorcycle
- ☐ Train
- ☐ Undetermined

HOMICIDE

- ☐ Alcohol Related
- ☐ Asphyxia
 - ☐ Other
 - ☐ Positional
 - ☐ Strangulation
 - ☐ Suffocation
- ☐ Assault
- ☐ Blunt Force
- ☐ Chemical/Poison
- ☐ Child Abuse
- ☐ Cutting/Stabbing
- ☐ Drowning
- ☐ Drug - Medication
- ☐ Elder Abuse
- ☐ Exposure
- ☐ Fire
- ☐ Firearm
- ☐ Homicidal Violence, NOS
- ☐ Intrauterine/Stillborn
- ☐ Motor Vehicle
- ☐ Other
- ☐ Restraint Related
- ☐ Undetermined

UNDETERMINED

- ☐ Alcohol Related
- ☐ Blunt Force
- ☐ Decomposed
- ☐ Drowning
- ☐ Drug - Medication
- ☐ Fire related
- ☐ Firearm
- ☐ Infant/Perinatal (not SIDS)
- ☐ Intrauterine/Stillborn
- ☐ Other
- ☐ Skeletal Remains
- ☐ Undetermined

Rev. 06/15

DETAINEE DEATH REVIEW: Agustina RAMIREZ-Arreola, A206266687
Healthcare and Security Compliance Analysis
Otay Mesa Detention Center
San Diego, California

As requested by the ICE Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Agustina RAMIREZ-Arreola while she was in the custody of the Otay Mesa Detention Center (OMDC), San Diego, California. A site visit was conducted August 28 through 30, 2018 by ERAU staff

(b)(6); (b)(7)(C) Management and Program Analyst and team leader, and (b)(6); (b)(7)(C) Inspection and Compliance Specialist, and Creative Corrections contract personnel (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert, and (b)(6); (b)(7)(C) Security Subject Matter Expert. Contractor participation was requested to determine compliance with the ICE 2011 Performance Based National Detention Standards (PBNDS), revised 2016, governing medical care and security operations.

This report was prepared collaboratively by (b)(6); (b)(7)(C) Creative Corrections contract manager. Included is a case synopsis, description of the facility and its medical services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of detainee RAMIREZ's medical record and detention file, tour of the medical clinic, housing unit, and intake area, interviews of staff, and review of policies, video surveillance recordings, hospital and specialist consultation records, and available incident related documentation.

SYNOPSIS

Detainee RAMIREZ was admitted to OMDC on June 3, 2018, 12 days after she was processed by US Customs and Border Patrol. She was 62 years old. RAMIREZ reported no chronic medical conditions during intake and symptom screening for tuberculosis was negative; however, two chest X-rays conducted approximately 17 hours following her admission were positive for possible tuberculosis. RAMIREZ was not isolated following notification the first chest X-ray was positive, pending results of the second. A provider ordered her transport to the hospital when informed the second chest X-ray confirmed the findings of the first. Transfer to the hospital was ordered because the facility's respiratory isolation rooms were occupied.

RAMIREZ was hospitalized for 30 days, during which she was isolated, tested, and treated for tuberculosis. Tests for active pulmonary tuberculosis disease were ultimately found negative; however, during examination by the infectious disease specialist, a heart murmur was identified. Further diagnostic testing found severe aortic stenosis, confirmed during cardiac consultation within a week following RAMIREZ's return to OMDC. Surgery was recommended and

completed 15 days later. During surgery, complications developed. After multiple attempted interventions, death was pronounced at 10:45 p.m. on July 25, 2018.

A death certificate and autopsy were not available as of the date of this report. A summary prepared by the cardiac surgeon states the presumptive cause of death was cardiogenic shock.

FACILITY DESCRIPTION

OMDC is owned and managed by CoreCivic, formerly Corrections Corporation of America. At the time of RAMIREZ's detention, Spectrum Security Services provided security for detainees admitted to hospitals; however, according to Acting Officer in Charge (b)(6); (b)(7)(C) Assistant Field Officer Director, responsibility for hospital details was assumed by CoreCivic starting August 1, 2018.

OMDC houses male and female ICE and US Marshal Service (USMS) detainees. On July 25, 2018, the total population was 1458, including 832 male and 142 female ICE detainees, and 384 male and 100 female USMS detainees.

Visitors to OMDC are issued visitor badges after producing identification. They pass through a metal detector and place personal items through an X-ray machine before being permitted to pass through a secure door into the facility. The facility uses the Milestone System for video surveillance. The team reviewed video showing detainee RAMIREZ's movement within the facility and selected 39 screenshots deemed most pertinent to the compliance analysis. Reviewers note system-generated timestamps from video are not synchronized with times documented by other means.

HEALTHCARE SERVICES

OMDC was accredited by the National Commission on Correctional Health Care (NCCHC) in June 2016. The health services department is staffed 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor STG International headquartered in Alexandria, Virginia. In addition, one nurse is contracted through Akahi Associates based in Honolulu, Hawaii. The staffing plan authorizes 73 positions, 17 of which are designated for commissioned officers of the US Public Health Service. They include the Clinical Director, Health Services Administrator (HSA), two assistant HSAs, one staff physician, two behavioral health professionals, a dentist, registered dental hygienist, nurse manager, two pharmacists, one program manager, and four registered nurses (RN). There are 51 authorized full-time contract positions

including seven advanced practice providers¹, one psychiatrist, three behavioral health professionals, 13 RNs, seven mental health RNs, nine licensed vocational nurses (LVN), one dental assistant, six medical records technicians, two pharmacy technicians, one radiation technician, and an administrative assistant. As-needed positions include four RNs and one LVN. According to CAPT (b)(6); (b)(7)(C) SA, there were three or four nursing vacancies during detainee RAMIREZ's detention; however, all shifts were covered with temporary duty nurses. There was also a vacancy for an assistant HSA. Review of credential files found all but four contained copies of current licensure. During the site visit, the HSA verified the licenses of the four nurses were active by accessing the California nursing licensure website.

OMDC's clinic has six medical examination rooms, an urgent care/treatment room, nursing triage room, nurses' station, pharmacy, medical records office, four-chair dental suite, large conference room, laboratory draw room, and several offices. The observation area has two nine-person dormitory-style units for mental health patients and six negative pressure rooms for respiratory isolation. Three holding tanks, which serve as waiting rooms, allow separation of genders. Intake screening and radiology rooms are located in the receiving and discharge processing area.

The IHSC e-Clinical Works (eCW) electronic medical record system is used at OMDC. The system does not have mandatory fields for entry of the times patient encounters are conducted, and OMDC healthcare professionals are not required to include the times they see patients in their free-form notes. Therefore, times referenced in this report reflect timestamps of vital sign entries and times healthcare professionals signed their notes.

DETENTION SUMMARY

Detainee RAMIREZ was classified low custody. She had no disciplinary incidents and filed no grievances. Her single request, in Spanish, was answered six days later. The response suggests she asked to obtain phone numbers from her property but then declined the opportunity to access the numbers. The response, in English, indicates her interest was in resetting her voice for the telephone system, which was facilitated. When not hospitalized, RAMIREZ was housed in general population.

SUMMARY OF EVENTS

Sunday, June 3, 2018

Detainee RAMIREZ was medically pre-screened by (b)(6); (b)(7)(C) RN upon arrival at OMDC. (b)(6); (b)(7)(C) documented the time of arrival was 5:48 p.m. and interpretation assistance was not provided. The RN also noted the detainee was not transferred from another facility.

¹ Advanced Practice Providers include nurse practitioners and physician assistants.

RAMIREZ acknowledged a current, illness or health problem (b)(6); (b)(7)(C) did not specify on the pre-screening form, and denied being on medication. The detainee's appearance, behavior, skin and breathing were all described as normal, she was alert, and there were no noticeable restrictions or difficulties in her ease of movement. (b)(6); (b)(7)(C) did not designate RAMIREZ for priority intake screening. The note was electronically signed at 8:07 p.m.

Note: According to HSA (b)(6); (b)(7)(C) pre-screening involves RNs boarding the transport bus and asking arriving detainees simple, routine health questions in Spanish, whether or not the nurses themselves speak the language fluently. If detainees want to elaborate on their responses, they are designated priority one status and brought into the facility for full screening using interpretation assistance as needed. (b)(6); (b)(7)(C) was reassigned to another duty station prior to the review team's site visit and therefore, was not available for interview.

Note: Documentation provided to reviewers indicates that consistent with RN (b)(6); (b)(7)(C) note, RAMIREZ was not transferred from another ICE detention facility. However, Form I-213, Record of Deportable/Inadmissible Alien, documents she entered the US on May 21, 2018 and was processed by US Customs and Border Patrol (CBP) 12 days before arrival at OMDC, May 22, 2018. Reviewers do not know when custody of RAMIREZ was transferred from CBP to ICE Enforcement and Removal Operations (ERO).

A screenshot from the Receiving Sally Port camera shows detainee RAMIREZ entered Intake at 5:45 p.m. The Inmate/Detainee Commitment Summary documents she was booked into OMDC at 5:55 p.m.

Medical and mental health intake screening was conducted by RN (b)(6); (b)(7)(C) using a telephonic service for Spanish interpretation. Vital signs entered at 7:55 p.m. were as follows: temperature normal at 97.2, blood pressure slightly elevated at 130/85, respirations normal at 18, and pulse rapid at 126. RAMIREZ's height was four feet, nine inches and she weighed 185 pounds. Because her pulse was elevated when first taken, it was retaken after ten minutes of rest and found slightly lower at 116. She was scheduled for two additional pulse checks.

Note: The pulse checks, scheduled in eCW for June 6 and 16, 2018, were not completed. (b)(6); (b)(7)(C) stated during interview that she did not know they were not done, and could not offer an explanation.

RN (b)(6); (b)(7)(C) wrote RAMIREZ stated she felt good and was not in any pain. She denied medical problems, except for having a cough and sore throat for three days. She was not taking medication on a regular basis and when asked if she had ever been treated by a doctor for a medical condition, she stated she had eye surgery ten years earlier to remove a piece of flesh. RAMIREZ denied use of tobacco, alcohol, or drugs, and the mental health screening was normal. A pregnancy test was negative. All questions related to tuberculosis symptoms were answered in the negative, including experiencing a prolonged cough, and she denied a history of tuberculosis infection. During

interview, (b)(6); (b)(7)(C) stated that because RAMIREZ's cough was only three days in duration, she did not consider it prolonged. Therefore, in her medical judgment, the reported cough was not a possible symptom of tuberculosis.

The intake screening was designated normal. Education was provided to address health, wellness, stress management, and access to medical, dental, and mental health care. Consent for treatment was signed, and RAMIREZ was medically cleared for custody. (b)(6); (b)(7)(C) signed her note at 8:08 p.m.

Officer (b)(6); (b)(7)(C) documented completion of the following admission processing forms: Assessment Questionnaire Information, Free Admission Telephone Call Form, and Custody Classification Worksheet. The Assessment Questionnaire Information form includes questions related to history of sexual assault and abuse, all of which were answered in the negative. Officer (b)(6); (b)(7)(C) was not interviewed; therefore, reviewers do not know whether she posed the questions in Spanish or if interpretation assistance was used. The telephone call form documents detainee RAMIREZ placed a three minute telephone call to her daughter (b)(6); (b)(7)(C). The Custody Classification Worksheet documents the detainee was rated low custody. The rating was approved by a supervisor on June 5, 2018.

June 4, 2018

A Detainee Personal Property Record Form initiated at 1:01 a.m. by Officer (b)(6); (b)(7)(C) (first name unknown) lists the following items: backpack, blouse, bras, cellphone, creams, deodorant, earring bows, eyeglass cleaner, eyeglass pouch, fiber pouches, jacket, jeans, make-up brush, money pouch, phone charger, shoes, socks, sweater, tablet with pen, toothpaste, toothbrush, underwear, vitamins, and wallet. Funds included one US dollar and enumerated Mexican currency. Two tubes of cream, nail polish and cologne were confiscated and destroyed per Disposition of Non-Allowable Property Form 14-6A. Receipts for the property and funds, in English, were initialed by detainee RAMIREZ in lieu of signature. She also initialed receipts for facility clothing, hygiene items, and bedding and linens.

The Offender System housing report documents detainee RAMIREZ was assigned to Alpha Unit cell 106, bed E. Alpha Unit is a two-tier, direct supervision, general population housing unit with eight-person rooms and dayroom. A screenshot from the Alpha Corridor camera shows RAMIREZ entering Alpha Unit at 3:37 a.m. A screenshot from the same camera shows she departed the housing unit at 7:59 p.m. heading towards Intake. The Receiving East camera captured detainee RAMIREZ standing with other detainees in a line near the Intake X-Ray room door at 8:16 p.m. She entered the room at 8:22 p.m.

During interview, HSA (b)(6); (b)(7)(C) explained that chest X-rays are the primary tuberculosis testing method at OMDC. She said one full-time radiology technician works the evening shift, 3:00 p.m. to 11:30 p.m. Monday through Friday. Because intake tuberculosis symptom screening was negative, isolation pending chest X-ray was not indicated, and because she arrived on a Sunday,

her chest X-ray was not taken until the evening following her admission. “Public Health Actions for Tuberculosis Care Guide: IHSC-Staffed Medical Clinics”, signed July 11, 2017 by CAPT (b)(6); (b)(7)(C) MD, authorizes the practice followed at OMDC.

Medical record documentation indicates two X-rays were taken. Per the Shina Systems Configuration Management screen print, the first was taken at 8:24 p.m.; the second at 8:43 p.m. The report for the first chest X-ray documents it was positive for active TB disease and “cannot exclude Active TB; NOT clear for general population.” The X-Ray was read by (b)(6); (b)(7)(C) MD and transcribed by Alox Sao at 11:29 p.m. Eastern Standard Time (EST)/8:29 p.m. Pacific Standard Time (PST). The report for the second X-ray confirmed the findings of the first. The second X-ray was read by (b)(6); (b)(7)(C) MD and transcribed by (b)(6); (b)(7)(C) 2:25 a.m. EST/11:25 a.m. PST. Neither of the radiology reports document the times they were sent to OMDC.

Note: The two radiology reports document procedure times of 11:06 p.m. EST/8:06 p.m. PST and 11:32 p.m. EST/9:32 PST. Other evidence indicates these times are inaccurate. Specifically, as noted, a screenshot from the facility’s security video shows RAMIREZ first entered the X-ray room at 8:22 p.m., and the Shina Systems screen print documents electronic time stamps of 8:24 p.m. and 8:43 p.m. for the two X-rays. When the discrepancies were pointed out to HSA (b)(6); (b)(7)(C) she said she had not noticed them and could offer no explanation.

A screenshot from the camera system shows detainee RAMIREZ approaching the entry door to Alpha Unit with other detainees at 8:45 p.m.

Note: Detainee RAMIREZ was returned to the housing unit despite two chest X-rays which were positive for suspected TB. The results of the second were not known when she returned to Alpha Unit; however, the evidence indicates OMDC medical staff were aware the first was positive and did not direct the detainee’s isolation. While possible the written report for the first chest X-ray was not received prior to completion of the second, the time of its transcription, 8:29 p.m. PST, and the fact that a second X-ray was performed 19 minutes after the first, points to staff’s awareness of the first positive finding, presumably by telephone. Per the above-cited IHSC Tuberculosis Care Guide, “Health staff should obtain a two view [chest X-ray] (PA² and lateral) as an additional verifier for any single view [chest X-ray] with an abnormal impression consistent with suspected TB disease (‘positive’) as soon as possible but no later than 72 hours of the initial abnormal, single view [chest X-ray] result.” The evidence suggests that the second chest X-ray was taken in accordance with these instructions.

² PA in this context stands for posteroanterior, meaning the radiation rays pass through the body from back to front.

As detailed below, after extensive testing, respiratory isolation, and treatment at the Alvarado Hospital Medical Center (AHMC), infectious pulmonary TB was ultimately ruled out. That was not known when RAMIREZ returned to Alpha unit at 8:45 p.m. on June 4, 2018; therefore, other detainees and staff were placed at risk for possible exposure to TB. Available information does not allow attribution of responsibility; nor does it allow determination of whether RAMIREZ was allowed to return to the housing unit due to lack of procedures that ensure detainees with positive chest X-rays are isolated pending results of a second, or staff failure to follow them. CAPT (b)(6); (b)(7)(C) MD, Clinical Director, and OMDC's designated Infection Prevention Officers, Lieutenant Commander (b)(6); (b)(7)(C) stated during interviews that OMDC is a high-risk location for tuberculosis transmission.

A telephone encounter initiated by RN (b)(6); (b)(7)(C) at 11:06 p.m., documents she notified Physician Assistant (PA) (b)(6); (b)(7)(C) of the results of the two chest X-rays. She wrote that because the negative pressure rooms in the Medical Housing Unit (MHU) were full, the provider ordered RAMIREZ's transport to the emergency room by facility van.

Note: As discussed above, the report for the second chest X-ray documents a transcription time of 11:25 p.m. PST., following RN (b)(6); (b)(7)(C) notification of PA Sacramento that both X-rays were positive. Reviewers assume OMDC staff were notified of the results of the second by telephone, before the findings were transcribed.

Note: Documentation of the chest X-ray results and notification of a provider for orders exists in the telephone encounter, only. There is no corresponding progress note. RN (b)(6); (b)(7)(C) informed the review team nurses are required to enter a progress note only if there is a patient encounter.

Screenshots from the camera system show detainee RAMIREZ leaving Alpha unit at 11:19 p.m. and entering intake at 11:22 p.m. She was wearing a mask.

June 5, 2018

A screenshot shows detainee RAMIREZ boarding an OMDC van at 12:52 a.m. She continued to wear a mask. A Transfer of Custody Receipt documents CoreCivic transport officers turned custody of RAMIREZ over to Spectrum Security Services officers at 6:30 a.m.

Note: Security logs documenting the time of arrival at AHMC and events during RAMIREZ's hospitalization were not available.

Detainee RAMIREZ was admitted to AHMC under the care of attending physician (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) MD. She was hospitalized for 30 days, during which OMDC nurses entered only 12 hospital updates, summarized below. Further information on care provided at the hospital is provided below (see July 5, 2018 and July 12, 2018).

Note: HSA (b)(6); (b)(7)(C) informed the review team that hospital updates are to be obtained daily when detainees are stable. Updates were not recorded for June 5, 7, 10, 12, 13, 15, 18, 19, 20, 22, 25, 26, and 27, and July 1 and 2, 2018.

Date	Update
June 6, 2018	Current diagnosis: rule out tuberculosis; condition stable. Three sputum samples ³ were collected and a purified protein derivative (PPD) skin test was planted.
June 8, 2018	PPD and two sputum samples were negative for TB but positive for extended spectrum beta-lactamase (ESBL) ⁴ . A CT scan of the chest, with contrast, showed pneumonia in the bilateral lobes and left upper lobe. Antibiotics were changed from Levaquin ⁵ to Augmentin ⁶ .
June 11, 2018	Results of the third sputum and the MTB (micro-bacterium tuberculosis) ⁷ VCR ⁸ were pending. An infectious disease consult was also pending.
June 14, 2018	The three sputum samples and MTB were negative. Rifampin, isoniazide (INH), pyrazinamide, and ethambutal (RIPE) therapy ⁹ was initiated on June 12, 2018 and was to be continued for five days.
June 16, 2018	No changes.
June 17, 2018	Day six of RIPE therapy. Discharge was pending clearance by the county public health department.
June 21, 2018	RIPE therapy was stopped on June 19, 2018 due to elevated liver enzymes. RIPE treatment was re-initiated this date, starting with Ethambutol, only. There were no episodes of nausea or vomiting. Liver enzyme lipase was to be retested the next morning. Test results for O&P (ova and parasites) ¹⁰ were pending. The medication

³ Sputum is mucous that must be coughed up from the lungs and tested to determine if the tuberculosis bacteria is present. For accuracy, three sputum samples are collected. If all three smears are negative, the patient is determined not to be actively infectious.

⁴ ESBL is a type of bacteria which produces an enzyme, beta lactamase, which has the ability to break down commonly used antibiotics and render them non-effective for treatment.

⁵ Levaquin is an antibiotic medication used to treat pneumonia, an infection of the lungs.

⁶ Augmentin is an oral antibacterial combination consisting of the antibiotic amoxicillin and the beta lactamase inhibitor clavulanate potassium.

⁷ MTB is another way of saying tuberculosis, caused by a microscopic bacteria.

(b)(6); (b)(7)(C) and OMDC's two infection control nurses were unfamiliar with the acronym VCR. Reviewers conclude VCR may be a typographical error and that the RN may have intended to type PCR. MTB PCR is a molecular based test for TB and is, in fact, referred to in a progress note by the infectious disease specialist in a hospital progress note dated July 4, 2018.

⁹ RIPE therapy is the administration of the four antibiotic drugs which are used in combination to treat tuberculosis. The vitamin pyridoxine (B6) is always included with INH dosing.

¹⁰ A parasite is an organism that lives in or on another organism (host) and benefits by deriving nutrients at the host's expense. Ova are eggs of the parasite. An AHMC laboratory report documents the tests were negative.

	Zofran was given the night before to relieve nausea, and Benadryl was given to treat insomnia. Intravenous hydration was started with normal saline ¹¹ and potassium ¹² .
June 26, 2018	RAMIREZ remained in respiratory isolation. An echocardiogram ¹³ revealed aortic stenosis ¹⁴ , and a cardiology evaluation and possible cardiac catheterization ¹⁵ were pending. She was reportedly crying all night because she could not call her family. Ethambutol was discontinued due to continued elevated liver enzymes. Benadryl and Visteril were ordered to be given as needed to relieve itching.
June 28, 2018	Ethambutol and Rifampin were restarted on June 27, 2018. Follow up liver enzyme testing was pending.
June 29, 2018	No treatment changes.
June 30, 2018	No treatment changes.
July 3, 2018	A cardiology evaluation and possible cardiac catheterization were pending, possibly as an outpatient procedure, following RAMIREZ's release from respiratory isolation. Ethambutol, Rifampin, and vitamin B6 had been administered for five days, and it was day three for INH. Discharge was being planned for the next day, following five days of RIPE.

July 4, 2018

A Transfer of Custody Receipt indicates Spectrum Security Services officers turned over custody of detainee RAMIREZ to CoreCivic officers at 9:00 p.m. A screenshot from the video camera system shows she entered the intake area at 9:42 p.m. and went directly to medical.

RN (b)(6); (b)(7)(C) initiated an encounter note documenting assessment of RAMIREZ following her return from AHMC. The RN wrote she is fluent in the detainee's language and did not use interpretation assistance. Vital signs associated with the encounter were not entered until 8:03 a.m. July 6, 2018, and RN (b)(6); (b)(7)(C) signed her note two hours later the same date. Vital signs were within normal limits (temperature 97.6, pulse 82, blood pressure 116/71, respirations 14, and pulse oxygen 96 percent). RAMIREZ was in no acute distress, well-developed, and well nourished. RN (b)(6); (b)(7)(C) wrote that the detainee was admitted to the MHU pending evaluation by the primary care provider the following day. A screenshot shows detainee RAMIREZ entering negative pressure room 1468 at 10:20 p.m.

July 5, 2018

¹¹ Normal saline is a mixture of sodium chloride (salt) and water, often used as an intravenous solution to keep the intravenous catheter cleared of blockage and bacteria.

¹² Potassium is an alkaline (pH greater than seven) chemical element.

¹³ An echocardiogram is a diagnostic tool which uses ultrasound (sound waves) to create images of the heart.

¹⁴ Aortic stenosis is a condition in which the valve in the large blood vessels branching off the heart (aorta) is abnormally narrowed, preventing the heart valve from fully opening and causing inability of the blood to flow from the heart to the rest of the body.

¹⁵ Cardiac catheterization is the insertion of a catheter into a chamber or vessel of the heart for diagnostic and interventional purposes.

RN (b)(6); (b)(7)(C) entered a tuberculosis monitoring report documenting submission of transnational referral to Cure TB¹⁶, RAMIREZ's placement on medical hold, and reporting of the case to the California Health Department in San Diego. Confirmatory sign-off by RN (b)(6); (b)(7)(C) at 11:14 a.m. on July 9, 2018 requested continued updates with final culture results when available, and a follow up comparison chest X-ray after six to eight weeks of TB treatment.

(b)(6); (b)(7)(C) entered two encounter notes this date. The lengthier note, for which vital signs were entered at 2:26 p.m., was documented as the PE-C, Physical Examination-Complex. At IHSC facilities, PE-C is the designation for the initial health appraisal of detainees with identified medical conditions. Vital signs were within normal limits (temperature 98.6, pulse 90, blood pressure 123/73, respirations 12), and RAMIREZ reported she was in no pain. In the narrative, (b)(6); (b)(7)(C) recounted that mild tachycardia was noted during intake and that the detainee was sent to the emergency room as a result of positive chest X-rays. He also noted that she had no history of pulmonary issues and was asymptomatic. (b)(6); (b)(7)(C) wrote that while RAMIREZ was undergoing TB workup and infectious disease consultation at the hospital, a heart murmur was noted. An ECG showed aortic stenosis, found severe by way of cardiac catheterization. The narrative further documents that on July 3, 2018, charge nurse (b)(6); (b)(7)(C) first name not specified called to request urgent aortic valve replacement per recommendation of cardiology. (b)(6); (b)(7)(C) wrote that he gave verbal approval through RN (b)(6); (b)(7)(C) but for reasons that were unclear, RAMIREZ was returned to OMDC on July 4, 2018. Later in his note, in Examination findings, (b)(6); (b)(7)(C) wrote that he spoke with charge nurse (b)(6); (b)(7)(C) first name not specified and was told the cardiologist decided the AVR procedure was not emergent and could be arranged on an outpatient basis. He also recommended follow up with cardiac surgeon (b)(6); (b)(7)(C) to consider outpatient surgery, and that RAMIREZ was cleared for surgery for general anesthesia and proposed cardiac operation.

In the Examination and Assessments sections of the encounter note, (b)(6); (b)(7)(C) addressed the aortic stenosis diagnosis as well as TB testing and treatment. He wrote, "Overall, suspect [chest X-ray] abnormality likely from pneumonia, not TB." He documented three sputum smears were negative for TB but in narrative notes, documented two were negative and two others, processed at AHMC, were presumably negative. RIPE therapy was started but pyrazinamide was stopped due to hepatitis/pancreatitis which resolved when stopped. (b)(6); (b)(7)(C) noted the infectious disease consultant determined RAMIREZ stable for discharge and clear for travel, but recommended continuation of three-drug TB treatment, avoiding pyrazinamide, and following smear cultures and liver enzymes.

Note: For added context, reviewers note that a progress note in the AHMC record by Dr. (b)(6); (b)(7)(C) infectious disease specialist, documents an assessment finding of latent TB infection. The finding of latent TB means there was past disease and that bacteria in

¹⁶ Cure TB is a program promoted by Center for Disease Control which works to prevent the spread of tuberculosis among people who cross international borders.

the lungs was inactive. Latent TB may become active again and result in infectious pulmonary disease. (b)(6); (b)(7)(C) progress note also states RAMIREZ was smear negative and negative on all MTB PCRs. The negative tests indicate tuberculosis bacteria was absent in the lungs, meaning the detainee was not infectious by airborne transmission. This finding does not, however, rule out the presence of tuberculosis in other parts of the body.

Per his progress note, (b)(6); (b)(7)(C) wrote that he discontinued TB isolation on July 3, 2018, and determined there were no contraindications from an infectious disease standpoint to preclude surgery for aortic stenosis.

The general examination conducted by (b)(6); (b)(7)(C) was normal except for a heart murmur of 3/6¹⁷, heard at the upper sternal border. The pulse rate and rhythm were normal. The assessments were enumerated as follows: encounter for general adult medical examination with abnormal findings; encounter for observation for other suspected diseases and conditions ruled out; non-rheumatic aortic valve stenosis¹⁸; and pneumonia due to Escherichia coli¹⁹.

Treatment orders included RIPE medications except pyrazinamide, and omeprazole as needed for heartburn; an urgent referral for follow up with cardiac surgeon (b)(6); (b)(7)(C) chronic care follow up on July 9, 2018 with OMDC PA (b)(6); (b)(7)(C)

Note: Referrals for outside consultations are not processed through the ICE Medical Payment Authorization Request system at facilities where healthcare services are provided by IHSC. The OMDC medical record does not document the processing of (b)(6); (b)(7)(C) referral but as discussed below, the consultation was, in fact, completed by (b)(6); (b)(7)(C) five days later, July 10, 2018.

Note: (b)(6); (b)(7)(C) did not see RAMIREZ until July 19, 2018. A blank follow up encounter note is present in the medical record for this date, suggesting the appointment was scheduled. (b)(6); (b)(7)(C) stated during interview that she did not know why she did not see detainee RAMIREZ as ordered by (b)(6); (b)(7)(C)

¹⁷ Heart murmurs are classified according to how loud the sound is with a stethoscope. A 3/6 murmur means the loudness was on a level three on a scale of one to six.

¹⁸ Nonrheumatic aortic valve stenosis means the condition is not caused by a history of rheumatic fever.

¹⁹ Escherichia coli is a bacteria that normally lives in the intestines of healthy people and animals, but some strains can cause diarrhea when consuming contaminated food, drink, or fouled water.

Additional treatment orders included Snellen and Ishihara vision testing²⁰ by RNs on July 6, 2018, and laboratory tests for HIV, comprehensive metabolic panel²¹, thyroid cascade²² profile, urinalysis with microscopic examination with reflex culture²³, and QuantiFERON TB Gold. In the Assessments section of his note, (b)(6); (b)(7)(C) documented the labs were to be drawn on July 6, 2018; in the Treatment section, he wrote they were ordered for July 5, 2018.

Note: The labs were not drawn until July 18, 2018, and there is no documentation vision testing was completed. The reason (b)(6); (b)(7)(C) orders were not followed is unknown.

The Examination section of (b)(6); (b)(7)(C) documents detainee RAMIREZ was medically cleared for custody, and RN (b)(6); (b)(7)(C) (first name unknown) was advised the patient may locate to general population; no respiratory isolation needed.

In his second encounter note for July 5, 2018, (b)(6); (b)(7)(C) documented the reason for the appointment was 23-hour observation/hospital return. The History of Present Illness and Examination sections refers to the PE-C for full details. Vital signs time-stamped 3:40 p.m. were the same as those entered for the PE-C.

A Telephone Encounter by (b)(6); (b)(7)(C) timed 4:30 p.m. documents he discussed dosing of rifampin and ethambutol with the pharmacist. The medication dosages were:

- Isoniazid (INH) 300 mg, one tablet daily in the morning
- Pyridoxine (Vitamin B6) 50 mg, one daily in the morning
- Rifampin 150 mg, three capsules, daily in the morning, after meal
- Ethambutol HCl 400 mg, two tablets daily in the morning
- Omeprazole 20 mg, as needed for heartburn at night

A screenshot from the video camera system shows detainee RAMIREZ exiting negative pressure room 1468 at 2:37 p.m. with linens and pillow in hand. At 2:33 p.m., she entered Alpha Unit. The Offender Management System Log documents RAMIREZ was assigned to cell 103, bed C at 2:37 p.m. Cell 103 is on the lower level of the housing unit; bed C is an upper bunk. Per the log, at 11:12 p.m. detainee RAMIREZ was reassigned to cell 207, bed F, a lower bunk on the upper level.

Detainee RAMIREZ submitted a request in Spanish. By response in English, dated July 11, 2018 a staff member whose signature is not legible notified the detainee she was given the opportunity

²⁰ A Snellen test is a test to determine visual acuity, using an eye chart.

²¹ A comprehensive metabolic panel (CMP) is a series of blood test that provide a snapshot of the body's chemistry and the way it uses energy through metabolism.

²² A thyroid cascade profile is a test used to diagnose common thyroid disorders. If the initial test result is normal, further testing (cascading) is deemed unnecessary.

²³ A urinalysis with microscopic examination with reflex culture involves a dipstick urine test to determine the chemical constituents in the urine, a microscopic examination to detect the presence of abnormal urine cells, and culture to identify the organisms causing infection.

to access her property for phone numbers and other items. She refused, saying she did not need anything, “just wanted to have your voice reset.” The response further notes the detainee’s voice was reset.

Note: Reviewers assume a voice re-set relates to the phone system.

July 6, 2018

The Offender Management System Log documents that at 9:18 p.m., detainee RAMIREZ was reassigned to cell 101, bed H, a lower bunk on the lower level. During tour of the housing unit, unit counselor (name unknown) indicated changes were made to detainee RAMIREZ’s cell and bed assignments pursuant to requests claiming hardship climbing the stairs and to upper bunks.

(b)(6); (b)(7)(C) documented an update to the initial infectious disease monitoring report, adding results of tests completed at the hospital; specifically, the Interferon Gamma Release Assay²⁴ was positive, and the HIV test was negative.

July 7, 2018

RN (b)(6); (b)(7)(C) conducted a nursing assessment to address RAMIREZ’s complaint of itchiness on her arms and legs. Spanish interpretation assistance was used. The detainee denied pain, and vital signs entered at 2:49 p.m. were within normal limits (temperature 98, pulse 88, blood pressure 125/68, and respirations 16). Risk for impaired skin integrity was the assessment and the plan, per RN Guideline 2008 (title not specified), was to start diphenhydramine HCL²⁵ 25 mg orally every six hours as needed for three days, keep-on-person (KOP). (b)(6); (b)(7)(C) signed her note at 3:00 p.m.

July 10, 2018

RN (b)(6); (b)(7)(C) entered an encounter note documenting RAMIREZ returned from consultation with cardiac surgeon (b)(6); (b)(7)(C) at 2:25 p.m. Interpretation assistance was not used based on the RN’s documented fluency in the detainee’s language. Vital signs entered at 2:34 p.m. were within normal limits (temperature 98.4, pulse 86, blood pressure 119/70, respirations 16, and pulse oxygen 99). Her weight was 181 pounds. RAMIREZ denied pain and offered no complaints. In the Treatment section of the encounter note, RN (b)(6); (b)(7)(C) wrote that an offsite provider discharge note was received with recommended treatment plan, “Patient needs aortic valve replacement surgery.”

²⁴ An Interferon Gamma Release Assay (IGRA) is a whole blood test used to aid in the diagnosis of tuberculosis infection. It does not differentiate latent (inactive) tuberculosis from active tuberculosis disease. QuantiFERON-TB Gold is a commonly used IGRA.

²⁵ Diphenhydramine HCL is the generic name for Benadryl, an antihistamine used to treat allergy, hay fever, and common cold symptoms.

Note: The referenced discharge note was not found in the medical record; however, as discussed below, a consult report prepared by (b)(6); (b)(7)(C) on July 10, 2018 was faxed to the facility on July 12, 2018.

(b)(6); (b)(7)(C) documented she notified onsite provider (b)(6); (b)(7)(C) and gave her “papers”. RAMIREZ was scheduled to see the PA for follow up on July 11, 2018, and was instructed to notify staff in the event of any shortness of breath, chest pain, or if otherwise needed. Per PA (b)(6); (b)(7)(C)’s authorization, RAMIREZ was returned to general population in stable condition. RN (b)(6); signed her note at 2:45 p.m.

Note: (b)(6); (b)(7)(C) did not see detainee RAMIREZ on July 11, 2018. The medical record does not document the reason she did not see RAMIREZ until July 19, 2018.

July 12, 2018

(b)(6); (b)(7)(C)’s six-page consult report dated July 10, 2018 was faxed to (b)(6); (b)(7)(C) attention at 9:45 a.m. Dr. (b)(6); (b)(7)(C) opened the fax coversheet on July 13, 2018. (b)(6); (b)(7)(C) opened the report by noting detainee RAMIREZ spoke Spanish only, and that her history was obtained with the assistance of a translator. He wrote that RAMIREZ had no knowledge of cardiovascular disease or a heart murmur prior to the recent hospitalization. He detailed events at AHMC, including three negative sputum tests, initiation of RIPE therapy, discontinuation of pyrazinamide upon development of symptoms of pancreatitis, and treatment for pneumonia. He detailed identification of the cardiac murmur and diagnosis of rheumatic valvular disease with severe aortic stenosis. In the Impressions section of the report, (b)(6); (b)(7)(C) documented RAMIREZ was a suitable candidate for surgical valve replacement with low surgical risk. He concluded the report with a recommendation for aortic valve replacement and documented that through a translator, the indications, risks and alternatives were explained to RAMIREZ. She indicated her consent.

July 17, 2018

A Telephone Encounter by (b)(6); (b)(7)(C) timed 4:38 p.m. documents a surgery referral was submitted pursuant to (b)(6); (b)(7)(C) recommendation. As detailed below, the surgery was conducted on July 25, 2018.

July 18, 2018

RN (b)(6); entered a note documenting blood was drawn for lab tests ordered on July 5, 2018. The specimens were drawn without difficulty and the patient tolerated the procedure well.

Note: During interview, (b)(6); (b)(7)(C) said he ordered that the labs be drawn on July 6, 2018 so the results would be available prior to the cardiology consultation. He noted that although the labs were drawn later than ordered, the tests were done in time for RAMIREZ’s surgery.

RN (b)(6); (b)(7)(C) conducted a nursing assessment to address RAMIREZ's complaint of continued itching. Spanish interpretation assistance was used for this encounter. Vital signs entered at 11:39 a.m. were within normal limits except for a mildly elevated blood pressure (temperature 98.2, pulse 94, respirations 16, pulse oxymetry 100, blood pressure 137/84). RAMIREZ complained of recurring itchiness all over, and RN (b)(6); (b)(7)(C) described the skin as very dry with a red rash over the detainee's left forearm and right upper arm. The skin on her back was intact, with no lesions. Other general examination findings were normal. The treatment plan was to start diphenhydramine HCL 25 mg orally every six hours as needed for three days, keep-on-person. Instructions, per the Nursing Guideline 2008 for allergies, were to increase fluid intake to eight eight-ounce glasses per day, take lukewarm showers, and to return to sick call in three days if symptoms persist or worsen. TN (b)(6); (b)(7)(C) signed her note at 11:55 a.m.

July 19, 2018

(b)(6); (b)(7)(C) conducted a post-cardiology consultation follow up encounter. Vital signs entered at 2:08 p.m. were within normal limits with the exception of a mildly elevated blood pressure (temperature 98.0, pulse 98, respirations 16, and blood pressure 134/80). PA (b)(6); (b)(7)(C) wrote, "[Patient] has been in Alvarado Hospital for more than one month originally sent for suspect TB, then found the heart problem. (b)(6); (b)(7)(C) has recommended surgery, referral has been placed. [Patient] reports prior to arrival, she had no idea she had the heart problem, reports she did get tired easily. [Patient] reports what bothers her most is the itching, possibly from one of the TB meds, pyrazinamide or ethambutol." The general examination found no obvious rash, although she was constantly scratching at her skin which caused welts and erythema. The systolic murmur was heard. She was diagnosed with nonrheumatic aortic stenosis and pruritus²⁶, unspecified. The treatment plan noted surgery for aortic valve stenosis was scheduled for July 25, 2018. PA (b)(6); (b)(7)(C) documented RAMIREZ became tearful and was concerned "about having surgery alone in the facility," and had no prior knowledge of heart problems. The treatment for pruritis related to tuberculosis medication included a teleconference with (b)(6); (b)(7)(C) IHSC Infection Control Specialist, and to start diphenhydramine HCL 25 mg orally three times daily as needed for 30 days, approved as a KOP medication. Provider follow up was scheduled for one week as needed post-surgery. Patient education was provided, and RAMIREZ was medically cleared for custody. P (b)(6); (b)(7)(C) signed the note at 2:47 p.m.

Note: This is the last patient encounter note in the medical record. As detailed below, the next entry was five days later, following RAMIREZ's transport to AHMC in advance of the scheduled surgery.

July 24, 2018

A Transfer of Custody Receipt indicates CoreCivic officers turned custody of detainee RAMIREZ over to Spectrum Security Services at 2:00 p.m.

²⁶ Pruritis is the medical term for itchiness.

Note: Spectrum Security Services logs were not provided to reviewers. Interview of five Spectrum officers²⁷ confirmed security supervision was maintained without incident. Officer (b)(6); (b)(7)(C) assigned to the 2:00 p.m. to 10:00 p.m. shift this date, stated RAMIREZ was nervous, emotional and crying during the shift.

(b)(6); (b)(7)(C) documented a hospital update at 2:03 p.m. RAMIREZ was being prepared for repair of the aortic stenosis and CABG (coronary artery bypass graft)²⁸ on July 25, 2018. Her current status was stable, and she was scheduled to be NPO (nothing by mouth) status after midnight.

July 25, 2018 – Day of Death

RN (b)(6); (b)(7)(C) documented a hospital update at 6:38 a.m. RAMIREZ was anxious and crying the evening before but was better at the time of the update.

Officers (b)(6); (b)(7)(C) were assigned to the 10:00 p.m. to 6:00 a.m. shift. Both officers documented in incident reports that detainee RAMIREZ was returned to surgery when complications developed after the first. Per their reports, death was pronounced in the operating room at 10:45 p.m.

In a Death Summary signed July 31, 2018, D (b)(6); (b)(7)(C) documented death was declared at 8:45 p.m. He wrote cardiopulmonary bypass surgery was initially completed without trouble, but as small needle holes in the right atrium were being repaired, RAMIREZ's blood pressure began to drop. After several failed interventions, the decision was made to place her on extracorporeal membrane oxygenation (ECMO)²⁹. The chest was left open and she was taken to the intensive care unit (ICU). Significant bleeding continued over the next several hours, and doctors attempted to keep up with the transfusion demand. Despite various interventions which failed to increase her cardiac index³⁰, it was decided to return RAMIREZ to the operating room. (b)(6); (b)(7)(C) wrote that following further interventions, "she initially looked good, but then would quickly fade." Despite all efforts, an adequate cardiac output could not be maintained to sustain life and the decision was made to stop all treatments. She sustained a rhythm³¹ for a while, but her blood pressure could not be sustained. Eventually she declined and expired. The cause of death was

²⁷ Officers (b)(6); (b)(7)(C) were interviewed.

²⁸ CABG is a form of bypass surgery to create new routes round the narrowed and blocked coronary arteries, permitting increased blood flow to deliver oxygen and nutrients to the heart muscle.

²⁹ ECMO is a technique of providing prolonged cardiac and respiratory support, outside the body, to persons whose heart and lungs are inefficient.

³⁰ Cardiac index is a measurement of the amount of blood being pumped out of the heart to the body. .

³¹ A cardiac rhythm refers to the transmission of electrical signals that normally control the heart rate and regularity of beats.

cardiogenic shock³². A possible contributing factor was an allergic reaction to protamine³³ following the first operation; another possible contributing factor was a very hypertrophied³⁴ noncompliant left ventricle³⁵.

Note: The time of death documented by (b)(6); (b)(7)(C) 8:45 p.m., is likely inaccurate. This conclusion is based on the following: the officers present at the time of death were assigned to the 10:00 p.m. to 6:00 a.m. shift; in their incident reports, the officers documented the time of death was 10:45 p.m.; a medical record entry the next day (see below) also documents the time of death was 10:45 p.m.; and AHMC nursing notes documenting that at 10:00 p.m., RAMIREZ remained in the operating room. A death certificate was not available to confirm the time of death.

During interview of Officer (b)(6); (b)(7)(C) she stated she notified her supervisor, Lieutenant (b)(6); (b)(7)(C) of the death. Spectrum Security Services Lieutenant (b)(6); (b)(7)(C) documented in his incident report that he immediately upon notification of the death by Officer (b)(6); (b)(7)(C) he contacted Supervisory Deportation and Detention Officer (b)(6); (b)(7)(C) (last name unknown).

July 26, 2018

Officer (b)(6); (b)(7)(C) wrote in their incident reports that they were relieved of any further duty at 2:50 a.m.

RN (b)(6); (b)(7)(C) entered a hospital update at 6:37 a.m. documenting the aortic replacement procedure the previous day; however, bleeding was noted and she was returned to the operating room. She died during the procedure at 10:45 p.m. ICE was notified.

(b)(6); (b)(7)(C) was notified of RAMIREZ's death by follow up to the telephone encounter initiated on July 19, 2018 by (b)(6); (b)(7)(C)

Post Death Actions

- A Detainee Property Inventory and the Trust Account Closing Receipt dated July 31, 2018 documents detainee RAMIREZ's property and funds were processed by OMDC for release to ICE. The property and US funds totaling \$62.65 was picked up by (b)(6); (b)(7)(C) (unknown) on August 21, 2018.

³² Cardiogenic shock is a fatal condition in which the heart is suddenly unable to pump enough blood to meet the body's needs.

³³ Protomine is a medication used to reverse the effect of heparin (an anticoagulant used to prevent blood clotting) during surgery.

³⁴ Hypertrophied means an abnormal enlargement of an organ or tissue.

³⁵ The left ventricle is one of four chambers in the heart, separated by the aortic valve, which pumps blood from the heart to the rest of the body.

- (b)(6); (b)(7)(C) entered a tuberculosis-case management update on July 31, 2018. Information added since the July 6, 2018 update included identification of an outside clinic and address verification should RAMIREZ be deported. For contact purposes, RAMIREZ's daughter was identified as (b)(6); (b)(7)(C) from Modesto, CA (b)(6); (b)(7)(C) signed her note at 1:21 p.m. Detainee RAMIREZ's death is not mentioned.

CONCLUSIONS

Medical

Detainee RAMIREZ did not report, and intake nurses did not observe, symptoms suggestive of TB. On that basis, she was cleared for general population housing pending chest X-ray. Because RAMIREZ was admitted on a Sunday evening, and as allowed by IHSC guidelines, her screening chest X-ray was not completed for approximately 17 hours following her admission. The X-ray was read promptly and per the radiology report, the detainee was not cleared for general population because active TB could not be ruled out. A second X-ray was conducted 19 minutes after the first to confirm the findings; however, RAMIREZ was sent back to her general population housing unit immediately after the second chest X-ray was taken. She was in the unit for more than two hours before results of the second chest X-ray were available, results which confirmed the initial positive findings. Although RAMIREZ was ultimately determined non-infectious, her return to the housing unit placed other detainees and staff at potential risk for exposure.

Upon notification of chest X-ray results, a provider ordered the detainee's transfer to the hospital to rule out TB. The transport, with respiratory mask, was facilitated quickly. RAMIREZ was hospitalized for 30 days. She was in respiratory isolation until the day before discharge from the hospital when, after testing and treatment for TB and pneumonia, the infectious disease physician documented a diagnosis of latent TB. During RAMIREZ's hospitalization, a heart murmur was incidentally identified and aortic stenosis was diagnosed.

Upon return to OMD, RAMIREZ was assessed by an RN and placed in respiratory isolation pending assessment by (b)(6); (b)(7)(C) the next day. (b)(6); (b)(7)(C) documented a detailed summary of the hospital record and comprehensive physical examination. He cleared the detainee for housing in general population and ordered continuation of recommended TB medications. He also ordered vision testing, laboratory studies, follow up by (b)(6); (b)(7)(C) and urgent referral for cardiac consultation. The consultation was completed five days later; however, (b)(6); (b)(7)(C) orders for vision testing, laboratory studies and provider follow up were not completed prior to the consultation as directed.

Detainee RAMIREZ was assessed by an RN when she returned from the cardiac consultation. The RN notified PA (b)(6); (b)(7)(C) that the cardiologist recommended aortic valve replacement surgery and per authorization of the PA, returned RAMIREZ to the housing unit with direction to notify

staff if she experienced shortness of breath or chest pain. The detainee was scheduled to see PA (b)(6); (b)(7)(C) next day; however, she was not seen by the provider until nine days later.

Pursuant to the cardiologist's recommendation, (b)(6); (b)(7)(C) submitted a referral for aortic valve replacement surgery. The surgery was completed eight days following the documented referral. The surgeon's death summary documents complications developed during surgery, and after multiple unsuccessful interventions over the course of several hours, life-sustaining efforts were discontinued. Official documentation of the time of death is not available.

Compliance Findings

Creative Corrections cites the following deficiency in the ICE PBNDS 2011, Medical Care, revised 2016.

Section (V)(C)(2), which states, "All new arrivals shall receive TB screening within 12 hours of intake and in accordance with [Center for Disease Control] guidelines." Center for Disease Control TB Guidelines, Prevention and Control of Tuberculosis in Correctional and Detention Facilities, state, "Persons who have radiographs suggestive of TB should be isolated immediately and evaluated further."

- Detainee RAMIREZ was allowed to return to her general population housing unit after an initial chest X-ray on June 4, 2018 identified possible TB. She was in the unit for approximately two and a half hours before results of a second chest X-ray were available, resulting in confirmation of results of the first and transfer to the hospital for isolation, testing, and treatment.

Reviewers recognize that the written report for the first chest X-ray, which states, "cannot exclude Active TB; NOT clear for general population", may not have been received when RAMIREZ was allowed to return to the housing unit. However, a second X-ray would not have been performed unless medical personnel were aware that the first was positive. Reviewers recommend review of procedures to ensure detainees are isolated when screening chest X-rays do not exclude active TB.

Areas of Concern

Creative Corrections cites the additional areas of concern for findings not addressed in the ICE detention standards:

- Detainee RAMIREZ's pulse was found elevated when checked twice during intake screening. The RN appropriately scheduled two monitoring checks; however, neither were completed.

- On July 5, 2018, (b)(6); (b)(7)(C) ordered laboratory studies and vision testing for July 6, 2018. Nurses did not draw laboratory samples until July 18, 2018, and there is no documentation vision testing was completed.
- (b)(6); (b)(7)(C) July 5, 2018 orders included direction for follow up assessment by PA (b)(6); (b)(7)(C) on July 9, 2018. She did not see RAMIREZ that date, nor did she see her on July 11, 2018 pursuant to referral by an RN following RAMIREZ's return from the cardiology consultation. Although the RN's note documents she informed PA (b)(6); (b)(7)(C) the cardiologist recommended surgery to correct aortic stenosis, PA (b)(6); (b)(7)(C) did not assess the detainee until July 19, 2018. Reviewers acknowledge the medical record documents RAMIREZ was stable when she returned from the cardiac consultation and continued to be stable when seen for sick call for complaint of itchy skin on July 18 and by (b)(6); (b)(7)(C) on July 19, 2018. However, given the consulting cardiologist's findings, completion of the scheduled July 11, 2018 provider follow up would have been prudent.
- Nurses did not enter daily updates during the detainee's hospitalization. RAMIREZ was transferred to the hospital during the early morning hours of June 5, 2018 and returned to OMDC at approximately 9:30 p.m. on July 4, 2018.

Safety and Security

Compliance Findings

The reviewer identified no deficiencies in the ICE 2011 PBNDS, revised 2016, governing safety and security.



U.S. Immigration
and Customs
Enforcement

JUL 24 2019

MEMORANDUM FOR: Nathalie Asher
Executive Associate Director
Office of Enforcement and Removal Operations

THROUGH: (b)(6); (b)(7)(C)
Associate Director
Office of Professional Responsibility

FROM: (b)(6); (b)(7)(C)
Acting Assistant Director

SUBJECT: Findings – Death of ICE Detainee
Efrain DE LA ROSA (b)(7)(E)

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility, External Reviews and Analysis Unit (ERAU) has completed its review of the facts and circumstances regarding the death of ICE detainee Efrain DE LA ROSA, who died on July 10, 2018, at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA), while in the custody of ICE. The Georgia Bureau of Investigations, Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging.

On February 9, 2018, a designated immigration officer from the Wake County 287(g) program encountered DE LA ROSA at the Wake County Detention Center (WCDC) in Raleigh, North Carolina, and lodged an Immigration Detainer – Notice of Action with the WCDC. On March 12, 2018, WCDC released DE LA ROSA into ICE's custody, and the following day, ICE transported DE LA ROSA to the Stewart Detention Center (SDC) in Lumpkin, GA.

On March 13, 2018, at 1:07 p.m., SDC admitted DE LA ROSA. At 10:55 p.m., a registered nurse (RN) completed DE LA ROSA's pre-screening and documented that DE LA ROSA denied having any current health problems or taking any medications.

On March 14, 2018, at 2:45 a.m., an RN completed DE LA ROSA's medical and mental health screening and documented that his vital signs were within normal limits except for an elevated blood pressure of 119/80.¹ DE LA ROSA reported that while previously

¹ According to the American Heart Association, this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic

incarcerated by the Virginia Department of Corrections, Marion Correctional Treatment Center (MCTC), MCTC treated him for schizophrenia. DE LA ROSA also reported taking eight different medications but ceased use approximately three months prior to his arrival at SDC because he could not sleep. The RN documented an abnormal intake screening and referred DE LA ROSA to a medical provider.

On March 15, 2018, a nurse practitioner (NP) conducted DE LA ROSA's initial physical assessment and documented DE LA ROSA's vital signs were within normal limits except for an elevated blood pressure of 113/80. DE LA ROSA reported a history of schizophrenia and hospitalization for the disease in 2004 and 2010 but could not recall the names of his past medications. DE LA ROSA also denied any current homicidal or suicidal ideations. The NP further documented DE LA ROSA was not currently exhibiting symptoms of a serious mental disorder or cognitive impairment but referred him to a mental health provider.

On March 16, 2018, a psychologist conducted a mental health assessment and determined there were no active symptoms of serious mental disorder or condition but listed treatment planning and supportive psychotherapy intervention within the note. Medical staff scheduled DE LA ROSA for a psychiatry evaluation and mental health follow-up and DE LA ROSA consented to receiving tele-psychiatry services.

On April 3, 2018, security staff placed DE LA ROSA into the restricted housing unit (RHU) for a disciplinary infraction. Three days later, the Institution Disciplinary Panel (IDP) sentenced him to 30 days segregation. While in segregation, medical staff was responsible for conducting daily segregation rounds and weekly mental health segregation rounds. Security staff was simultaneously responsible for documenting daily activities and security rounds. DE LA ROSA remained in disciplinary segregation until April 18, 2018. Security staff placed DE LA ROSA in general population post release from disciplinary segregation.

On April 21, 2018, DE LA ROSA submitted an incident statement requesting transfer to another cell as he alleged his cellmate told him he was going to kill him. On April 24, 2018, SDC re-assigned DE LA ROSA to the RHU pending investigation for protective custody. On this same date, a Psychiatric Mental Health Nurse Practitioner (PMHNP) conducted a mental health assessment and documented DE LA ROSA's vital signs were within normal limits except for an elevated blood pressure of 135/88. During the assessment, DE LA ROSA declined medication treatment. The PMHNP completed an initial suicide risk assessment² and determined DE LA ROSA was at "Moderate Acute Risk"³ for suicide; the PMHNP ordered one-on-one suicide watch and scheduled a mental health follow-up for the next day. Prior to placement in the RHU for suicide watch, two security officers conducted a strip search of DE LA ROSA.

reading of 80 to 89.

² The suicide risk assessment includes risk and protective factors and mental status examination elements.

³ Consideration for moderate acute risk includes, but is not limited to, the presence of suicidal ideation with vague plan and/or intent in the presence of multiple risk factors and high acute distress.

On April 27, 2018, during a follow-up suicide risk assessment, mental health providers determined DE LA ROSA required a higher level of care and therefore referred him to Columbia Regional Care Center (CRCC) for in-patient hospitalization.

On May 4, 2018, SDC transported DE LA ROSA to CRCC for mental health treatment, where he remained until June 12, 2018. While receiving treatment at CRCC, medical staff prescribed DE LA ROSA with Norsavc⁴ for hypertension and psychotropic medications Haldol⁵ and Zyprexa⁶ for schizophrenia. The CRCC medical record indicated he was generally compliant with treatment.

On June 12, 2018, upon DE LA ROSA's return to SDC, a prescribing provider ordered amlodipine, haloperidol, and olanzapine. DE LA ROSA did not sign a consent form for the two psychotropic medications, haloperidol and olanzapine

On June 14, 2018, medical staff began attempts to administer the medication ordered on June 12, 2018, to DE LA ROSA. Although the Medication Administration Record (MAR) documents DE LA ROSA only took his psychiatric medications on three occasions, surveillance footage proved one entry false and the Health Services Administrator (HSA) believed the other two were highly unlikely considering DE LA ROSA refused all other medication administrations up to and including the day of his suicide. While nurses notified an NP on 17 occasions that DE LA ROSA refused his medications, the NP never saw him, and medical staff never informed the Clinical Director. Furthermore, medical staff did not check DE LA ROSA's blood pressure from June 20, 2018, through July 10, 2018, despite that DE LA ROSA refused to take his hypertension medication, as well. Overall, documentation of DE LA ROSA's medication refusals were limited and notifications to a provider concerning DE LA ROSA's refusals were inconsistent.

On June 19, 2018, security staff placed DE LA ROSA into the RHU for another disciplinary infraction, for which the IDP later sentenced him to 30 days segregation, where he remained until his death on July 10, 2018. Behavioral health providers (BHPs) assessed DE LA ROSA on four occasions during this period of segregation. In two of those instances, on June 20 and July 10, 2018, the BHP documented that he met the criteria for having a serious mental illness (SMI). However, there was no documentation to support that the BHP completed the required SMI criteria follow-up actions.

On July 10, 2018, at 10:33 p.m., one hour and 53 minutes after security staff last conducted a security round, an officer discovered DE LA ROSA standing by the bunk in his cell with socks wrapped around his neck and tied to the top bunk rail. The officer immediately called a medical emergency via radio. At 10:35 p.m., officers entered DE LA ROSA's cell, utilized a cut-down tool to remove the socks from DE LA ROSA's neck, and within a minute, initiated cardio pulmonary resuscitation (CPR). Other security and medical staff responded without delay; however, a review of the video

⁴ Norvasc is a brand name for amlodipine.

⁵ Haldol is a brand name for haloperidol.

⁶ Zyprexa is a brand name for olanzapine.

footage and documentation identified multiple issues, including the absence of devices needed for the emergency response and improper administration of CPR by multiple staff members. Six minutes after the officer initiated the medical emergency, a nurse requested Emergency Medical Services (EMS). SDC security immediately called EMS, who arrived on scene within nine minutes of being called. At 11:06 p.m., EMS departed SDC and arrived to SGRMC at 11:25 p.m. SGRMC hospital staff immediately performed CPR on DE LA ROSA but were unable to revive him. At 11:29 p.m., a SGRMC physician pronounced DE LA ROSA dead.

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care SDC provided DE LA ROSA, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found deficiencies in SDC's compliance with certain requirements of the ICE Performance-Based National Detention Standards (PBNDS) 2011.

1. ICE PBNDS 2011, *Medical Care*, Section (V)(U)(4), requires the distribution of medication be performed in accordance with specific instructions and procedures established by the HSA in consultation with the Clinical Medical Authority (CMA). Medical staff should maintain all written records of prescribed medication given to or refused by detainees and provide these medications on schedule and without interruption, absent exigent circumstances. Video evidence showed an RN falsely recorded the refusal of psychiatric medications on the night of DE LA ROSA's suicide, July 10, 2018. Furthermore, ERAU was unable to confirm if the June 14 and June 17, 2018 amlodipine administrations were given or refused due to illegible entries on the MAR.
2. DE LA ROSA did not sign a general consent for treatment form when first admitted to SDC, in contravention of the ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(1), which requires that documented informed consent be obtained for health care services upon admission to the facility.
3. There is no documentation medical staff requested DE LA ROSA sign a separate consent form for the psychotropic medications, haloperidol and olanzapine, when ordered on June 12, 2018, in contravention of the ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4), which requires a separate documented informed consent for psychotropic medications, to include a description of the medication's side effects, prior to administration.
4. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(9), requires that 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 treatments. Medical staff documented DE LA ROSA refused his medications on the MAR 29 times between June 15 - July 10, 2018 but completed refusal forms for only 21 of the 29 refusals. Furthermore, medical staff documented "No-Show" on the MAR 20 times between June 14 - 26, 2018. Fifteen of the 20 "No-Shows" occurred

after security placed DE LA ROSA in segregation; therefore, DE LA ROSA could not voluntarily report to receive medications. There is no documentation medical staff confirmed the detainee was refusing medications on these 15 occasions, that they explained the risks associated with these refusals, or that they completed refusal forms.

5. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(10), requires the CMA and facility administrator to look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding. Medical staff did not notify the Clinical Director that DE LA ROSA was refusing medications; therefore, the Clinical Director was unaware of this issue. However, nurses sent 17 telephone encounters to an NP, the mid-level provider responsible for following up on medication refusals or “No-Shows.” The NP indicated that she did not see DE LA ROSA because medical postponed scheduled appointments, but medical staff were unable to produce documentation supporting scheduling occurred at all.
6. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(F), requires all suicidal detainees placed in an isolated confinement setting to receive welfare checks at least every eight hours conducted by clinical staff. However, medical staff did not meet the eight-hour timeframe on at least three occasions. On April 25, 2018, there was an 8 hour and 45-minute gap between welfare checks; on April 27, 2018, there was a 10 hour and 10-minute gap between welfare checks; and on April 29, 2018, there was a 10 hour and 1-minute gap between welfare checks.
7. Per Office (b)(6); (b)(7)(C) who rode in the ambulance with DE LA ROSA, SDC did not offer him a critical incident debriefing or supportive counseling services, in contravention of ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(K), which requires that a critical incident debriefing following a suicide be offered to all affected staff and detainees within 24 to 72 hours after the critical incident.
8. Security staff did not complete a reclassification review within the 24 hours preceding DE LA ROSA’s release from disciplinary segregation on April 18, 2018, in contravention of ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3), which requires staff to complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU).
9. ICE PBNDS 2011, *Disciplinary System*, Section (V)(A)(6) and (8), requires that when a detainee has a diagnosed mental illness, the facility shall consult a mental health professional to provide input as to the detainee’s competence to participate in the disciplinary hearing, if the mental illness had any impact on his or her behavior, and if certain types of sanctions may hinder the detainee’s treatment or recovery plan. There is no documentation that security staff consulted a mental health professional prior to disciplinary hearings on April 6 and June 21, 2018, or that the hearing officer

considered the degree to which DE LA ROSA's mental illness may have contributed to his behavior.

10. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H), requires that a detainee in IDP proceedings shall have the right to due process, which includes the right to have an IDP hearing within 48 hours after the conclusion of the investigation. In cases where a hearing is delayed, the IDP must document the reason and obtain approval from the facility administrator. On April 4, 2018, at 10:52 a.m., Sergeant (b)(6); completed the investigation for the April 3, 2018, disciplinary incident. The IDP hearing commenced at 12:42 p.m. on April 6, 2018, more than 48 hours after the conclusion of the investigation. The hearing officer did not document the reason for the delay.
11. On April 24, 2018, officers conducted a strip search of DE LA ROSA prior to his placement on suicide watch but did not document the specific facts that led the officers to believe DE LA ROSA was in possession of contraband, in contravention of ICE PBNDS 2011, *Searches of Detainees*, Section (V)(D)(2)(b), which requires staff to have a reasonable suspicion that contraband may be concealed on the person prior to conducting a strip search and document the facts associated to the suspicion.
12. ICE PBNDS 2011, *Special Management Units*, Section (V)(A)(3)(a-b), requires that a supervisor conduct a review, to include an interview with the detainee, within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. A supervisor is also required to conduct an identical review after the detainee has spent seven days in administrative segregation. There is no documentation security staff interviewed DE LA ROSA during administrative segregation status reviews on April 26, 2018, and May 3, 2018. Furthermore, the May 3, 2018, status review was delinquent, as it was due on May 1, 2018, seven days after DE LA ROSA's initial placement in segregation.
13. ICE PBNDS 2011, *Special Management Units*, Section (V)(B), requires a detainee be placed in disciplinary segregation only by order of the IDP and after a hearing in which the detainee has been found to have committed a prohibited act. Security staff ordered DE LA ROSA's placement in disciplinary segregation on April 3, 2018, and June 19, 2018, although the charges were not adjudicated until April 6, 2018, and June 21, 2018, respectively.
14. ICE PBNDS 2011, *Special Management Units*, Section (V)(B)(3), requires that a supervisor conduct a review, to include an interview with the detainee, of their status in disciplinary segregation every seven days and document those findings after every review. The supervisor may recommend the detainee's early release from the SMU but must have the facility administrator's approval before the detainee may be returned to the general population. First, there is no documentation security staff reviewed DE LA ROSA's placement status in disciplinary segregation from April 6 to April 18, 2018. Second, on April 18, 2018, Security (b)(6); (b)(7)(C) directed DE LA ROSA's release to the general population after serving only 15 days of the 30-day

sanction. Security Chief (b)(6); (b)(7)(C) did not document an interview of DE LA ROSA, a recommendation reason for early release, or obtain approval from the facility administrator before the release.⁷ Last, the July 3, 2018, disciplinary segregation status review was delinquent, as it was due on June 29, 2018, seven days after the June 22, 2018, status review; the reviews conducted were also devoid of documentation to support security staff interviewed DE LA ROSA.

15. There was no record of whether the lunch meal was served or refused on April 5, April 6, April 29, and June 22, 2018, in contravention of ICE PBNDS 2011, *Special Management Units*, Section (V)(D)(1), which requires a permanent log be maintained in the SMU to record all activities concerning SMU detainees.
16. ICE PBNDS 2011, *Special Management Units*, Section (V)(M), requires that detainees in SMU be personally observed and logged at least every 30 minutes on an irregular schedule. SDC was unable to produce Confinement Watch Logs for April 4, April 17, and July 3, 2018; therefore, ERAU could not verify completion of 30-minute rounds for those dates. Furthermore, on July 10, 2018, Officer (b)(6); (b)(7)(C) logged security rounds at 9:13 p.m., 9:39 p.m., and 10:04 p.m. Video surveillance footage showed Officer (b)(6); (b)(7)(C) signed documents on the clipboard next to the detainee's cell but did not look in the cell to personally observe DE LA ROSA.

ERAU noted three additional violations of facility-specific policy and seven areas of concern, which are further discussed in the attached report. If you have any questions, please contact me or have a member of your staff contact Acting Unit Chief (b)(6); (b)(7)(C) at (202) 732-0531.

Attachment

cc: Matthew Albence
Tae Johnson

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

⁷ The ICE detention standards do not address suspension of the balance of a disciplinary segregation sanction outside the status review process.

Official Report



Division of Forensic Sciences
Georgia Bureau of Investigation
State of Georgia

Headquarters

DOFS Case #: 2018-1017193

Report Date: 10/02/2018

Kathryn P. Lee
Deputy Director

* NAME Accredited *



Requested Service: Autopsy

Agency: Stewart Co. Coroner

Agency Ref#: (b)(6); (b)(7)(C)

Requested by: (b)(6); (b)(7)(C)

Case Individuals:

Victim: Efran Romero De La Rosa

Evidence:

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

DECEDENT

Results and Conclusions:

Evidence Submission: 001

A complete examination was performed on the body of Efran Rosa at the Georgia Bureau of Investigation, Division of Forensic Sciences, in Decatur, Georgia on the 12th day of July 2018 commencing at 0800 hours, pursuant to the Georgia Death Investigation Act. The autopsy was performed by (b)(6); (b)(7)(C) M.D.

EXTERNAL EXAMINATION:

The body was received in the supine position in a black plastic disaster bag. An identification tag bearing the decedent identifier "Dela-Rosa-Efrain Romero" was attached to the zipper. A white identification band was around the left wrist. A yellow identification tag was attached to the right first toe.

The body was that of an unembalmed, well-developed, well-nourished White Hispanic male who weighed 144 pounds, was 5'6" in height, and appeared compatible with the reported age of 40 years. The body had been refrigerated and was cool to touch. Rigor mortis was present, equal, and broken with difficulty within the extremities. Lividity was present and fixed on the posterior aspects of the body, except in areas exposed to pressure. Injuries to the body will be described below, see "Evidence of Injury."

The body was received clad in:

1. A red short-sleeved shirt
2. White underwear
3. Red pants

Personal effects received with the body included: two white towels and a peach sheet. The clothing was incinerated and personal effects were appropriately disposed.

Evidence of medical therapy:

1. An endotracheal tube was emanating from the oral cavity and was secured by a strap device. Copious amounts of gastric contents were present within the tube.
2. A defibrillator pad was on the upper right side of the chest.
3. An intravascular line was in the radial aspect of the right wrist and was secured with blue adhesive gauze.
4. A needle puncture site was in the left antecubital fossa and was covered with blue adhesive gauze.
5. An intraosseous line was in the left anterior proximal leg.

The head was normocephalic and the face was morphologically unremarkable. The facial bones and mandible were free of palpable fracture. The scalp hair was black, curly, and worn

at a short length (< 2"). The facial hair consisted of a medium length beard and moustache (~1-1/2"). The corneae were clear. The irides were brown. The conjunctivae were tan with no petechial hemorrhages. The sclerae were white. The nasal skeleton was palpably intact. The nose was normally formed and without injury. The earlobes were normally formed and unremarkable. The external auditory canals, external nares, and oral cavity were free of foreign material and abnormal secretions. The lips, teeth, tongue, gums, and buccal mucosa showed no evidence of injury. The teeth were natural and in a good to fair state of repair with the two maxillary central incisors having previously placed yellow metal dental restorations. The external meati, pinnae and mastoid regions were unremarkable. The trachea was within the midline of the atraumatic neck. The neck was neither crepitant nor excessively mobile.

The chest was normally formed, symmetrical and palpably unremarkable. A 1-1/8 x 1" hypopigmented patch was on the anterior aspect of the right shoulder. There was no increase in the anterior-posterior diameter of the chest. The abdomen was flat and soft to palpation. The external genitalia were those of a normal adult uncircumcised male; the testes were bilaterally descended within the scrotal sac. The anus was unremarkable. The posterior torso was normally formed and palpably unremarkable.

The extremities were symmetrical, well-developed, and appropriately hair bearing. The appendicular skeleton was stable to palpation and manipulation. All digits were present. The fingernails were long, soiled, and intact. There was no peripheral edema. Tattoos were not noted. Needle tracks were not observed.

EVIDENCE OF INJURY:

I. Hanging

An 11-3/4" near-circumferential, brown, continuous, ligature furrow was on the skin of the neck. The ligature furrow crossed the superior third of the thyroid cartilage, 11" below the top of the head and then extended superiorly on both sides of the neck, passing 2" below the right ear external auditory meatus, and 3-1/2" below the left ear external auditory meatus. The highest point of the furrow, where the knot was located, was on the upper right side of the back of the neck, located 6-1/2" below the top of the head, and 5-1/2" to the right of the posterior midline. The width of the furrow ranged from 3/16" on the left side to 1/4" on the remaining aspects. The depth of the furrow was up to 1/16". There was a 1-1/2 x 3/4" abraded, dried area on the anterior aspect of the neck, just left of the anterior midline of the neck. The anterior neck dissection showed a 2" area of hemorrhage at the medial aspect of the left mid-sternocleidomastoid muscle and a 1-1/2" area of hemorrhage the lateral aspect of the left mid-sternocleidomastoid muscle.

II. Additional Injuries

A 3/4" x 1/2" crusted wound with erythematous borders was on the anterior aspect of the left proximal arm. A 3/4 x 1/2" red contusion was adjacent to the right elbow. On internal examination, there was a fracture of the sternum at the costochondral junction of the left fourth rib with mild associated soft tissue hemorrhage.

INTERNAL EXAMINATION:

The injuries, having been described above, will not be described below.

BODY CAVITIES:

The body was opened by the usual thoraco-abdominal incision and the chest plate was removed. The subcutaneous fat and musculature were free of injury. No adhesions or abnormal collections of fluid were present in any of the body cavities. In-situ examination of the organs shows normal organ morphology and normal anatomical position. The lungs were expanded bilaterally. The diaphragms were intact. The organs were removed using the Virchow technique. There was no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

HEAD AND CENTRAL NERVOUS SYSTEM:

The scalp was reflected and was free of hemorrhage. The calvarium of the skull was removed. The dura mater and falx cerebri were intact and free of discoloration and thickening. There was no epidural, subdural, or subarachnoid hemorrhage present. The leptomeninges were thin and delicate. The cerebral hemispheres were symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels were intact. There was no significant atherosclerosis of the Circle of Willis. Coronal sections through the cerebral hemispheres revealed a normal distribution and development of gyri and sulci. The cortices were tan, uniform, and free of contusion or discoloration. The white matter was homogeneous and symmetric. The deep nuclei were tan, uniform, and symmetric. Transverse sections through the brain stem and sagittal sections through the cerebellum demonstrated the appropriate distribution of gray and white matter. The substantia nigra was normally pigmented. The ventricular system was normally formed and the cerebrospinal fluid was clear. The brain weighed 1340 grams.

NECK:

See "Evidence of Injury."

Examination of the soft tissues of the neck, including strap muscles, thyroid gland and large vessels, revealed no atraumatic abnormalities. The hyoid bone and larynx were intact. The epiglottis was unremarkable. No foreign objects were in the airway.

CARDIOVASCULAR SYSTEM:

The pericardial surfaces were smooth, glistening and unremarkable; the pericardial sac was free of significant fluid or adhesions. The coronary arteries arose normally, followed the usual right dominant distribution and were widely patent, without evidence of significant atherosclerosis or thrombosis. The chambers and valves exhibited the usual size-position relationship and were unremarkable. The epicardium, valve leaflets, chordae tendinae, and endocardium were normally formed. The myocardium was red-brown, firm and unremarkable; the atrial and ventricular septa were intact. The left ventricular free wall thickness was 1.5 cm; the ventricular septum thickness was 1.6 cm; the right ventricular free wall thickness was 0.6 cm. The aorta and its major branches arose normally, followed the usual course and were palpably unremarkable. There was no lipid streaking, tortuosity, widening, or aneurysm of the aorta. The vena cava and its major tributaries returned to the heart in the usual distribution and were palpably unremarkable. The heart weighed 300 grams.

RESPIRATORY SYSTEM:

The upper airway was clear of debris and foreign material; the mucosal surfaces were smooth, yellow-tan and unremarkable. The pleural surfaces were smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma was pink, exuding minimal amounts of bloody fluid; no focal lesions were noted. The pulmonary arteries were normally developed, patent and without thrombus or embolus. The right lung weighed 520 grams; the left 480 grams.

LIVER & BILIARY SYSTEM:

The liver had a smooth, glistening and intact capsule, covering dark red-brown, moderately congested parenchyma with no focal lesions noted. The gallbladder contained < 10 mL of green-brown, mucoid bile; the mucosa was velvety and unremarkable. The extrahepatic biliary tree was patent, without evidence of calculi. The liver weighed 1280 grams.

ALIMENTARY TRACT:

The tongue exhibited no evidence of recent injury. The esophagus was lined by gray-white, smooth mucosa. The gastric mucosa was arranged in the usual rugal folds and the lumen contained 400 mL of thick tan digestate; no tablets, capsules or pill fragments were identified. The small and large bowel serosae were unremarkable. The pancreas had a normal yellow-tan lobulated appearance without calcification and the ducts were clear. The appendix was in the right lower abdominal quadrant.

GENITOURINARY SYSTEM:

The renal capsules were smooth and thin, semi-transparent and stripped with ease from the underlying smooth, red-brown cortical surfaces. The cortices were slightly congested and sharply delineated from the red-purple unremarkable medullary pyramids. The calyces, pelves

and ureters were unremarkable. The urinary bladder contained < 20 mL of cloudy yellow urine; the mucosa was gray-tan and unremarkable. The testes and seminal vesicles were without note. The prostate gland was unremarkable. The right kidney weighed 120 grams; the left 140 grams.

RETICULOENDOTHELIAL SYSTEM:

The spleen had a smooth, intact capsule covering red-purple, moderately firm parenchyma; the lymphoid follicles were unremarkable. The regional lymph nodes appeared normal. The spleen weighed 100 grams.

ENDOCRINE SYSTEM:

The thyroid gland was unremarkable. The adrenal glands were unremarkable.

MUSCULOSKELETAL SYSTEM:

Muscle development was normal. No palpable bone or joint abnormalities were noted.

OTHER PROCEDURES:

1. Documentary photographs were obtained.
2. The organs were returned to the body.
3. Specimens for toxicological analysis: femoral blood and vitreous fluid
4. Serology: one blood-stain card
5. Small portions of the major organs were retained.
6. Evidence: postmortem fingerprints
7. Materials reviewed: investigative report, incident report (b)(6); (b)(7)(C)

PATHOLOGIC DIAGNOSES

- I. Hanging
 - A. Suspended from top bunk
 - B. Independent cell
 - C. Near-circumferential ligature
- II. Postmortem Toxicology
 - A. Haloperidol: lower than the lowest calibrator of 50 mcg/L
 - B. Ethyl alcohol: negative

OPINION:

This 40 year old, White male, Efran Rosa, died of Hanging. As per investigation, he was seen hanging in his solitary cell from the top bunk bed by two socks during rounds. No note was present. Based on information available at this time the manner of death is certified as suicide.

CAUSE OF DEATH:

Hanging

MANNER OF DEATH:

Suicide

Only those items discussed in the results above were analyzed for this report. The above represents the interpretations/opinions of the undersigned analyst. Evidence analyzed in this report will be returned to the submitting agency. Biological evidence (body fluids and tissues) will be destroyed after one year. This report may not be reproduced except in full without written permission of the laboratory.

Technical notes and data supporting the conclusions and findings in this report are maintained within the laboratory case records.

This case may contain evidence that must be preserved in accordance with O.C.G.A. § 17-5-56.

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

Associate Medical Examiner

404-270-8 (b)(6);

(b)(6); (b)(7)(C) gbi.ga.gov

Related Agencies:

DOC-Criminal Investigations Division
Southwestern Judicial Circuit
GBI-Medical Examiner-HQ DOFS
Stewart Co. District Attorney
GBI-Reg. 03-Americus

ACN: (b)(6);

ACN: 0300080119

End of Official Report

DETAINEE DEATH REVIEW: Efrain DE LA ROSA, A209910301
Healthcare and Security Compliance Analysis
Stewart Detention Center
Lumpkin, Georgia

As requested by the ICE Office of Professional Responsibility, External Review and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Efrain DE LA ROSA while detained at the Stewart Detention Center (SDC). A site visit was conducted August 14 through 16, 2018 by ERAU personnel (b)(6); (b)(7)(C), Section Chief, and R (b)(6); (b)(7)(C) ERAU Management and Program Analyst and team leader; and Creative Corrections contract personnel (b)(6); (b)(7)(C) Security Subject Matter Expert, and (b)(6); (b)(7)(C) Registered Nurse, Healthcare Subject Matter Expert. Creative Corrections' participation was requested to determine compliance with the 2011 Performance Based National Detention Standards, 2016 revisions, governing healthcare and security operations.

This report was prepared collaboratively by (b)(6); (b)(7)(C) Creative Corrections contract manager. Included is a case synopsis, description of the facility and its medical services, detention summary, a narrative review of events, and conclusions. DE LA ROSA's vital signs documented by healthcare personnel are appended. The information and findings herein are based on analysis of detainee DE LA ROSA's medical record and detention file, tour of the medical area and restricted housing unit, interviews of staff and detainees, analysis of video footage, and review of policies and incident related documentation.

SYNOPSIS

Detainee DE LA ROSA was 40 years old when admitted to SDC on March 13, 2018. He died by suicide on July 10, 2018. He had no known medical conditions but reported a diagnosis of schizophrenia for which he was treated at a mental health facility while serving a Federal Bureau of Prisons sentence. He was received without medications but reported he was previously on several. He was promptly evaluated and determined asymptomatic for active serious mental illness.

Three weeks following his arrival, DE LA ROSA was charged and based on evidence and his admission, found guilty of making inappropriate remarks of a sexual nature to an officer. He spent 15 days in segregation, during which nurses and mental health providers made required rounds. Two days before the detainee was returned to general population, he was offered and refused evaluation for psychiatric medications following statements he hears voice from God. No suicidal ideation was identified during this or earlier segregation rounds.

DE LA ROSA was in general population only six days when returned to segregation for protective custody and parallel assignment to suicide watch ordered by a mental health provider. The detainee said he is the anti-Christ and speaks with God; also, that he would be dead in three days. Medications were offered and refused. Over the course of the next three days, the detainee continued to voice similar delusions and decline medications. He was referred to Columbia Regional Care Center for advanced care and when a bed became available a week later, was transferred.

DE LA ROSA remained at Columbia Regional Care Center for approximately six weeks, during which psychiatric medications were prescribed for treatment of schizophrenia. An antihypertensive medication was ordered as well. Documentation from the hospital indicates he was usually compliant with treatment. The medications were ordered by the SDC Clinical Director upon DE LA ROSA's return to detention, but the evidence indicates he accepted no prescribed doses prior to his suicide approximately a month later.

Asymptomatic of signs of serious mental illness, the detainee was placed in general population upon return to SDC, but one week later was assigned to segregation for again making inappropriate remarks to an officer. Over the course of the next three weeks, nurses made daily rounds and DE LA ROSA was seen by a mental health provider in required weekly intervals. Active symptoms of mental illness were not identified, up to and including on the morning of his suicide.

Shortly after 10:30 p.m. on July 10, 2018, DE LA ROSA was found hanging from socks tied from the top bunk bed in his cell. A medical emergency was called and staff performed cardiopulmonary resuscitation until Emergency Medical Services arrived and transported him to the hospital. He was never resuscitated. Death was pronounced shortly after arrival.

An autopsy report is not available as of the date of this report.

FACILITY DESCRIPTION

The SDC is privately owned and has been operated by CoreCivic, formerly the Corrections Corporation of America (CCA), since 2006. SDC houses only male detainees. On July 10, 2018, the day of DE LA ROSA's death, the detainee population was 1835.

The facility is double fenced with razor wire along the top and in between the fences. Visitors must place personal items on a belt for screening through an X-ray machine, pass through a metal detector and show identification before being admitted to the facility through a secure door. Video surveillance cameras are used throughout the facility to monitor and record events.

HEALTH CARE SERVICES

Healthcare is provided 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor InGenesis Medical Staffing. InGenesis subcontracts with STG International, Maxim Healthcare Services, Prestige Healthcare, and Akahi Associates.

The staffing plan authorizes 84 positions, eight of which are designated for commissioned officers of the U.S. Public Health Service serving IHSC. They include the Health Services Administrator (HSA) who is a non-practicing midlevel provider; two assistant HSAs, one of whom is a registered nurse (RN) and the other an information technology specialist; one licensed clinical social worker (LCSW), a nurse manager, RN program manager, dentist, and pharmacist. An IHSC General Schedule (GS) for Federal Pay physician serves as Clinical Director, and the IHSC telepsychiatry program is available as needed. Full time contract positions include two staff physicians, eight advanced practice providers¹, 25 RNs, 11 licensed vocational nurses (LVN), one psychiatrist, one psychiatric nurse practitioner, four behavioral health professionals (BHP), a dentist, two dental assistants, contract coordinator, six medical record technicians, two pharmacy technicians, a radiation technician, and two administrative assistants. As-needed positions include one advanced practice provider, two LVNs, and four RNs.

Captain (b)(6); (b)(7)(C) HSA, informed the review team that CoreCivic will be taking over all healthcare services by end of calendar year 2018. IHSC personnel will be reassigned and employment offers may be offered to current contract staff at the discretion of CoreCivic. HSA Blankenship stated that the current nursing vacancy rate is 60 percent because many nurses have opted to seek other positions offering job security with comparable pay and benefits. He also stated that only two of the total complement of five behavioral health professional positions were filled during DE LA ROSA's detention and both the providers are soon departing. Pending transition to CoreCivic healthcare services, US Public Health Service temporary duty mental health providers provide coverage and IHSC telepsychiatry services remain available.

Credentials of all providers, nurses, and mental health professionals involved in the care of detainee DE LA ROSA were reviewed and confirmed current and primary-source verified. CoreCivic and IHSC training records document all staff involved in the emergency response are currently certified in CPR and AED.

The National Commission on Correctional Healthcare conducted a reaccreditation survey on January 29 and 30, 2018 and set an August 22, 2018 deadline for submitting evidence of corrective action for deficiencies in five essential standards. None of the cited deficiencies were pertinent to DE LA ROSA's care and death.

¹ Advanced practice providers include nurse practitioners and physician assistants.

SDC's clinic was undergoing expansion and renovation at the time of the site visit. Upon completion, there will be four general use examination rooms, a large physician examination room with laboratory, a two-chair dental clinic, an urgent care room, nurses' station, two mental health offices, and a large medication room with an outside window for medication pass. The number of isolation cells will be doubled from two to four, each with anterooms and negative pressure capability. One of two cells designated for suicide watch is padded, and both are equipped with anti-ligature hardware. The clinic has two holding cells which serve as waiting areas. Offices for administrative personnel, a conference room, and the medical records area are located outside the main clinic. IHSC's electronic medical record system, e-Clinical Works (eCW), is currently used at SDC.

DETENTION SUMMARY

Detainee DE LA ROSA was classified high custody due to a lengthy criminal history that included multiple misdemeanor and felony convictions, including escape. His housing history included approximately three weeks in general population, 15 days in segregation for a disciplinary violation, six days in general population following release from segregation, and placement on protective custody and simultaneous suicide watch for ten days pending transfer to an inpatient mental health facility. Upon his return to SDC approximately six weeks later, DE LA ROSA was in general population for five days, then was moved to segregation following another disciplinary incident. Both disciplinary incidents involved inappropriate comments of a sexual nature to female officers. On the day of his suicide, he was serving a disciplinary segregation sanction for the second incident.

DE LA ROSA had no visitors. Phone logs document he made four phone calls during his stay. The first call was placed on March 18, 2018; the last call was placed on June 24, 2018. It is unknown if any of the calls were completed as the longest duration was three minutes.

Detainee DE LA ROSA had limited funds upon his admission to SDC and spent all but 31 cents a week after his arrival. He submitted no grievances and one incident report alleging he was threatened by his cellmate. The report appears to have resulted in his assignment to protective custody simultaneous with placement on suicide watch.

SUMMARY OF EVENTS

Tuesday, March 13, 2018

The Inmate Housing History Report documents DE LA ROSA's date of admission was March 13, 2018, as does the Inmate Information Sheet which specifies the time of admission was 1:07 p.m.

RN (b)(6); (b)(7)(C) re-screened DE LA ROSA at 10:55 p.m., documenting he arrived at 10:30 p.m. She entered that she is fluent in the detainee's native language in response to the eCW prompt asking whether interpretation was provided. The language used is not documented. DE LA ROSA denied having any current health problems and taking medication. He was described as alert and normal in appearance and behavior. There were no noticeable restrictions or difficulties in movement or breathing, and there were no skin abnormalities.

Note: The discrepancy in the time of admission documented by RN (b)(6); (b)(7)(C) and on the Inmate Information Sheet cannot be explained by reviewers.

ICE Form 203, Order to Detain, documents that ERO rated DE LA ROSA high custody based on a criminal history that included Carjacking while Armed. An ICE Custody Classification Worksheet² completed by SDC Officer (b)(6); (b)(7)(C) (first name unknown) reflects DE LA ROSA was appropriately rated high custody based on the severity of the charge/conviction associated with the ERO encounter, his single most serious conviction, and multiple prior misdemeanor and felony convictions that included the offense of escape.

Note: The classification rating was not approved by a supervisor until March 29, 2018.

DE LA ROSA signed a form acknowledging he was given facility orientation and that an orientation video would be shown in housing units daily between 8:00 a.m. and noon. He also signed forms acknowledging that he was issued a radio with batteries and a lock.

Wednesday, March 14, 2018

The Detainee Commitment Summary documents DE LA ROSA was booked into SDC at 1:51 a.m. on this date.

Note: Reviewers cannot reconcile the admission time of 1:07 p.m. documented on the Inmate Admission Sheet and booking almost 12 hours later, at 1:51 a.m.

Note: The SDC detention file does not document DE LA ROSA's primary language or English language proficiency. EARM documentation dated February 9, 2018 indicates his primary language was English and that he declined interpretation assistance during the interview with ICE.

RN (b)(6); (b)(7)(C) conducted medical and mental health intake screening at 2:45 a.m. She entered that she speaks Spanish and that interpretation was not provided because she is fluent in the detainee's language. She also noted that the detainee reported he speaks fluent English. She

² The ICE Custody Classification Worksheet is Appendix 2.2.A of the 2011 PBNDS, revised in 2016, Custody Classification System.

documented that medical information accompanied DE LA ROSA to SDC and stamped her name on each of four pages received from the Wake County Detention Facility (WCDF) in Raleigh, NC.

According to the WCDF Medical Summary dated March 13, 2018, DE LA ROSA was not on medications and a purified protein derivative (PPD) skin test for tuberculosis (TB) was read as negative on February 12, 2018. A one page Wake County Sheriff's Office Report of Physical Examination dated February 13, 2018 includes two illegible notations in the Abnormal Findings section. One appears to reference the Mouth and Teeth and an observation regarding two upper incisor teeth. The second abnormal finding notes a scar on the right hand, with no further description. The WCDF Problem List has seven items, all dated February 13, 2018, most of which are not legible. Legible entries include a scar to the dorsal side of the right hand, prior incarceration in the Virginia Department of Corrections, and schizophrenia³.

Note: The WCDF documentation provides no further information on the diagnosis of schizophrenia and any treatment thereof during the month preceding DE LA ROSA's transfer to SDC.

(b)(6); (b)(7)(C) documented DE LA ROSA reported feeling good and denied pain or medical problems. His vital signs were within normal limits except for a mildly elevated blood pressure of 119/80⁴, his height was 62 inches, and his weight was 137 pounds. He admitted to use of alcohol, tobacco products, and drugs. Regarding alcohol, he reported his last use was in December 2017 and replied, "To get drunk" when asked how much he drank. He last used tobacco a month ago, smoking ten to 12 cigarettes. The detainee estimated he snorted \$20 worth of cocaine and smoked \$40 worth of crack cocaine per week; last use two months earlier. He denied alcohol and drug withdrawal symptoms, symptoms of tuberculosis, and dental problems.

In answer to questions related to his mental health history, DE LA ROSA said he was treated for schizophrenia while incarcerated in a federal prison in Virginia. He was released on September 11, 2017 after serving 14 years. The detainee also reported he was treated at the Marion Correctional Treatment Center in Virginia⁵. He said that while incarcerated, he took eight different medications for schizophrenia and stopped using any medication approximately three months before he arrived at SDC because he could not sleep. Asked if he hears voices others cannot hear, he offered that he "hears God talk to him when detained" and that God still talks to him. Asked if

³ Schizophrenia is a chronic mental health disorder that affects how a person thinks, feels, and behaves, often losing touch with reality. It is characterized by possible auditory and visual hallucinations (apparent perception of something not present), delusions (belief that is firmly maintained despite being contradicted by reality), depression, self-harm and harm to others.

⁴ Blood pressure of 119/80 falls within American Heart Association parameters for stage one hypertension.

⁵ Marion Correctional Treatment Center is a behavioral health unit licensed for acute care, outpatient, and residential mental health services. It houses male offenders determined in need of care outside the scope of services available in prisons. Time spent at the Marion treatment center is part of a federal sentence.

he believes someone can control his mind, he said, "Only God." The mental health screening was negative for suicidal or homicidal ideation. He appeared to have normal physical characteristics and emotional attributes. His speech, comprehension, and focus were normal. A scar near the thumb of his left hand was noted; other observations of physical conditions were normal.

(b)(6); (b)(7)(C) documented access to care was explained, informational brochures were provided, and that the detainee was referred to a provider due to the abnormal intake screening. The note also states, "Tuberculosis and [chest X-ray] explained to patient and process completed with appropriate shielding." DE LA ROSA was cleared for custody.

Note: There is no chest X-ray report in the medical record, and if completed, the reason is unclear. WCDF documents TB clearance by way of PPD one month earlier. The information related to a chest X-ray may be pre-populated on the eCW form and not amended by RN (b)(6); (b)(7)(C)

Note: Detainee DE LA ROSA did not sign general consent for treatment during intake screening. As discussed below, there are two consent forms in the medical record. The first, dated March 16, 2018, gave consent for tele-psychiatry services; the second, completed on June 12, 2018 when the detainee returned from psychiatric hospitalization, was a consent for general treatment.

At 4:50 a.m., Officer (b)(6); (b)(7)(C) completed an Assessment Questionnaire Information form, documenting answers of no for 15 victimization and predatory history/risk screening questions. She stated on interview that DE LA ROSA was cooperative and there was nothing unusual about the intake process. A transaction receipt in his detention file reflects the detainee arrived with a \$14.00 check for which he signed a receipt time stamped 4:52 a.m. His personal property consisted of a wallet, cellphone, one pair each of jeans, socks and underwear, two jackets, and a sweater. Detainee DE LA ROSA signed and was issued a receipt for the property items. He was issued facility clothing, hygiene supplies, linens, and the facility handbook and signed a form acknowledging understanding that his mail and non-legal phone calls would be monitored. The detainee also signed a Prison Rape Elimination Act (PREA) pamphlet and PREA Zero Tolerance Policy.

Per the Housing History Report, DE LA ROSA was assigned to general population housing unit 6, pod A, cell 110 at 10:02 a.m.

Thursday, March 15, 2018

Nurse Practitioner (NP) (b)(6); (b)(7)(C) conducted the initial physical assessment at 9:30 a.m. Vital signs associated with the encounter, entered at 7:00 a.m., were within normal limits except for a mildly elevated blood pressure of 113/80⁶. DE LA ROSA denied a history of any chronic medical

⁶ Blood pressure of 113/80 falls within American Heart Association parameters for stage one hypertension.

conditions and dental problems, and general examination findings were normal. (b)(6); (b)(7)(C) wrote that DE LA ROSA reported a history of schizophrenia and said he did not remember the names of any past medications. The detainee said he last took medications three months ago and according to (b)(6); (b)(7)(C) note, "he told the doctor in North Carolina outreach program that the medications make him unable to sleep, so they stopped the medication." DE LA ROSA also said he used to hear voices from God and that he was hospitalized for schizophrenia in 2004 and 2010. He said he believed someone can control his mind and that he hears voices others do not hear, but stated the last time he heard voices was in September 2017. He denied suicidal or homicidal ideations. (b)(6); (b)(7)(C) entered no in answer to the question, "Is the patient exhibiting symptoms of a serious mental disorder or symptoms of cognitive impairment?"

The treatment plan for schizophrenia was to refer DE LA ROSA to mental health. He was advised to continue daily activities even if he did not feel like it, engage in regular exercise, and notify an officer or nurse if he starts having thoughts of harming himself or others or hearing voices. Dr. (b)(6); (b)(7)(C) Clinical Director, co-signed (b)(6); (b)(7)(C)'s note on March 17, 2018.

Friday, March 16, 2018

(b)(6); (b)(7)(C) US Public Health Service psychologist on temporary duty assignment, conducted a mental health assessment pursuant to NP (b)(6); (b)(7)(C) referral. (b)(6); (b)(7)(C) did not document the time of the encounter, but signed her note at 5:25 p.m. In her note, she wrote that the session was chaperoned by an officer observing directly from outside a large office window and that the encounter was conducted in English. DE LA ROSA gave an account of his past treatment consistent with what he reported to (b)(6); (b)(7)(C) adding that he had been sent to a "mental health prison." He stated he had friends to talk to for support and that he speaks to God; also, that he planned to call his brother for support while detained. He denied any obstacles in his developmental years and said he completed high school in Mexico. He discussed his use of crack cocaine in 2001 or 2002 for a period of two years on the weekends, and having snorted cocaine more recently in January and February "almost every day." His alcohol intake consisted of five beers every one to two weeks; most recently, one to six months ago. DE LA ROSA reported he was convicted of driving under the influence of alcohol in 2004 and possibly on one other occasion. He said he went to prison in 2004 and to a mental health prison years later.

DE LA ROSA was described as appearing his stated age, being appropriately dressed, and demonstrating good eye contact. He was cooperative with the interview and appeared to be well focused and able to concentrate. He showed no abnormalities of psychomotor activity or body movement, was fully oriented, and appeared aware of his surroundings. His affect⁸, mood, speech, insight, and judgment were normal. He was goal-directed and logical with no evidence of a delusional thought process. Aggressive behavior was not observed, and he appeared to have

(b)(6); (b)(7)(C) as not available for interview during the site visit.

⁸ Affect refers to the emotional tone a person expresses, which can be appropriate or inappropriate in relationship to the situation.

adequate anger and impulse control. He denied suicidal or homicidal ideations, gestures, or plan. The mental status exam concluded there were no current symptoms of a serious mental disorder or condition.

DE LA ROSA was given a brochure addressing progressive muscle relaxation, meditation, and positive thinking. He said he would use the techniques when necessary. He said he ~~was future~~ oriented and looked forward to being released and reunited with his family/parents. (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) wrote that the detainee stated, "God told me I will go speak in the land of Israel, Iraq and Arabia and 'go to Heaven' in the future." She further wrote that while discussing his past diagnosis of schizophrenia, he adamantly denied any current symptomology or command hallucinations, and explicitly denied suicidal or homicidal ideations. DE LA ROSA agreed to notify staff if he had any issues or felt unsafe with himself. He had no complaints regarding his mental status or safety in general population.

In the treatment section of the eCW encounter note, (b)(6); (b)(7)(C) listed treatment planning and supportive psychotherapy as interventions. In the Preventive Medicine section, (b)(6); (b)(7)(C) entered yes answers to pre-populated treatment plan elements. The Preventive Medicine section opens with the following explanation, "Due to the unpredictable nature of the immigration process including length of detention stay, the purpose of psychological intervention will be the stabilization of presenting symptoms, acute crisis intervention, and brief supportive/solution-focused psychotherapy." The plan includes multiple elements focusing on wellness, coping and stress management skills, and direction/understanding that staff are to be notified in the event an urgent need arises to access healthcare staff for mental health services. It also states evaluation by psychiatry was scheduled and that follow-up was scheduled in four weeks. DE LA ROSA agreed with the plan and signed consent for tele-psychiatric services.

Note: The medical record includes an initial psychiatry appointment note on April 18, 2018. The note was blank, suggesting the appointment was not conducted. The note was signed by (b)(6); (b)(7)(C) MD on July 19, 2018, nine days following DE LA ROSA's death. As discussed below, the detainee was seen by a prescribing mental health provider, a Psychiatric Mental Health Nurse Practitioner, on April 24, 2018.

Sunday, March 18, 2018

The Telnate daily telephone call report documents detainee DE LA ROSA attempted a telephone call at 9:34 p.m. The call lasted one minute.

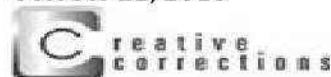
Tuesday, March 20, 2018

The Commissary Summary documents the detainee purchased two 20 ounce bottles of Coke and 25 Chili Ramen noodles. The purchase price was \$13.69 with tax leaving an account balance of \$0.31.

Tuesday, April 3, 2018

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Per written report of Officer (b)(6); (b)(7)(C) at 5:45 p.m. she reported to the case counselor and unit manager that detainee DE LA ROSA stared at her in the housing unit for the entire eight hour shift. He told her that God told him they belonged together and she would get fired soon so they could go to Mexico. He was removed from the pod and told by Unit Manager (b)(6); (b)(7)(C) to stop making these comments to staff. However, when he returned to the pod he told Officer (b)(6); (b)(7)(C) he loved her and did not care that she had told on him. Because DE LA ROSA ignored Unit Manager (b)(6); (b)(7)(C) warning, Officer (b)(6); (b)(7)(C) wrote an Incident of Prohibited Acts and Notice of Charges for Making Sexual Proposals or Threats. Officer (b)(6); (b)(7)(C) charges were supported by an Incident Statement written by Officer (b)(6); (b)(7)(C) who wrote that detainee DE LA ROSA told her that he had been told by God to tell her that she was going to be his girlfriend and he loved her.

During separate interviews, Officer (b)(6); (b)(7)(C) and Unit Manager (b)(6); (b)(7)(C) were asked for recollections about this incident and about detainee DE LA ROSA in general. Officer (b)(6); (b)(7)(C) recalled that he talked to other detainees and attended meals but he “didn’t like to shower.” She stated that detainee DE LA ROSA paced around the entire shift and frequently went to the faucet by the officer’s station. He constantly stared at her and when she looked at him, he looked away. She said another detainee approached her and commented that detainee DE LA ROSA stared at her for her entire shift and told her she needed to “write him up.” She then spoke with the unit counselor and unit manager. Unit Manager (b)(6); (b)(7)(C) stated that (b)(7)(E) came to her and reported that detainee DE LA ROSA had been inappropriate. She confirmed she spoke to him outside the unit and told him he cannot speak to officers that way and needed to stop. She stated he said OK but “went right back and did it again.” She instructed the officer to write a report and reviewed it for accuracy. Shift Supervisor (b)(6); (b)(7)(C) (first name unknown) ordered DE LA ROSA’s placement in disciplinary segregation for a disciplinary infraction. The placement order was documented on a Confinement Record, a CoreCivic form used for assigning detainees to segregation, administrative review within 72 hours, and release from the status.

Note: The detainee had yet to be found guilty of the rule violation; therefore, assignment he should have been assigned to administrative segregation pending disciplinary hearing. Inexplicably, a copy of the Confinement Record form reflecting release from segregation on April 20, 2018 (see below) shows initial assignment to administrative rather than disciplinary segregation as appears on the original order.

RN (b)(6); (b)(7)(C) assessed DE LA ROSA for segregation clearance at 8:20 p.m. Associated vital signs, entered at 7:26 p.m., were within normal limits except for a mildly elevated blood pressure of 128/89⁹. DE LA ROSA denied current thoughts of suicide and had no medical complaints. He denied suicidal and homicidal ideation and visual and auditory hallucinations. His speech was spontaneous and he answered questions appropriately. He was well developed, well-nourished, in

⁹ A blood pressure of 128/89 falls within American Heart Association parameters for stage one hypertension.

no acute distress, and appeared to be within normal limits of behavior, affect, and cognitive functioning. He did not appear to have any acute or unresolved medical conditions which might worsen in segregation, and no active psychosis, mania, suicidal ideations, or homicidal ideations. He was educated on how to access medical, mental health, and dental care while in segregation. RN (b)(6); (b)(7)(C) entry also documents, “A telephone encounter sent to mental health. Detainee has previous mental health encounter with diagnosis of schizophrenia in [eCW]. Detainee is on no medications.” DE LA ROSA was cleared for housing in segregation.

Note: The referenced telephone encounter was timed 10:15 p.m. As detailed below, DE LA ROSA was seen by mental health staff the next day, April 4, 2018.

According to a Confinement Activity Record (see discussion of the purpose of the form, below), the detainee was placed in Restricted Housing Unit (RHU)¹⁰, cell 205, at 8:29 p.m. A written notation on the Incident of Prohibited Acts and Notice of Charges form documents a copy was provided to detainee DE LA ROSA at 10:48 a.m. on April 4, 2018.

As detailed below, detainee DE LA ROSA’s assignment to segregation for this incident continued until April 19, 2018. He returned to segregation for a second disciplinary incident on June 19, 2018, remaining on segregation status until his suicide on July 10, 2018. The following information is offered to provide a foundation for the reader’s understanding of expectations with respect to healthcare and security personnel rounds for detainees in segregation for non-medical or mental health reasons.

- Per SDC RHU Post Orders and the ICE Special Management Units detention standard, officers are to make and document rounds at least every 30 minutes on an irregular schedule. The SDC Post Order further specifies that officers are to look in cells during rounds to observe detainees and confirm their welfare. SDC does not have an electronic system for recording rounds; instead, officers manually record the time of their rounds on a Confinement Watch Log posted on a clipboard outside each cell. Each entry is signed. Also on the clipboard is a Confinement Activity Record on which meals, recreation, visits, and other activities are documented. Although the names are very similar, the Confinement Activity Record and Confinement Record used to order placement and release from segregation are different forms.
- IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units (SMU), requires daily face-to-face rounds by RNs or medical providers. Rounds are to include querying detainees regarding medical, dental, and behavioral health concerns or requests, with particular consideration given to possible suicidal ideations. Rounds are to be documented in the medical record in SOAP (Subjective-Objective-Assessment-Plan) format and summarize the patient’s disposition, to include whether the patient is stable.

¹⁰ SDC’s RHU is a special management unit as defined in the ICE detention standards.

The directive also requires documentation of rounds in the SMU Log Book. At SDC, RNs record the time of their round, with signature, on the Confinement Watch Log and sign the Confinement Activity Record. The Confinement Watch Log also has a “Medications Dispensed” section nurses are to sign documenting morning, noon, and/or evening delivery of medication, when applicable.

- Per the same IHSC directive, behavioral health or medical providers are to conduct weekly face-to-face visits with detainees in the SMU to assess behavioral health needs. The visits are to be documented in the medical record and in the SMU log. Assessment of detainees with active psychiatric symptoms are to be conducted on a daily basis.

Officers’ entries to the DE LA ROSA’s Confinement Watch Logs and Confinement Activity Records are addressed in the below narrative describing DE LA ROSA’s first segregation period on an exception basis; i.e., refusals to participate in offered activities and missing entries. Entries for his stay on suicide watch and second segregation period are provided in total. Rounds by healthcare staff are described based on medical record entries.

Wednesday April 4 2018

Sergeant (b)(6); (b)(7)(C) (first name unknown) documented in a written report that he conducted an investigation into the disciplinary charges filed the day before. He wrote that the detainee admitted he told Officer (b)(6); (b)(7)(C) that he loved her and wanted her to go to Mexico with him. Sergeant (b)(6); (b)(7)(C) wrote, “Detainee was smiling and said he didn’t do anything wrong. He do love her [sic].” The sergeant advised DE LA ROSA of his rights and referred the charges to the Institution Disciplinary Panel (IDP). The detainee acknowledged in writing that he was notified of his rights. The report documents the investigation was started at 10:43 a.m. and concluded at 10:52 a.m.

The initial segregation nursing round was conducted at 11:27 a.m. by RN (b)(6); (b)(7)(C). RN (b)(6); (b)(7)(C) entered answers of no to pre-populated questions on the form related to thoughts of suicide, medical complaints or requests, and referral for health care services. In the Examination section, the following template language appears: “Detainee has spontaneous speech and answers questions appropriately, in no acute distress, well developed, well nourished. Detainee appears to be within normal limits of behavior, affect, and cognitive functioning. Detainee does not appear to have any acute or unresolved medical conditions that may worsen in segregation. Detainee does not appear to have active psychosis, mania, suicidal ideations, or homicidal ideations.” RN (b)(6); (b)(7)(C) electronically signed the note five days later, at 8:23 a.m. on April 9, 2018.

Note: The eCW template language is not in SOAP note format, and RN (b)(6); (b)(7)(C) did not add subjective findings reflecting individualized assessment of detainee DE LA ROSA. RNs who conducted subsequent segregation nursing rounds used the same template language with no supplemental information reflecting individualized assessment.

Note: RN (b)(6); (b)(7)(C) was not interviewed regarding the delay in signing his note. During interview of RN (b)(6); (b)(7)(C), she said nurses hand write their notes during rounds and enter them in eCW following return to the clinic. She said that although nurses are expected to make all entries prior to the end of their shift, occasionally, some are missed.

The medical record documents LCSW (b)(6); (b)(7)(C) conducted a clinical segregation assessment this date, presumably pursuant to RN (b)(6); (b)(7)(C) referral. LCSW (b)(6); (b)(7)(C) did not note the time of the encounter but electronically signed her note at 3:17 p.m. In the data checklist section of the eCW form, she entered DE LA ROSA's diagnosis of schizophrenia, that he did not meet serious mental illness (SMI) criteria, had no active symptoms, and that he was receiving mental health treatment by way of talk therapy¹¹. He denied thoughts of suicide and was described as well groomed, happy, pleasant, and cooperative. His affect was appropriate, his judgment insightful, and his thought process was logical and presented in an organized fashion. He did not exhibit paranoid thought content, and there was no evidence of current suicidal or homicidal potential. He stated he was fine and adjusting well to being in segregation. He presented as psychiatrically stable and able to remain in segregation. Mental health providers were to follow up on a weekly basis, and the detainee was instructed to request mental health services if he had any issues. Staff were to continue to monitor and report any changes to mental health or a medical provider. He was reminded of the process for obtaining additional services should the need arise. LCSW (b)(6); (b)(7)(C)'s note was co-signed 15 days later, April 19, 2018, by LCDR (b)(6); (b)(7)(C), LCSW, IHSC Eastern Regional Mental Health. She concurred that DE LA ROSA did not meet SMI criteria and the restricted housing assignment was adequate to address his mental health needs. She recommended continuity of care needs as medically indicated to address coordination of chronic care management.

As referenced above, the programmed data checklist on the eCW clinical segregation assessment form includes a question asking if the detainee meets SMI criteria. IHSC Directive 07-05, Serious Mental Disorders or Conditions, states, "SMI determination is based on significant psychiatric impairment of the detainee. The detainee must meet **one or more** of the following criteria based on the evaluation completed by the mental health care provider:

- a. "One or more active psychiatric symptoms: disorganization of thought or behavior, active hallucinations or delusions, catatonia¹², severe depressive symptoms, suicidal ideation, homicidal ideation, severe exacerbation of manic¹³ symptoms and marked anxiety and impulsivity;

¹¹ Talk therapy, also referred to as psychotherapy involves an encounter by a mental health professional to help patients cope with their feelings, problem solve, and change behavior patterns which might contribute to their symptoms.

¹² Catatonia refers to abnormality of movement and behavior arising from a disturbed mental health state.

¹³ Manic episodes refers to a mood swings involving extreme elation.

- b. History of more than two psychiatric hospitalization in the past three months and still presenting moderate to severe symptoms;
- c. Presently taking psychiatric medications and still presenting active moderate to severe symptoms;
- d. Continues to display harm to self or others in spite of psychiatric treatment and/or psychiatric hospitalizations; and,
- e. Serious limitations in mental functioning (communicating, taking care of activities of daily living, social skill, etc.) due to mental disability or severe medical conditions impairing mental function i.e. dementia or traumatic brain injury.”

The directive requires that upon identification of a detainee as having significant psychiatric impairment based on SMI criteria, the behavioral health provider (BHP) must immediately notify the HSA and enter specified information in a spreadsheet submitted to IHSC headquarters on a weekly basis. As noted, LCSW (b)(6); (b)(7)(C) determined DE LA ROSA did not meet SMI criteria during her assessment.

Note: During the course of the detention period, there were two encounters in which a provider determined SMI criteria was met; however, the detainee was not exhibiting active psychiatric symptoms so no action was taken (see June 20, 2018 and July 10, 2018). In all other mental health encounters in which SMI was specifically addressed, providers found the criteria were not met.

No Confinement Watch Log was produced for this date. The Confinement Activity Record documents DE LA ROSA refused a shower. Entries were made for all three meals; however, the documented times breakfast and lunch were served appear incorrect. The log documents breakfast was served at 06:54 a.m. and lunch two minutes earlier at 06:52 a.m.

Thursday, April 5, 2018

RN (b)(6); (b)(7)(C) completed a segregation round at 10:21 a.m. His medical record entry consisted of the template language quoted above.

Detainee DE LA ROSA was provided with notice the IDP hearing would be held the following day at noon.

The Confinement Activity Record documents the detainee received breakfast and dinner and refused recreation. There was no entry for the lunch meal.

Friday, April 6, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 9:26 a.m. using template language.

Per report of the IDP, a hearing was held at 12:42 p.m., more than 48 hours after the conclusion of the investigation. The signature of the hearing officer is illegible. DE LA ROSA waived his right to a staff representative and declined to call any witnesses. He stated that he told the officer he loves her and they will go to Mexico together. He added that she loves him too and “God put her here to use her. It was the will of God.” The detainee was found guilty of the charge based on the officer’s incident report and the detainee’s admission and received a sanction of 30 days disciplinary segregation. The sanction was approved by a supervisor (signature illegible) on the same date. The detainee was provided with a copy of the report on April 9, 2018 by Assistant Shift Supervisor Baines (first name unknown). A Disciplinary Segregation Order form was also completed.

The Confinement Activity Record documents that the detainee received breakfast and dinner. There was no entry for the lunch meal.

Saturday, April 7 to Tuesday, April 10, 2018

RN (b)(6); (b)(7)(C) and English documented daily segregation rounds using template language in their medical record entries.

The Confinement Activity Record for the period documents DE LA ROSA refused recreation on April 8, 2018 and a shower on April 9, 2018.

A special reclassification review was completed (b)(6); (b)(7)(C) first name unknown) on April 10, 2018 using the ICE Custody Classification Sheet. Two additional points were added for the disciplinary infraction, and the classification of high was continued. A supervisor (signature illegible) approved the classification on April 11, 2018.

Wednesday, April 11, 2018

Lieutenant (b)(6); (b)(7)(C) LCSW, conducted the weekly mental health segregation round, noting no deterioration in DE LA ROSA’s condition while in segregation. She did not note the time of the encounter but signed her medical record entry at 11:36 a.m. In the Data Checklist, LCSW (b)(6); (b)(7)(C) noted DE LA ROSA did not meet SMI criteria. She wrote that DE LA ROSA was lying in bed when approached and indicated he did not have any issues at that time. He presented in a calm manner and there were no signs of ineffective coping or acute emotional distress. He was friendly, cooperative, and appropriate in speech, and no suicidal or homicidal potential was observed. LCSW (b)(6); (b)(7)(C) note was co-signed by LCDR Cannon eight days later, April 19, 2018. She concurred that the patient does not meet current SMI criteria.

Note: Asked where segregation mental health assessments are conducted, LCSW (b)(6); (b)(7)(C) stated during interview that they are sometimes conducted through the cell door rather than in an area which more reliably assures patient confidentiality. She stated she believes that during rounds conducted at the cell, DE LA ROSA spoke as openly as he would have in an office.

The daily nursing segregation round was conducted by RN (b)(6); (b)(7)(C) at 9:41 a.m. Template language was used in the medical record entry.

Per the Confinement Activity Record, DE LA ROSA refused both recreation and a shower.

Thursday, April 12 to Sunday, April 15, 2018

RNs (b)(6); (b)(7)(C) conducted daily segregation rounds using template language.

The Confinement Activity Record documents DE LA ROSA refused recreation on April 12, 13, and 14, 2018. Recreation was not offered on April 15, 2018 due to rain.

Note: A seven day review of the detainee's status in disciplinary segregation was due on April 13, 2018. No record of the review was present in the detention file.

Monday, April 16, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 11:00 using template language. She did not specify a.m. or p.m.; however, the Confinement Watch Log entry reflects the round was conducted at 11:00 a.m.

In a late entry signed April 17, 2018, LCSW (b)(6); (b)(7)(C) documented completion of a mental health follow up encounter this date. She did not specify the time. She wrote DE LA ROSA reported that he was in segregation "because I told my girl I can't wait for us to be together", referring to a female officer. When asked if he understood the inappropriateness of this behavior, he responded, "Well it was true." Asked about auditory or visual hallucinations, he stated, "I only hear the voice of God." He denied any content that was commanding, threatening, or stressful in nature. He refused when asked if he was willing to be evaluated for medication. He denied any increase in mental health symptoms resulting from segregation, stating, "I don't worry about nothing. I'm in the hands of God" and reported that he hears from God every day. He stated he began to hear the voices while in prison in 2005, and that the voices give him peace because they are there with him. He denied thoughts of self-harm. LCSW (b)(6); (b)(7)(C) determined he was not a danger to himself or others.

Note: LCSW (b)(6); (b)(7)(C) did not use the eCW Clinical Segregation Assessment form; therefore, she did not complete the data checklist that expressly addresses whether the detainee meets SMI criteria. However, her note suggests the criteria were not met.

(b)(6); (b)(7)(C) documented confirmatory sign-off of LCSW (b)(6); (b)(7)(C) note on April 25, 2018, without comment.

A refusal form documents detainee DE LA ROSA refused evaluation for medication because he denied mental health symptoms, including auditory and visual hallucinations, depression, anxiety, thoughts of self-harm, and said that he did not need any medicine. The form was signed by DE LA ROSA and LCSW (b)(6); (b)(7)(C) and witnessed by LCSW (b)(6); (b)(7)(C) 12:00 p.m. His signature certified his understanding of possible or probable consequences of his refusal, to include auditory hallucinations or other symptoms which could worsen, causing stress, impairment in functioning, and thoughts of self-harm.

The Confinement Activity Record for this date notes DE LA ROSA refused recreation.

Tuesday, April 17, 2018

RN (b)(6); (b)(7)(C) conducted a daily segregation round at 9:23 a.m. using template language.

The Confinement Watch Log was not produced for this date.

Wednesday, April 18, 2018

RN (b)(6); (b)(7)(C) conducted a nursing segregation round at 9:00 a.m. using template language.

LCSW (b)(6); (b)(7)(C) conducted a mental health segregation round and completed the Clinical Segregation Data Checklist. She noted DE LA ROSA was lying in bed when approached and indicated he had no issues at that time. He presented in a calm manner and did not present any signs of ineffective coping or acute emotional distress at the time of the encounter. He did not meet SMI criteria, and there was no change in the assessment or treatment plan. LCSW (b)(6); (b)(7)(C) did not note the time of the encounter but signed her note at 10:58 a.m. No confirmatory sign off by another provider was entered on the note.

The Confinement Record form documents "Release to General Population on 4-18-2018." The form was signed by Security Chief Charleton Dethrow two days later, April 20, 2018 at 5:53 p.m.

Note: According to the Special Management Units standard, early release may be recommended if the supervisor conducting a status review determines "time in disciplinary segregation is no longer necessary to regulate the detainee's behavior." A recommendation for early release must be approved by the facility administrator before the detainee is returned to general population. There is no documentation suspension of the balance of DE LA ROSA's 30-day disciplinary segregation term resulted from a status review, nor is there documentation of the rationale or approval of the decision.

The Housing History Report documents that DE LA ROSA was moved from the RHU to general population housing unit 7B, cell 113 at 6:10 p.m.

Note: A Special Reclassification Assessment was not completed within 24 hours prior to DE LA ROSA's transfer from the RHU. As discussed above, a reclassification assessment

which factored the disciplinary conviction was conducted on April 10, 2018; however, the Disciplinary System standard states reclassification assessments must be conducted within 24 hours prior to release from segregation.

Note: There is no documentation DE LA ROSA ever showered during the 15 days he was in the RHU. Per policy, detainees are to be offered the opportunity to shower at least three times a week. Refusals were documented on April 4, 9 and 11, 2018; N, for no, was recorded on all other days. Assuming an entry of N signifies a shower was not offered, DE LA ROSA did not have the opportunity to shower three times per week.

Thursday, April 19, 2018

The housing history report documents detainee DE LA ROSA was moved to unit 5B, cell 212 at 12:41 p.m. He remained in this cell until April 24, 2018 when he was placed on suicide watch and protective custody (see below). DE LA ROSA's cellmate from this date through April 23, 2018, Somphes PHONSAT, was interviewed but stated he did not recall the detainee.

Saturday, April 21, 2018

CCA (CoreCivic) form 5-1c, "Incident Statement", completed in Spanish was present in the detention file. It is unsigned but lists DE LA ROSA's name at the top. Loosely translated using Google Translate, the message states, "I want to move to the hole because my new cellmate told me he was going to kill me." No response to the statement is noted on the form.

Note: Reviewers cannot explain the incident statement. The form includes questions asking, "Did you receive any injuries?" and, "Were you evaluated by medical?", both of which are blank. Also blank is the section, "to be completed by CCA staff if the civilian/other or inmate/resident refused to complete the 5-1c." If the form is made available to detainees for reporting incidents, and assuming DE LA ROSA submitted the incident statement, date and acknowledgement of receipt is not documented, nor is follow up action.

Tuesday, April 24, 2018

Commander (b)(6); (b)(7)(C) Psychiatric Mental Health Nurse Practitioner¹⁴ (PMHNP) on temporary duty assignment, conducted a mental health assessment. He wrote the reason for the encounter was auditory hallucinations, although there is no documentation of a referral by healthcare or security staff. PMHNP (b)(6); (b)(7)(C) did not note the time although vital signs associated with the encounter were time stamped 10:51 a.m. (pulse and respirations) and 1:33 p.m. (blood pressure). Except for a mildly elevated blood pressure of 135/88¹⁵, DE LA ROSA's vital signs were within normal limits. PMHNP (b)(6); (b)(7)(C) wrote that the detainee spoke English fluently but he encouraged use of a Spanish interpreter as this was DE LA ROSA's primary language. The

¹⁴ Psychiatric Mental Health Nurse Practitioners are authorized to prescribe medication.

¹⁵ Blood pressure of 135/88 falls within American Heart Association parameters for stage one hypertension.

detainee declined. PMHNP (b)(6); (b)(7)(C) documented DE LA ROSA presented to the behavioral health clinic wearing red detention attire with appropriate grooming and hygiene. He was calm and cooperative during the interview, and his speech was clear, coherent, and regular in rate, rhythm, and volume. He reported he had been sleeping through the night. He was fully oriented, his mood was good, and his affect was broad with some noted inappropriateness of laughter¹⁶ at times. His thoughts were largely linear and goal-oriented. There were no loose associations¹⁷ or flight of ideas¹⁸. He stated he was filled with the Holy Spirit and could speak with and be answered by God. He stated that he is the “Anti-Christ” and, “I will be dead within three days. I just want to be alone and relax. I do not want to be with the other people in the dormitory. I don’t want anything to happen. I might die three times.” PMHNP (b)(6); (b)(7)(C) did not observe DE LA ROSA responding to internal stimuli and noted his insight and judgment were limited. The detainee denied suicidal and homicidal ideations, plan, or intent and denied low mood or anxiety.

The encounter note documents LCSW (b)(6); (b)(7)(C) was asked to join the interview because she had been following DE LA ROSA to this point. The detainee was noted to be vague in his responses, and repeated that he was the Anti-Christ and would be dead in three days, possibly dying three times. The providers concluded DE LA ROSA was a potential danger to himself and others in the dormitory. PMHNP (b)(6); (b)(7)(C) ordered one-on-one suicide watch/direct observation with all applicable precautions and daily evaluations. The detainee was offered medication to address his psychosis; however, he declined, stating, “I don’t need medications.”

In a separate encounter note, PMHNP (b)(6); (b)(7)(C) completed a suicide risk assessment documented as a late entry and signed three days later. The eCW suicide risk assessment instrument includes risk and protective factors and mental status examination elements. Information and observations documented in PMHNP (b)(6); (b)(7)(C) earlier note were included in the suicide risk assessment, with the conclusion that DE LA ROSA was at “Moderate Acute Risk” and one-to-one suicide watch was indicated. His unwillingness to begin medication treatment was noted.

A Special Needs Form completed by LCSW (b)(6); (b)(7)(C) and approved by PMHNP (b)(6); (b)(7)(C) at 1:45 p.m. directed DE LA ROSA’s placement on suicide watch in a safety cell. A safety smock and blanket were to be issued and the detainee was to receive food with no saran wrap and utensils. Handwritten instructions state, “Security will maintain 1:1 visual. No belongings outside of smock/blanket. Finger foods only.”

An untimed memorandum from Unit Manager Minns to Chief of Unit Management (b)(6); (b)(7)(C) (first names unknown) documents that detainee DE LA ROSA was placed in administrative

¹⁶ Inappropriate laughter is laughter that is unexpected due to dissociation from the topic or circumstance. For example, if a patient laughs about dying, this would be inappropriate.

¹⁷ Loose associations occur when a patient’s responses are not relative to the questions being posed to him.

¹⁸ Flight of ideas refers to disconnected rambling or a rapid shifting of ideas with only superficial associated connection between them.

segregation pending investigation for protective custody. The detainee signed the memorandum. A Confinement Record documents assignment to the status at 2:37 p.m. and the reason for placement as, "Separation from general population for the purpose of protection from other inmates/residents for reason of personal safety." The form includes the note, "Per Medical Suicide Watch 1:1."

Note: Reference in the memorandum and Confinement Record protective custody and separation from general population for DE LA ROSA's personal safety cannot be unexplained with certainty. If related to the April 21, 2018 incident statement that DE LA ROSA wanted to move because his cellmate said he wanted to kill him, placement on protective custody occurred three days later. If related to an incident or event that occurred this date, possibly precipitating referral for evaluation for auditory hallucinations by PMHNP (b)(6); (b)(7)(C) no documentation exists.

A Record of Search form documents that DE LA ROSA was strip searched at 2:48 p.m. Shift supervisor (b)(6); (b)(7)(C) approved the search, the reason for which was suicide watch.

Note: Justification for the strip search based on specific reasonable suspicion that the detainee may have been concealing contraband was not documented.

The housing history report documents the detainee's assignment to RHU 7A, cell 201 at 10:23 a.m. At 4:45 p.m. he was assigned to cell 112 for suicide watch.

Note: Reviewers cannot explain the times recorded on the housing history report. It is possible cell 201 was designated when it was determined DE LA ROSA's placement on protective custody was called for; then, the cell assignment was changed to 112 when suicide watch was ordered.

HSA (b)(6); (b)(7)(C) explained that the RHU is used for suicide watch when designated cells in the medical housing unit (MHU) are unavailable. He indicated that when demand exceeds supply, the observation cells in the MHU are used for detainees deemed most acutely ill. Because at the time of DE LA ROSA's detention, renovations in the MHU were underway, availability of observation cells was limited. HSA (b)(6); (b)(7)(C) acknowledged that cells in the RHU are not anti-ligature, but stressed that all detainees placed on suicide watch are on constant, one-on-one observation status.

Officers assigned to suicide watch are stationed immediately outside the cell. Every 15 minutes, the officer must record on the Suicide Observation Checklist the activity in which the detainee is engaged, such as sleeping, walking or standing at door. A Confinement Activity Record is also maintained. Per the Significant Self-Harm and Suicide Prevention and Intervention standard and IHSC Operations Memorandum 16-002, Significant Self-Harm and Suicide Prevention and

Intervention, a qualified clinician/health care provider (RN or higher) must check detainees who are potentially or actively suicidal at least once every eight hours. The eCW form used for documenting suicide watch rounds by RNs is not the same used for segregation rounds. It includes vital signs and SOAP elements.

RN (b)(6); (b)(7)(C) conducted the first suicide watch nursing assessment at 5:45 p.m., entering vital signs time stamped 6:43 p.m. The vital signs were within normal limits except for a slightly elevated blood pressure of 123/78¹⁹. His note documents DE LA ROSA was placed in segregation cell 7A/MHU overflow, and that nursing services were to include rounds and taking vital signs every shift; also, that daily rounds would be conducted by a mental health provider. DE LA ROSA denied pain, was compliant with the nursing assessment, and denied suicidal and homicidal ideations and auditory and visual hallucinations. RN (b)(6); (b)(7)(C) wrote that he stated, "God the Almighty is the only one I talk to. He hasn't said anything new though." RN (b)(6); (b)(7)(C) did not sign his note until 2:23 p.m. the next day, April 25, 2018.

Wednesday, April 25, 2018

RN (b)(6); (b)(7)(C) conducted the second suicide watch nursing assessment, entering in two places that the time of the round was 1:00 a.m. She documented DE LA ROSA was compliant with the nursing assessment and denied suicidal and homicidal ideations. He also denied auditory and visual hallucinations but stated, "God talks to me. We have conversations. He tells me that there are a lot of things that are going to happen to me." He denied pain and except for a mildly elevated blood pressure of 132/87²⁰, his vital signs, time stamped 6:24 a.m., were all within normal limits.

Note: Discrepancies in the manually entered encounter time for this and subsequent nursing encounters and associated vital signs may be explained by delayed entry of information from handwritten notes in eCW. Nurses do not have access to computers during rounds for real-time entry.

The next sequential medical record entry was made by LCSW (b)(6); (b)(7)(C) who wrote in her note that DE LA ROSA was seen for follow up suicide risk assessment. She did not note the time of the encounter, and did not sign her note until 4:14 p.m. the next day. The note documents DE LA ROSA stated he did not want to keep repeating himself as he had already told "the police yesterday what was going to happen"; also, that God was speaking to him and that he had already died, and if he dies again he will be raised from the dead. He stated he did not need any medications because nothing was wrong with him. He smiled during the assessment, even when questioned about death, dying, and plans that God has given to him. He stated he wanted to return to Mexico and "see females." He reported he does not have any children or family because he was incarcerated for 14 years for robbery. He stated that he does not want to be in general population because he does "not want to fight with people." LCSW (b)(6); (b)(7)(C) assessed his level of insight and judgment as poor.

¹⁹American Heart Association standards categorize a blood pressure of 123/78 as elevated.

²⁰ A blood pressure of 132/87 falls within American Heart Association for stage one hypertension.

LCSW (b)(6); (b)(7)(C) co-signed her note on April 30, 2018, documenting concurrence with the assessment and plan.

In the next medical record entry, RN (b)(6); (b)(7)(C) documented she completed a nursing suicide watch assessment at 9:45 a.m. DE LA ROSA was observed walking out of his cell. His mood was calm, and his speech was clear with no thoughts of self-harm voiced on interview. He reported hearing voices the previous night, stating he felt better since he was able to sleep through the night. Vital signs time stamped 3:56 p.m. were within normal limits with the exception of an elevated blood pressure of 147/83²¹. He was described as alert, well-hydrated, and in no acute distress. The general examination showed good eye contact, good judgment and insight, no auditory or visual hallucinations, thought content without suicidal ideation or delusions, and thought process logical and goal directed.

(b)(6); (b)(7)(C) documented a mental health assessment that included vital signs time stamped 10:09 a.m. The vital signs were the same as those taken by RN (b)(6); (b)(7)(C) including the elevated blood pressure. (b)(6); (b)(7)(C) wrote that DE LA ROSA denied suicidal or homicidal ideation but stated that God was trying to kill him. The general examination was normal; the assessment was “suicidal ideations”; and the treatment plan was to continue to monitor DE LA ROSA in MHU. (b)(6); (b)(7)(C) signed her note at 1:16 p.m.

Note: Compliance with the eight-hour timeframe for healthcare rounds cannot be positively determined. As noted, the medical record documents DE LA ROSA was seen by RNs at 1:00 a.m. and 9:45 a.m. He was also seen by (b)(6); (b)(7)(C) sometime before 1:16 p.m., and by LCSW (b)(6); (b)(7)(C) at an unknown time.

Thursday, April 26, 2018

RN (b)(6); (b)(7)(C) documented completion of a suicide watch nursing assessment at 9:50 a.m. The RN noted DE LA ROSA was alert, verbal, in no distress, calm and pleasant, and made eye contact. No complaints, suicidal or homicidal ideations, or visual and auditory hallucinations were voiced. Associated vital signs, time stamped 9:39 a.m., were within normal limits, with the exception of an elevated blood pressure of 137/88²².

Note: The time of the last healthcare contact cannot be determined; however, it appears a nursing round on midnight shift may have been missed.

The next sequential entry in eCW is a mental health assessment documented by (b)(6); (b)(7)(C) he did not note the time of the encounter, but associated vital signs were time stamped 10:43 a.m. The vital signs were the same as those entered by RN (b)(6); (b)(7)(C) DE LA ROSA denied suicidal or homicidal ideations and stated no one was trying to kill him. The general examination findings

²¹A blood pressure of 147/83 falls with American Heart Association parameters for stage two hypertension.

²² A blood pressure of 137/88 falls within American Heart Association parameters for stage one hypertension.

were normal and the assessment, treatment, and follow-up plans remained unchanged. The note was signed at 2:02 p.m.

RN (b)(6); (b)(7)(C) conducted the next nursing round but did not note the time and did not enter vital signs. She documented a segregation evaluation using template language used for segregation rather than suicide watch rounds. The note was signed on July 19, 2018.

Note: RN (b)(6); (b)(7)(C) completion of a standard segregation round indicates she was unaware DE LA ROSA was on suicide watch or she failed to perform required duties. The former is questionable because an officer was stationed outside the cell and the detainee was in suicide garb. If RN (b)(6); (b)(7)(C) did, in fact, speak with DE LA ROSA it would have been evident he was on suicide watch. RN (b)(6); (b)(7)(C) was no longer employed at SDC at the time of the site visit; therefore, she could not be questioned on the matter. During interview of RNs (b)(6); (b)(7)(C), they stated nurses who conduct rounds in the RHU have a roster identifying detainees on mental health observation and suicide watch status.

The next sequential medical record entry was made by LCSW (b)(6); (b)(7)(C). She did not note the time. In the narrative, she wrote DE LA ROSA stated he did not want to harm himself; however, he still believed that he was going to die three horrible deaths. He said he does not need any medication because he was “perfectly fine.” He denied auditory or visual hallucinations. He stated that God talks to him, although he could not share what God told him that day. LCSW (b)(6); (b)(7)(C) wrote that it started to rain during the assessment. DE LA ROSA began smiling and stated, “See that is God.” He smiled throughout the session and continually nodded his head. He was adamant that he was going to die, stating that it was no longer in three days; however, he would die three horrible deaths. He also stated that he hears things and does not want to be around others due to what he is hearing. When asked if he was fearful and to whom he was referring when hearing things, he did not elaborate. He denied that what he was hearing was from hallucinatory voices. He stated that he did not want to be housed in general population.

Risk factors in the suicide risk assessment were absent for current thoughts of suicide, but present for feelings of hopelessness, helplessness, fear for his own safety, uncontrolled mental health symptoms, and non-compliance with medication treatment. Mental status examination findings were poor judgment and insight, focus on the concept of death, thoughts of unreality, and perceptual disorders in the form of auditory hallucinations. His affect was inappropriate and his mood was apathetic. Assessment findings were delusional disorder and schizophrenia. He was to remain on suicide watch due to fixations with death, delusions, and hallucinations. The note was signed at 11:00 a.m. on April 27, 2018 and documented as a late entry. There was no confirmatory sign-off by another provider.

RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment at 6:00 p.m. He wrote DE LA ROSA was lying on his bed and woke up when his name was called. The detainee was alert, verbal, and

in no distress. He was calm and pleasant, made eye contact and voiced no complaints. He reportedly was eating his meals. He denied hallucinations and suicidal or homicidal ideations. He denied pain, and the general examination was normal.

Note: Vital signs were not recorded, although the treatment note specifies vital signs were to be obtained every shift.

RN (b)(6); (b)(7)(C) documented she completed the next nursing assessment at 8:55 p.m., noting DE LA ROSA was cooperative with the examination and engaged in conversation, using good eye contact. RN (b)(6); (b)(7)(C) wrote that he had been evaluated by mental health and that he would possibly be released to general population the next day. Vital signs time stamped 12:36 a.m. on April 27, 2018 were within normal limits and he denied pain. The general examination was normal.

Note: Based on mental health provider encounter notes, there is no indication DE LA ROSA's return to general population was contemplated.

ICE form I-855, Administrative Segregation Review, was completed and signed. The signature, which appears in the Supervisory Immigration Enforcement Agent or contract equivalent line, is illegible. The reviewing staff person noted the detainee was on medical segregation status and checked YES for the following questions: "Does the reason for initial placement remain valid?" and, "Is the detainee unwilling or unable to live in the general population?" The reviewer also checked the box recommending removal from protective custody status, presumably in error. The Field Office Director signature line and date are blank, although the box "Continue Status" is checked.

Note: The individual who completed the review did not document interview of the detainee as required by the Special Management Units standard. In fact, the ICE form does not include a section for documenting completion of an interview.

The Confinement Activity Record documents DE LA ROSA went to court at 9:45 a.m. and returned at 9:50 a.m. On this date only, monitoring checks every 15 minutes were documented on a Mental Health Observation Checklist form rather than Suicide Observation Checklist form. The reason is unknown although the forms are identical except for the title.

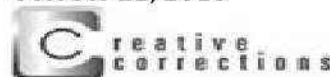
Friday, April 27, 2018

RN (b)(6); (b)(7)(C) shepherd conducted a suicide watch nursing assessment at 9:30 a.m., entering the same information appearing in RN (b)(6); (b)(7)(C) note the day before.

Note: The last healthcare round was conducted by RN (b)(6); (b)(7)(C) more than 12 hours earlier, at 8:55 p.m. on April 26, 2018. RN (b)(6); (b)(7)(C) did not record vital signs, and did not sign her note until July 19, 2018.

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PMHNP (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment in the clinic, noting a CoreCivic officer was posted at the door. He did not note the time of the encounter. Associated vital signs time stamped 8:51 a.m. were all within normal limits with the exception of a mildly elevated blood pressure of 122/71²³. PMHNP (b)(6); (b)(7)(C) documented that on direct questioning, DE LA ROSA denied suicidal ideation, plan, or intent to cause self-harm. However, he continued to express grandiose beliefs that he was the antichrist and would soon die three horrible deaths and be resurrected three times. He was vague in responding to questions about this. He reported he was an instrument of God and would be used to save the world from itself. He reported speaking directly to God and being answered by God. He stated, "I do not fear death. I am in the hands of God." He reported he was previously worried and cried about dying the three horrible deaths but had accepted this as "the way" and was no longer afraid. He was provided education and encouragement to accept treatment, but he continued to refuse, stating, "I don't need medications. Why would I need them? Don't you believe in the Bible?" He was noted to have fixed delusions and had consistently declined care and medication interventions over the past three days while on suicide observation. PMHNP (b)(6); (b)(7)(C) determined the detainee continued to be a danger to himself and potentially to others. The case was discussed with LCSW (b)(6); (b)(7)(C) and plans were made to refer him to Columbia Regional Care Center (CRCC) for inpatient hospitalization. PMHNP (b)(6); (b)(7)(C) signed his note at 1:35 p.m. and LCSW (b)(6); (b)(7)(C) documented confirmatory sign-off concurring with the plan on May 2, 2018.

Note: HSA (b)(6); (b)(7)(C) informed the review team that ICE has a contract with CRCC for care of detainees requiring psychiatric services outside the facility's scope. Detainees are transferred once a bed becomes available. Referrals to CRCC do not require processing through the IHSC Medical Payment Authorization Request system.

RN (b)(6); (b)(7)(C) conducted a nursing assessment, recording vital signs time stamped 12:40 p.m. within normal limits except for an elevated blood pressure of 148/90²⁴. She did not note the time of the encounter. She wrote that DE LA ROSA was standing at the cell door, smiling. He stated, "I had a good night's sleep. God is speaking to me. No bad dreams. I'm okay." RN (b)(6); (b)(7)(C) noted DE LA ROSA was asymptomatic relative to the elevated blood pressure and that Dr. (b)(6); (b)(7)(C) was made aware. The general examination was normal.

Detainee DE LA ROSA was seen next by (b)(6); (b)(7)(C). The time of the encounter was not documented, although associated vital signs were time stamped 2:39 p.m. The vital signs were the same as those entered by RN (b)(6); (b)(7)(C) including blood pressure of 148/90. (b)(6); (b)(7)(C) documented normal general examination findings.

²³ American Heart Association standards categorize a blood pressure of 122/71 as elevated.

²⁴ A blood pressure of 148/90 falls with American Heart Association parameters for stage two hypertension.

At 10:30 p.m. RN (b)(6); (b)(7)(C) conducted a nursing assessment, noting DE LA ROSA was sitting on his bed, alert and fully oriented. His respirations were non-labored, and the general examination was normal. Vital signs time stamped 2:36 a.m. on April 28, 2018 were within normal limits except for a continued elevated blood pressure of 146/86²⁵.

Note: During interview of HS (b)(6); (b)(7)(C) he stated nurses are expected to follow guidelines in IHSC Directive 03-10, Intake Screening and Intake Reviews, in determining what if any action is to be taken when a detainee's blood pressure is elevated. The directive states, "If the systolic blood pressure is greater than 139 or the diastolic blood pressure is greater than 89, the screener will schedule the resident for a midlevel provider or physician evaluation." The directive further requires provider notification if the systolic blood pressure is greater than 150, or the diastolic blood pressure is greater than 100. RN (b)(6); (b)(7)(C) did not refer the detainee to a provider, possibly because when seen earlier in the day by (b)(6); (b)(7)(C) DE LA ROSA's blood pressure was slightly higher than when taken during her round and the provider issued no orders. RN (b)(6); (b)(7)(C) may have also recognized that the detainee was being evaluated by a provider on a daily basis and that his blood pressure would be evaluated the next day.

Saturday, April 28, 2018

RN (b)(6); (b)(7)(C) conducted a nursing assessment at 8:45 a.m. DE LA ROSA denied pain, and his vital signs time stamped 8:23 a.m. were within normal limits, including a mildly elevated blood pressure of 124/80²⁶. The general examination was normal, and he denied suicidal ideations, hallucinations, or delusions.

Note: The last healthcare round was conducted more than ten hours earlier, at 10:30 p.m. on April 27, 2018.

(b)(6); (b)(7)(C) documented a mental health observation assessment, entering the same vital signs taken by RN (b)(6); (b)(7)(C). The time of the encounter is not noted, although the vital signs were time stamped 8:40 a.m. DE LA ROSA denied suicidal or homicidal ideations. He stated he felt well and had no significant medical complaints. The general examination was normal. (b)(6); (b)(7)(C) signed his note at 11:46 a.m.

RN (b)(6); (b)(7)(C) conducted the next nursing assessment at 4:39 p.m. Vital signs time stamped 2:29 p.m. were within normal limits, except for a slightly elevated blood pressure of 124/76²⁷. The general examination was normal.

²⁵ A blood pressure of 146/86 falls within American Heart Association parameters for stage two hypertension.

²⁶ A blood pressure of 124/80 falls within American Heart Association parameters for stage one hypertension.

²⁷ American Heart Association standards categorize a blood pressure of 124/76 as elevated.

Sunday, April 29, 2018

RN (b)(6); (b)(7)(C) conducted a nursing assessment at 12:50 a.m. Vital signs time stamped 11:13 p.m. on April 28, 2018 were within normal limits, except for a slightly elevated blood pressure of 124/79²⁸. The general examination was normal.

The next sequential entry in the medical record was made by N (b)(6); (b)(7)(C). The time of the encounter was not noted, although associated vital signs were time stamped 7:11 a.m. The detainee's blood pressure was mildly elevated at 139/88²⁹; other vital signs were within normal limits. NP (b)(6); (b)(7)(C) documented DE LA ROSA denied complaints and suicidal or homicidal ideation. The general examination findings were normal.

RN (b)(6); (b)(7)(C) documented a nursing assessment at 8:15 a.m. entering the same vital signs as those recorded by N (b)(6); (b)(7)(C). The vital signs were time stamped 7:05 a.m.

The next nursing assessment was conducted by RN (b)(6); (b)(7)(C) at 2:29 p.m. DE LA ROSA continued to deny suicidal or homicidal ideations or hallucinations. Vital signs time stamped 2:03 p.m. were within normal limits except for a mildly elevated blood pressure of 125/86³⁰, and the general examination was normal.

The Confinement Activity Record documents the detainee received breakfast and dinner but there was no entry documenting whether he received or refused lunch.

Monday, April 30, 2018

RN (b)(6); (b)(7)(C) conducted a nursing assessment at 12:30 a.m. Vital signs time stamped 10:18 p.m. on April 29, 2018 included an elevated blood pressure of 145/88³¹; others were within normal limits. He denied pain. The general examination was normal.

Note: The last healthcare round was conducted ten hours earlier.

Note: As discussed, IHSC Directive 03-10 requires scheduling a detainee with systolic blood pressure above 139 for evaluation by a provider. RN (b)(6); (b)(7)(C) did not document taking this action; however, as noted above, DE LA ROSA was being evaluated by a provider on a daily basis.

The next nursing assessment was made at 8:25 a.m. by RN (b)(6); (b)(7)(C). DE LA ROSA denied pain, hallucinations, and suicidal or homicidal ideations. His vital signs, time stamped 12:36 p.m., were

²⁸ American Heart Association standards categorize a blood pressure of 124/79 as elevated.

²⁹ A blood pressure of 139/88 falls within American Heart Association parameters for stage one hypertension.

³⁰ A blood pressure of 125/86 falls within American Heart Association parameters for stage one hypertension.

³¹ A blood pressure of 145/88 falls within American Heart Association parameters for stage two hypertension.

within normal limits except for an elevated blood pressure of 152/92³². Regular rate and rhythm were documented for the heart examination.

Note: RN (b)(6); (b)(7)(C) did not notify a provider of the elevated blood pressure as required by IHSC Directive 03-10. HSA (b)(6); (b)(7)(C) confirmed during interview that this blood pressure was significantly elevated and a provider should have been notified.

(b)(6); (b)(7)(C) entered a mental health encounter note that included vital signs time stamped 12:29 p.m. The time of the encounter is not documented. Vital signs were all within normal limits, except for an elevated blood pressure of 142/80³³, and the physical examination was normal. DE LA ROSA denied suicidal or homicidal ideations. (b)(6); (b)(7)(C) signed her note at 3:38 p.m.

Note: As detailed above, RN (b)(6); (b)(7)(C) documented completion of a nursing round at 8:25 a.m. for which associated vital signs were not entered until 12:36 p.m. They included a blood pressure reading of 152/92. Vital signs entered at 12:29 p.m. for (b)(6); (b)(7)(C) encounter included a lower blood pressure of 142/80. Although RN (b)(6); (b)(7)(C)'s entry of vital signs taken during her round was delayed by four hours, the documentation suggests DE LA ROSA's blood pressure, did, in fact, lower somewhat between 8:25 a.m. and 12:29 p.m.

LCSW (b)(6); (b)(7)(C) completed a follow-up suicide risk assessment. She did not note the time of the encounter and did not sign her entry until 3:11 p.m. the next day. In her narrative, LCSW (b)(6); (b)(7)(C) documented DE LA ROSA continued to present with fixed delusions and consistently declined medication intervention. He presented with thought disorder and was deemed at risk of being a danger to himself and others. The referral for admission to CRCC remained pending. Risk factors noted in the suicide risk assessment included current thoughts of suicide, feelings of hopelessness/helplessness due to continued incarceration, uncontrolled mental health symptoms, as evidenced by his delusional thinking, and non-compliance with mental health treatment based on his refusal to accept medications. His appearance and affect were described as odd. He was friendly, cooperative, and fully oriented. He remained delusional and focused on the concept of death. There was no confirmatory sign-off on LCSW (b)(6); (b)(7)(C) note.

Warden Charlie Peterson documented administrative review of DE LA ROSA's status at 3:31 a.m. The review was entered in the section of the Confinement Record form stating administrative review must be completed within 72 hours.

Note: Warden Peterson did not document his administrative review until the sixth day following DE LA ROSA's placement on administrative segregation. However, reviewers

³² A blood pressure of 152/92 falls with American Heart Association parameters for stage two hypertension.

³³ A blood pressure of 142/80 falls with American Heart Association parameters for stage two hypertension.

note the section of the Confinement Record form for documenting administrative review does not appear to be designed to constitute a status review as defined by the Special Management Unit standard. Instructions state the section must be completed for initial placement and includes space only for printed name, title, signature and date of the authority completing the section. It does not include space for documenting determination of whether continued assignment to segregation is justified and the rationale. Based on documentation in DE LA ROSA's detention file, reviewers conclude that status reviews mandated by the standard are not documented on the Confinement Record; rather, they are documented on ICE forms I-885, (Administrative Segregation Review) and I-887 (Disciplinary Segregation Review). As noted above, an initial status review was documented on ICE form I-885 on April 26, 2018 and as discussed below, the next status review was conducted and documented on a second I-885 form on May 3, 2018.

Tuesday May 1 2018

RN (b)(6); (b)(7)(C) conducted a nursing assessment at 8:43 a.m. DE LA ROSA was lying on his bunk with covers over his head, but he responded immediately when called. He voiced no hallucinations and no suicidal or homicidal ideations. Vital signs time stamped 9:18 a.m. were within normal limits except for mildly elevated blood pressure of 139/81³⁴.

Note: Because LCSW (b)(6); (b)(7)(C) did not note the time of her encounter the day before, positive determination of whether the eight hour timeframe was met is not possible. However, a round may have been missed on midnight shift.

(b)(6); (b)(7)(C) entered a mental health encounter note with the same associated vital signs entered earlier by (b)(6); (b)(7)(C). The vital signs were time stamped 12:09 p.m. The examination was normal. (b)(6); (b)(7)(C) signed her note at 3:11 p.m.

LCSW (b)(6); (b)(7)(C) documented a Wellness Check, noting that DE LA ROSA continued to present with fixed delusions and focus on concepts of death. Risk factors included feelings of hopelessness, helplessness and being a burden to others. When asked about his feelings of hopelessness and helplessness, the detainee said "because sometimes I feel like bad because I am in jail." Asked about feeling he was a burden to others, he said, "because I am the antichrist, I reject Jesus-Christ." Agitation was present with description, "Yeah, I want to be with my girlfriends." LCSW (b)(6); (b)(7)(C) noted DE LA ROSA was accepted by CRCC and travel arrangements were pending. She signed her note at 3:37 p.m. No confirmatory sign-off was entered.

At 4:00 p.m. RN (b)(6); (b)(7)(C) conducted a nursing assessment, documenting DE LA ROSA's denial of any suicidal or homicidal ideations or hallucinations. The general examination was normal.

³⁴ A blood pressure of 139/81 falls within American Heart Association parameters for stage one hypertension.

Note: Vital signs were not recorded.

Wednesday, May 2, 2018

(b)(6); (b)(7)(C) documented an assessment with associated vital signs time stamped 8:45 a.m. DE LA ROSA's blood pressure was mildly elevated at 137/89³⁵; other vital signs were within normal limits. The general examination was normal. (b)(6); (b)(7)(C) signed her note at 4:13 p.m.

RN (b)(6); (b)(7)(C) entered a note documenting a nursing assessment with associated vital signs time stamped 9:03 a.m. She did not note the time of the round. Vital signs were within normal limits except for a mildly elevated blood pressure of 128/88³⁶, and the detainee denied pain or discomfort.

Note: Because (b)(6); (b)(7)(C) did not document the time of their rounds, reviewers cannot determine time elapsed since the last healthcare contact completed at 4:00 p.m. the day before.

LCSW (b)(6); (b)(7)(C) conducted a follow up suicide risk assessment, noting DE LA ROSA "continues to present with inappropriate laughter and continues to believe that he will die three terrible deaths soon." When asked about suicidal ideations, he replied, "No, not right now." He continued to present with a thought disorder and was at risk of acting impulsively and inflicting self-harm. LCSW (b)(6); (b)(7)(C) again noted DE LA ROSA was pending transfer to CRCC. She did not record the time of the encounter and did not sign her note until 7:33 a.m. the next day. There was no confirmatory sign-off on the note.

RN (b)(6); (b)(7)(C) conducted a nursing assessment at 9:30 p.m. Vital signs time stamped 9:56 p.m. were unchanged from those recorded by (b)(6); (b)(7)(C) at 8:45 a.m. When asked how he was doing, DE LA ROSA replied, "Everything is fine." The general examination was normal.

Note: Time elapsed since the last healthcare encounter cannot be established.

Thursday, May 3, 2018

LCSW (b)(6); (b)(7)(C) conducted a suicide risk assessment documenting no change in findings. She noted transfer for a higher level of care remained pending. She did not document the time of the encounter but signed her note at 3:54 p.m. There was no confirmatory sign-off on the note.

Note: Because LCSW (b)(6); (b)(7)(C) did not document the time of her encounter, reviewers cannot establish time elapsed since RN (b)(6); (b)(7)(C) nursing assessment the evening before.

³⁵ A blood pressure of 137/89 falls within American Heart Association parameters for stage one hypertension.

³⁶ A blood pressure of 128/88 falls within American Heart Association parameters for stage one hypertension.

(b)(6); (b)(7)(C) conducted an assessment recording vital signs time stamped 9:57 a.m. DE LA ROSA's blood pressure was elevated at 141/101³⁷; other vital signs were within normal limits. The general examination was normal (b)(6); (b)(7)(C) did not document the time of her encounter but signed her note at 1:08 p.m.

A nursing assessment note entered by RN (b)(6); (b)(7)(C) documented DE LA ROSA was standing in his cell with no distress observed and no medical complaints voiced. The time was not recorded, although vital signs time stamped 3:19 p.m. were within normal limits except for an elevated pulse rate of 104 and mildly elevated blood pressure of 121/89³⁸. He denied pain and the general examination was normal.

RN (b)(6); (b)(7)(C) conducted the next nursing assessment at 9:40 p.m., noting DE LA ROSA was resting quietly and in no distress. He denied suicidal or homicidal ideation. The officer reported he had been masturbating earlier in the shift. Vital signs time stamped 9:56 p.m. were all within normal limits, except for a mildly elevated blood pressure of 135/80³⁹. The general examination was normal.

ICE Form I-885, Administrative Segregation Review, was completed this date, documenting the detainee was in special housing for medical segregation. An illegible signature appears in the Supervisory Immigration Enforcement Agent or contract equivalent signature line. YES was checked for the following questions: "Does the reason for initial placement remain valid?" and, "Is the detainee unwilling or unable to live in the general population?" Removal from protective custody status was not recommended. An illegible signature appears on the Field Office Director signature line, with check mark entered for "Continue Status".

Note: The status review was conducted seven days following the first, but ten days following DE LE ROSA's placement on administrative segregation. The Special Management Units standard states a status review is to be conducted within 72 hours of placement and "after the detainee has spent seven days in segregation." Technically, this status review was late.

Note: The form does not document interview of the detainee.

Friday, May 4, 2018

(b)(6); (b)(7)(C) entered a mental health observation encounter note with associated vital signs time stamped 9:44 a.m. The vital signs were normal except for a mildly elevated blood pressure of 135/80. (b)(6); (b)(7)(C) documented DE LA ROSA was calm and cooperative and denied any physical complaints. He further noted the detainee was to be transferred to CRCC that day.

³⁷ A blood pressure of 141/101 is within American Heart Association for stage two hypertension.

³⁸ A blood pressure of 121/89 falls within American Heart Association for stage one hypertension.

³⁹ A blood pressure of 135/80 falls within American Heart Association for stage one hypertension.

Note: Because (b)(6); (b)(7)(C) did not note the time of the encounter, positive determination of time elapsed since RN (b)(6); conducted a nursing assessment at 9:40 p.m. is not possible. A round on midnight shift may have been missed.

A transfer summary prepared by (b)(6); (b)(7)(C) Anderson documents diagnosis of schizophrenia, delusional disorders, and suicidal ideation and that DE LA ROSA was negative for TB and cleared for travel. She listed a suicide smock and suicide blanket as the only personal belongings allowed.

The Confinement Activity Record documents DE LA ROSA received breakfast at 7:20 a.m. and per the Confinement Watch Log, a security round was conducted at 7:30 a.m. The Confinement Record documents the detainee was “Released to Intake” but does not specify the time. The Offender Management System report documents that at 7:32 a.m., DE LA ROSA was permanently released.

Note: Reviewers were not provided with records documenting whether CoreCivic officers transported DE LA ROSA to and from CRCC. Based on available information, custody supervision was turned over to CRCC upon the detainee’s admission.

Records from CRCC document DE LA ROSA was under the care of (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) MD, psychiatrist, from admission on May 4, 2018 until discharge on June 11, 2018. The Psychiatric Discharge Summary documents both the admitting and discharge diagnosis was schizophrenia, and the History of Present Illness section documents DE LA ROSA’s acknowledgement that he refused to take medications at SDC because, “Nothing is wrong with me.” The Hospital Course states the following:

“On admission to CRCC, the patient reported that he was able to hear the voice of God. It was initially thought that the patient’s beliefs could have been part of his religious belief system, rather than evidence of psychosis. However, as the patient became more comfortable discussing his experiences it became clear that the patient had delusions. He disclosed that he is the Anti-Christ and that he has been killed twice before and has arisen from the dead. He said he believed but was less guarded and interacted better with other patients. He was initially resistant to taking medication but he would be killed again shortly but said he was not permitted by god to disclose when that would happen. He denied suicidal thoughts. He was begun on Zyprexa⁴⁰ and Haldol⁴¹. He continued to be delusional, but was less guarded and interacted better with other patients. He was initially resistant to taking medication but by the time of discharge he was compliant. He said he would consider taking medication after discharge although he did not feel he needed it. He

⁴⁰ Zyprexa is an antipsychotic medication used to treat mental disorders including schizophrenia.

⁴¹ Haldol is an antipsychotic medication used to treat mental disorders, including schizophrenia.

continued to deny suicidal thoughts and there was never evidence that he was suicidal while hospitalized. He participated in group activities.”

The Mental Status Exam section of the CRCC discharge summary documents DE LA ROSA’s “auditory hallucinations of the voice of God” and the delusion that he is the anti-Christ continued. His insight and judgment were described as chronically impaired. Laboratory test results were found non-contributory, and his condition was stable for discharge having reached the maximum hospital benefit. Discharge medications were Zyprexa 20 mg and Haldol 5 mg, both at night time. Although not reflected in the discharge summary, the CRCC record documents he was also given antihypertensive medication amlodipine when his blood pressure was found elevated. The Medication Reconciliation for Discharge/Transfer form lists amlodipine along with Zyprexa and Haldol as discharge medications.

Note: CRCC nursing notes reflect that the order for Zyprexa included direction to administer the medication intramuscularly if he refused the medication. The record does not document whether Zyprexa was ever administered involuntarily, but nursing notes state he was “usually” medication compliant.

Monday, June 11, 2018

The day before DE LA ROSA returned to SDC, (b)(6); (b)(7)(C) (first name unknown) completed a classification review. The review was documented on an ICE Custody Classification Worksheet. He was again rated high. A supervisor approved the classification two days later, June 13, 2018. The signatures of (b)(6); (b)(7)(C) and the supervisor are illegible.

Tuesday, June 12, 2018

RN E (b)(6); (b)(7)(C) completed medical pre-screening, recording the time of arrival was 8:30 a.m. He conducted the intake screening at 9:00 a.m., entering vital signs time stamped 6:33 a.m. Vital signs were within normal limits, including blood pressure of 115/73. Listed medical problems were schizophrenia, hypertension, and history of alcohol abuse. He arrived with the antipsychotic medications Haldol 5 mg and Zyprexa 20 mg and the antihypertensive medication Norvasc⁴² 10 mg. Although DE LA ROSA denied ever hearing voices that others do not hear and RN (b)(6); (b)(7)(C) observed no behaviors of concern, the RN appropriately designated the intake screen abnormal and referred the detainee to a provider. DE LA ROSA was cleared for custody.

The Commitment Summary documents DE LA ROSA was booked into SDC at 9:44 a.m. As explained Office (b)(6); (b)(7)(C) during interview, he was “restored into the system.” At 9:51 a.m., she conducted a PREA Risk Assessment, documenting answers of no to each question. The Housing History Report documents that at 10:17 a.m., the detainee was assigned to cell 104 in pod 7B, a general population unit for detainees classified high and medium high.

⁴² Norvasc is a brand name for amlodipine.

Note: Reviewers assume DE LA ROSA's return was handled as a new intake because his transfer to CRCC was documented as a permanent release.

LCSW (b)(6); (b)(7)(C) conducted a mental health assessment, noting CRCC return as the reason for the appointment. She did not enter the time of the encounter and did not sign her note until July 11, 2018, following DE LA ROSA's death. Her note was locked on that date without confirmatory sign-off. LCSW (b)(6); (b)(7)(C) wrote, "Detainee states he was given medication that he did not feel helped. He states that his life is the same. He states that he still feels that he will suffer three terrible deaths in the future but he will never kill himself. He states that while in Virginia he told his therapist about his first death. He states that he told them in Columbia about his second death and three more in the future and God will raise him from the dead. He states that he will never harm himself. He states that he only hears the voice of God but he must pray to find the answer of what he is saying. He states that he is not in any type of pain. He states that sometimes he sees pictures in his mind that makes him happy when he is feeling sad. He states that he does not know how to explain it but he feels happiness from God. He states he feels okay now. He states that he does not feel that his mind is confused. He could identify the date, the place and time. He was future oriented to go to Mexico to see his family. He states that while in Columbia, CRCC he could call his brother, he states that his brother does not believe in him so he is not sending him money. He states that he must prove to his brother that he is changed. He states that he last had his medication on last night. He states that he does not want to continue to take his medications because he does not need it. Patient and writer discussed medication compliance and reoccurrence of symptoms."

By telephone encounter timed 3:09 p.m., (b)(6); (b)(7)(C) ordered daily administration of amlodipine 10 mg in the morning, and daily administration of olanzapine⁴³ 20 mg and haloperidol⁴⁴ 5 mg, both in the evening.

Note: The medical record does not include a specific consent form for the two psychiatric medications.

Note: The Medication Administration Record (MAR) documents the three medications were ordered this date but not started until June 14, 2018. Reviewers cannot explain the delay, although it is possible (b)(6); (b)(7)(C)'s order was received after the pharmacy closed on June 12, 2018 and the order for amlodipine was not filled until after morning medication administration hours on June 13, 2018. It is also possible that the psychiatric medications were not in stock and had to be ordered. As detailed below, DE LA ROSA took none of his medications up to and including the day of his suicide.

⁴³ Olanzapine is generic Zyprexa.

⁴⁴ Haloperidol is generic Haldol.

Wednesday, June 13, 2018

NP (b)(6); (b)(7)(C) completed an abbreviated physical examination at 9:00 a.m., noting DE LA ROSA had been examined at SDC within the past 90 days, on March 15, 2018. Except for a slightly elevated blood pressure of 123/77⁴⁵, vital signs time stamped 6:08 a.m. were within normal limits. DE LA ROSA denied any pain. The NP conducted an Abnormal Involuntary Movement Scale (AIMS) test to determine if the detainee was experiencing side effects from psychotropic medications. The score was zero. Follow-up was scheduled for two weeks.

Note: There was no documentation a medical provider followed up in two weeks; however, DE LA ROSA was seen by a mental health provider, PMHNP (b)(6); (b)(7)(C) for a segregation round on June 27, 2018.

Thursday, June 14, 2018

Additional intake procedures were completed following the same process as when DE LA ROSA was originally admitted on March 14, 2018. In addition to the property listed on the first inventory, chewing gum, shoe laces, keys, canvas shoes and an additional pair of socks were receipted. DE LA ROSA was again issued facility clothing, hygiene supplies, linens, a lock, radio with batteries, a PREA pamphlet, PREA Zero Tolerance Policy and the facility handbook. He signed an agreement for monitoring of his mail and phone calls, and a form acknowledging he received an orientation and that an orientation video would also be shown in the housing unit on a daily basis.

Note: Reviewers cannot explain why these processes were completed two days after DE LA ROSA returned from CRCC.

Per the Housing History Report, the detainee was moved to Pod 5A in cell 213 at 1:36 p.m.

As noted above, medications ordered on June 12, 2018 were started this date. They included antihypertensive medication amlodipine to be given in the morning and psychiatric medications Haldol and Olanzaprine to be given in the evening. Daily medication administration attempts through the day of DE LA ROSA's suicide are summarized in tables, below. As detailed, the MAR documents that on all but three days, prescribed medications were not administered because DE LA ROSA did not report for medication pass or refused to take them. MAR entries documenting successful administration on the three days were, in fact, determined false (see below); therefore, the evidence indicates DE LA ROSA took no doses of ordered psychiatric or antihypertensive medications after he returned to SDC.

The Medical Care standard states that if treatment is refused, medical staff will explain the risks and document their efforts. It also states that refusal forms are to be signed. IHSC Directive 02-08, Refusal of Treatment, states detainees have the right to refuse medical treatment at any time. It also sets more detailed requirements for actions to be taken if treatment is refused. It states that

⁴⁵ American Heart Association standards categorize a blood pressure of 123/77 as elevated.

the healthcare professional must educate the detainee based on the treatment being refused and complete the IHSC Refusal Form in its entirety each time the detainee refuses treatment. The directive also states that if a nurse provides the education, he or she “should refer the refusal documentation to a medical provider, BHP, or dentist, as appropriate, for review. The detainee should be scheduled for a face-to-face visit with the medical provider, BHP or dentist to review the treatment plan and receive follow up education.”

As shown in the below tables, there were multiple occasions NS, for No Show, was entered. On no occasion where NS was entered did nurses document any effort to account for the detainee to confirm that his failure to report constituted refusal of the medications and if so, educate him on associated risks and obtain his signature on a refusal form. Also as shown, providers were not consistently notified DE LA ROSA was not taking ordered medications and when notified, a provider did not consistently follow up.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Illegible	No	No	-
Haldol, Olanzapine	No Show	-	-	-

Friday, June 15, 2018

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes, detainee refused to sign	Telephone Encounter to NP Sekeithia Austin	No
Haldol, Olanzapine	No Show	-	-	-

Note: This was the first of 17 telephone encounters nurses sent to NP (b)(6); (b)(7)(C) notifying her DE LA ROSA was refusing medications. NP Austin was the provider designated responsibility for following up on medication refusals. At no time did she see the detainee, and only once was his blood pressure checked. As discussed below, his blood pressure was checked and found within normal limits on June 19, 2018 as part of the segregation clearance process. When asked why she did not see DE LA ROSA, NP (b)(6); (b)(7)(C) stated she conferred with mental health personnel and reviewed the detainee’s chart, but he was rescheduled for following days because, “There were not enough staff to bring him.” Although requested, reviewers were not provided with appointment lists to confirm postponed appointments were rescheduled. According to HSA (b)(6); (b)(7)(C), the Mortality Review Committee recommended that providers document why appointments are not carried out.

Saturday, June 16, 2018

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzapine	No Show	-	-	-

Sunday, June 17, 2018

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Illegible			
Haldol, Olanzapine	Refused	Yes	Telephone Encounter to LCSW Harvey	LCSW 6-19-2018

Monday, June 18, 2018

The Telnate daily report documents detainee DE LA ROSA attempted a phone call at 3:39 p.m. logged as incomplete.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzapine	NS	-	-	-

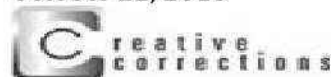
Tuesday, June 19, 2018

LCSW (b)(6); (b)(7)(C) documented an encounter with DE LA ROSA “following reports that detainee had been refusing medications.” She wrote that he stated he does not need medication but still believes he is the anti-Christ. He denied thoughts of wanting to harm himself or hearing any voices. The detainee was provided with medication education and the importance of compliance, and was instructed to report to staff immediately should he begin to have thoughts of self-harm or command auditory hallucinations. LCSW (b)(6); (b)(7)(C) did not record the time of the encounter but signed her note at 10:55 a.m. (b)(6); (b)(7)(C) psychologist, entered confirmatory sign-off on June 26, 2018. He wrote, “Reviewed and concur. [Behavioral Health Unit] will continue to monitor patient’s continuity of care needs and MSE in consult with the [Mental Health] team and (b)(6); (b)(7)(C) If higher level of care becomes necessary, please notify [Behavioral Health Unit] for assistance with care coordination as needed.”

An Incident of Prohibited Acts and Notice of Charges form timed 4:44 p.m. documents DE LA ROSA approached Officer (b)(6); (b)(7)(C) and told her she was beautiful. He also told her she was scared when she took his ID the day before. He rubbed his foot on her foot and acted like he was going to touch her buttocks. He then stated, “You gotta big butt just like I like them.” Officer (b)(6); (b)(7)(C) charged the detainee with the prohibited act of Making Sexual Proposals. On interview, Officer

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(b)(6); (b)(7)(C) stated that the incident began the day before. She said she was holding pod doors open and monitoring movement to the dining room when detainee DE LA ROSA walked up close to her and acted inappropriately. She had taken his ID and was going to write a disciplinary report but she got busy and ran out of time. She returned his ID to the unit officer. Officer (b)(6); (b)(7)(C) reported that on this date, June 19, 2018, she was again holding doors open when detainee DE LA ROSA walked up and stepped on her foot. She told him to stop. She then reported his actions to the counselor and unit manager.

R (b)(6); (b)(7)(C) cleared DE LA ROSA for segregation at 5:10 p.m. Vital signs inexplicably time stamped 2:30 p.m. were within normal limits, except for a mildly elevated blood pressure of 132/86⁴⁶. DE LA ROSA was in no acute distress and within normal limits of behavior, affect, and cognitive functioning. R (b)(6); (b)(7)(C) was no longer employed at SDC at the time of the site visit; therefore, she was not interviewed to determine if she reviewed DE LA ROSA's medical record and was aware of his ongoing delusions and that he was refusing psychiatric medications.

A Confinement Record completed by (b)(6); (b)(7)(C) (first name unknown) at 6:05 p.m. assigned detainee DE LA ROSA to disciplinary segregation.

Note: The detainee had not been found guilty of the violation; therefore, the assignment was incorrect. He should have been assigned to administrative segregation pending disciplinary hearing.

Per the housing history report, DE LA ROSA was moved to cell 107 in RHU Pod 7A at 6:05 p.m.

An Investigative Report by Officer (b)(6); (b)(7)(C) (first name unknown) documents he referred the matter to the IDP after the detainee admitted that he approached the officer. Per the report, the investigation started at 6:43 p.m. and ended at 6:53 p.m.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	-	-	-
Haldol, Olanzaprine	No Show	-	-	-

Wednesday, June 20, 2018

RN (b)(6); (b)(7)(C) conducted the first nursing round at 9:00 a.m. using the template verbiage for segregation rounds described previously.

⁴⁶ A blood pressure of 132/86 falls within American Heart Association parameters for stage one hypertension.

LCSW (b)(6); (b)(7)(C) conducted the first mental health provider segregation round. In her narrative assessment, she wrote that DE LA ROSA was in segregation for making sexual proposals toward staff. When questioned about his behavior, he said, "She's beautiful and I like her." She noted the detainee had limited mental functioning and was denying the need for any medications. He indicated he did not have any concerns related to being in segregation and said, "I feel good wherever I go." The detainee denied thoughts of self-harm and LCSW (b)(6); (b)(7)(C) noted, "He did not present with any signs of ineffective coping or acute emotional distress at the time of the encounter." However, in answer to the question, "Does the detainee meet SMI criteria?" the LCSW entered yes, specifying in the Criteria field, "One or more psychiatric symptoms, Presently taking psychiatric medications and still presenting active moderate to severe symptoms. Serious limitations in mental functioning." In conflict with that entry, LCSW (b)(6); (b)(7)(C) entered no in answer to the question, "Does the detainee present any active symptoms?" She noted DE LA ROSA was not compliant with his treatment, and answered yes to the question, "Would the detainee benefit from a higher level of care?" The treatment plan consisted of weekly visits by a BHP or sooner if clinically indicated or he requested. LCSW (b)(6); (b)(7)(C) signed her note at 4:13 p.m. (b)(6); (b)(7)(C) documented confirmatory sign-off on June 26, 2018 entering the same narrative he entered for LCSW (b)(6); (b)(7)(C) 9, 2018 encounter note.

Note: LCSW (b)(6); (b)(7)(C) informed the review team that she advised IHSC headquarters via e-mail that SDC was not an appropriate placement for DE LA ROSA. Neither she nor HSA (b)(6); (b)(7)(C) were able to produce a copy of the e-mail. As noted above, IHSC Directive 07-05, Serious Mental Disorders or Conditions, requires immediate notification of the HSA that a detainee meets SMI criteria and listing the detainee on a spreadsheet provided to IHSC headquarters on a weekly basis. Although LCSW (b)(6); (b)(7)(C) encounter note documents DE LA ROSA met SMI criteria and that he would benefit from a higher level of care, she also documented he had no active symptoms.

DE LA ROSA was informed by way of Notice of IDP Hearing form that his hearing would be held the next day. DE LA ROSA did not request staff representation or any witnesses.

Per the housing history report, the detainee was moved to cell 105 in Pod 7B at 12:31 p.m. Warden Peterson explained to the review team that all detainees housed in the RHU were moved to 7B because the air conditioning in Pod 7A was not working properly. At the time of the site visit, Pod 7A was once again functioning as the RHU.

Detainee DE LA ROSA remained in Pod 7B, cell 105 until his suicide on July 10, 2018. Review of minutes from weekly Restricted Housing Unit meetings held with ERO, Core Civic, health services administration, and mental health professionals confirmed DE LA ROSA's case was regularly reviewed while he was in segregation. Participants agreed his status should not change based on the nature of the disciplinary incident.

Pod 7B has two tiers and 40 double occupancy cells, although Warden Peterson stated detainees are housed alone when the pod is used for segregation. There are two staircases, one on each side of the unit. The officer's station is positioned at the front of the pod and consists of two tables with chairs. The dayroom has one stainless steel table with four affixed stools in front of the officer's station. There are four fixed cameras mounted near the ceiling in each corner of the pod. The review team was given video footage from all housing unit cameras, although footage from the front left camera provided an unobstructed view of cell 105 and therefore, was used for this analysis.

Cell 105 is the fifth cell to the right of the officer's desk. The cell door is steel and has viewing windows in the top and bottom portions covered with wire mesh on the inside. A food tray/handcuff port is in the center of the door. The port can be opened from outside the cell, only. Immediately to the left inside the door is a light switch and intercom button. The intercom alerts in RHU control; the light switch operates the brighter light inside the cell. A night light within the light fixture is operated in RHU control. The cell has a metal bunk bed along the back wall with a three rung metal ladder welded on the left side. Metal squares are welded in the center of the top bunk to prevent a fall. On the right wall there are two small tables welded to the wall; on the left wall there is a stainless steel toilet/sink combination fixture. A security mirror is above the sink, to the right of which is a sprinkler head. To the right of the sprinkler is the encased light. The door opens toward the dayroom and is manually opened with a key. The RHU Control Center is between Pods 7A and 7B and has windows allowing direct observation into both. Monitors display views from the cameras within the pods. As discussed above, officers assigned to RHU pods are responsible for conducting and documenting security rounds every 30 minutes on an irregular schedule.

The Confinement Activity Record documents DE LA Rosa was given dinner, showered, and allowed recreation.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	No	Telephone Encounter to N (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	No Show	-	-	-

Note: No Show was entered for amlodipine and the psychiatric medications through June 26, 2018; refusals were entered thereafter. Medications for detainees in segregation must be distributed cell to cell; therefore, entry of No Show is unexplained. If nurses did, in fact, go to DE LA ROSA's cell and he refused the medications, proper entries for refusal should have recorded on the MAR.

Thursday, June 21, 2018

RN (b)(6); (b)(7)(C) conducted a segregation nursing round at 9:36 a.m. She used template language to document her round.

Per report of the IDP, a hearing was held at 10:55 a.m. on the charge of Making Sexual Proposals. The hearing officer, Assistant Shift Supervisor (b)(6); (b)(7)(C) Gainer wrote, "Detainee stated he did everything the officer said he did." DE LA ROSA was found guilty and received a sanction of 30 days disciplinary segregation. A disciplinary segregation order was completed.

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation from 8:17 a.m. to 9:17 a.m.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	-	-	-
Haldol, Olanzaprine	No Show	-	-	-

Friday, June 22, 2018

RN (b)(6); (b)(7)(C) entered a segregation nursing round using template language.

According to the IDP Report, a copy of the disciplinary hearing findings was delivered to DE LA ROSA by Assistant Shift Supervisor (b)(6); (b)(7)(C).

ICE form I-887, Disciplinary Segregation Review, completed this date resulted in continuation of DE LA ROSA's status. Yes was checked for the following three questions: "Does the reason for initial placement remain valid?"; "Does the detainee pose a threat to others?"; and, "Is the detainee defiant towards authority?" Illegible signatures appear in the Supervisory Immigration Enforcement Agent or contract equivalent and Field Office Director lines. The "Continue Status" box was checked by whomever signed as Field Office Director.

Note: The form does not document that the detainee was interviewed.

Confinement Activity Records document DE LA ROSA received breakfast and dinner; no entry was made for the lunch meal. Recreation, a shower, and use of the telephone were logged, although the Telmate report does not list any calls this date. It is possible DE LA ROSA used another detainee's Personal Identification Number to use the phone.

Note: There are two Confinement Activity Records with different entries dated June 22, and none for June 23, 2018. Given the sequential order of the logs, the reviewer surmises the second was misdated.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	No	Telephone Encounter to NP Austin	No
Haldol, Olanzaprine	No Show	No	No	-

Saturday, June 23, 2018 through Tuesday, June 26, 2018

RNs (b)(6); (b)(7)(C) documented segregation nursing rounds using template language.

Confinement Activity Records document DE LA ROSA received three meals and recreation each day. A shower was logged on June 25, 2018. The Telmate report documents the detainee attempted an international phone call at 3:43 p.m. on June 24, 2018 which was terminated after two minutes. On June 26, 2018 the detainee went to Court at 12:01 p.m. and returned at 12:23 p.m.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	No Show	No	No	-
Haldol, Olanzaprine	No Show	No	No	-

Wednesday, June 27, 2018

RNs (b)(6); (b)(7)(C) entered a segregation round at 9:25 a.m. using template language.

PMHNP (b)(6); (b)(7)(C) conducted a mental health segregation review answering all programmed questions on the eCW form but offering no free form narrative. He documented DE LA ROSA's diagnosis of schizophrenia, that he had no active symptoms, and did not meet SMI criteria. Mental health treatment in the form of psychotropic medications and talk therapy were noted, and yes was entered in response to the question concerning compliance. Asked to explain, PMHNP (b)(6); (b)(7)(C) informed reviewers that DE LA ROSA reported he was taking his medications and because he seemed so much better, he assumed the detainee was being truthful. PMHNP (b)(6); (b)(7)(C) shared that he was surprised when later told DE LA ROSA refused all his medications.

PMHNP (b)(6); (b)(7)(C) documented the detainee's mood was happy, his affect was appropriate, his behavior was pleasant and cooperative, and his judgment was insightful. He denied thoughts of harming himself and suicide. PMHNP (b)(6); (b)(7)(C) did not document the time of the encounter but signed his note at 4:11 p.m. (b)(6); (b)(7)(C) co-signed the note on June 29, 2018, entering the same narrative note documented in his confirmatory sign-off entries for previous mental health encounters.

The Confinement Activity Record documents DE LA ROSA received all three meals and showered.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes; detainee refused to sign	No	-
Haldol, Olanzaprine	Given	-	-	-

Note: The initials documenting that psychiatric medications were given are RH identified by HSA (b)(6); (b)(7)(C) as RN (b)(6); (b)(7)(C). During interview, HSA (b)(6); (b)(7)(C) stated RN (b)(6); (b)(7)(C) was separated from service by her employer, InGenesis, after it was discovered she falsified a July 10, 2018 entry on DE LA ROSA's MAR. Specifically, she entered he refused both psychiatric medications when in fact, analysis of video footage found she did not approach the cell. Given the proven false entry, and based on DE LA ROSA's consistent non-compliance with medication treatment, HSA (b)(6); (b)(7)(C) concluded it is highly unlikely that RN (b)(6); (b)(7)(C) administered the psychiatric medications on this date, June 28, and June 30, 2018 as documented (see below). Reviewers concur with his conclusion.

Thursday, June 28, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 9:50 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals, recreation, and mail.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to N (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Given	-	-	-

Note: The entry documenting that the psychiatric medications were given was made by RN (b)(6); (b)(7)(C) and is assumed false. See June 27, 2018 note.

Friday, June 29, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 8:14 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals and recreation and that he showered and exchanged laundry.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No

Saturday, June 30, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round using template language. She did not specify the time.

The Confinement Activity Record documents DE LA ROSA received three meals and recreation.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Given	-	-	-

Note: The entry documenting that the psychiatric medications were given was made by RN Harris and is presumed false. See June 27, 2018 note.

Sunday, July 1, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 8:58 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals and attended recreation.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	No	-
Haldol, Olanzaprine	Refused	No	No	-

Monday, July 2, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 11:45 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received three meals and attended recreation. He was not offered a shower.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzaprine	Refused	No	No	-

Tuesday, July 3, 2018

RN (b)(6), (b)(7)(C) documented completion of a segregation round at 8:10 a.m. using template language.

Security Chief Dethrow completed ICE form I-887, Disciplinary Segregation Review, concluding the reason for the initial placement remained valid. He checked the box indicating he recommended the detainee's removal from disciplinary segregation status, apparently in error. The Field Office Director signature, also dated July 3, 2018, is illegible and no box is checked for the three options: concur with recommendation, release or continue status.

Note: This status review was delinquent. Per the Special Management Units standard, a status review is to be conducted every seven days. The previous review was conducted on June 22, 2018. No record of a status review completed on June 29, 2018 was found in the detention file.

Note: Security Chief Dethrow did not document interview of the detainee.

The Security Chief also signed the Confinement Record form documenting completion of a 72-hour administrative review this date.

Note: As discussed above, completion of the administrative review section of the Confinement Record form appears to be a CoreCivic requirement that is independent of the status review process mandated by the Special Management Units standard. It is nonetheless noted that the section was not completed within 72 hours of the initial assignment as required per the form. When completed, DE LA ROSA had been in segregation for 14 days.

The Confinement Activity Record documents that the detainee received all three meals and attended recreation. His cell was searched, he refused use of the telephone and exchanged laundry. It was also noted he went to Court at 1:26 p.m. and returned at 1:59 p.m.

Note: The Confinement Watch Log for this date was not produced.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	No	No	-
Haldol, Olanzaprine	Refused	No	No	-

Wednesday, July 4, 2018

RN (b)(6); (b)(7)(C) completed a segregation round at 9:05 a.m. using template language in her medical record entry.

PMHN (b)(6); (b)(7)(C) entered a mental health segregation round note that exactly matches his entry on June 27, 2018, including that DE LA ROSA did not meet SMI criteria. He provided no free form comments, and documented DE LA ROSA was compliant with mental health treatment. He did not record the time of the encounter but signed his note at 12:43 p.m. The entry was co-signed by (b)(6); (b)(7)(C) on July 9, 2018, who added the same narrative note he entered with earlier confirmatory sign-off entries.

Note: DE LA ROSA's continued refusal of medications was not noted by PMHN (b)(6); (b)(7)(C). As before, PMHN (b)(6); (b)(7)(C) have documented compliance with treatment based on the detainee's self-report.

The Confinement Activity Record documents the detainee received all three meals, attended recreation, showered, and refused the opportunity to use the telephone and library.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes, detainee refused to sign	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No

Thursday, July 5, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 9:30 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received all three meals, attended recreation and refused the opportunity to go to the library.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	No	-
Haldol, Olanzaprine	Refused	Yes	No	-

Friday, July 6, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation round at 8:15 a.m. using template language.

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation. He showered and received mail.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	No	-
Haldol, Olanzaprine	Refused	Yes	No	-

Saturday, July 7, 2018

RN Daniels documented completion of a segregation round at 9:04 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to N (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to N (b)(6); (b)(7)(C)	No

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation.

Sunday, July 8, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation rounds at 7:56 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP Austin	No
Haldol, Olanzaprine	Refused	Yes	Telephone Encounter to NP Austin	LCSW 7-10-2018

The Confinement Activity Record documents DE LA ROSA received all three meals and attended recreation.

Monday, July 9, 2018

RN (b)(6); (b)(7)(C) documented completion of a segregation rounds at 8:12 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	No	Telephone Encounter to NP (b)(6); (b)(7)(C)	LCSW 7-10-2018

The Confinement Activity Record documents DE LA ROSA received all three meals, attended recreation, showered, and exchanged laundry.

The Housing Photo Report documents that at 11:03 a.m., detainee (b)(6); (b)(7)(C) was assigned to cell 104, the cell next to detainee DE LA ROSA's. During interview by the review team he stated DE LA ROSA told him he was in disciplinary segregation for kicking a door. (b)(6); (b)(7)(C) said he did not sound depressed, although they were only housed next to each other for a brief time. He stated they talked through the food port at meal times and recalled that DE LA ROSA did talk about God.

Tuesday, July 10, 2018 – Day of Medical Emergency

RN (b)(6); (b)(7)(C) entered completion of a nursing round at 8:26 a.m. using template language.

Medication Administration

Medication	MAR	Refusal Form	Referred to Provider	Provider Follow Up
Amlodipine	Refused	Yes	Telephone Encounter to NP (b)(6); (b)(7)(C)	No
Haldol, Olanzaprine	Refused	No	No	-

Note: Refusal of the psychiatric medications was documented by RN (b)(6); (b)(7)(C). As discussed above, HSA (b)(6); (b)(7)(C) review of video footage found she did not go to DE LA ROSA's cell and therefore, concluded she falsified the entry.

LCSW (b)(6); (b)(7)(C) conducted a mental health segregation follow-up, signing her entry at 1:04 p.m. She did not note the time of the encounter, but based on an entry to the Confinement Activity Record documenting DE LA ROSA's departure from the unit for medical, reviewers conclude the encounter was completed between 11:35 a.m. and 11:55 a.m. LCSW (b)(6); (b)(7)(C) documented DE LA ROSA met SMI criteria, specifying, "One or more active psychiatric symptoms. Presently taking psychiatric medications and still presenting active moderate to severe symptoms. Serious limitations in mental functioning." In the narrative, LCSW (b)(6); (b)(7)(C) wrote, "Detainee presents as pleasantly delusional. Content of delusions are spiritual in nature. Detainee spoke about good and bad spirits and how the holy spirit is in him. Detainee denies hearing any voices or having thoughts

of wanting to hurt himself or believing that he is going to die. Detainee was psychiatrically hospitalized and returned to SDC on June 12. He stated that he has no desire to take medications and does not need them. Detainee appears to be at baseline. BHP reminded detainee of the benefits of being compliant with medication, and he smiled and stated, 'I don't need them'. Detainee did not present as a danger to self or others at the time of the encounter. Detainee aware of the process to obtain additional services should the need arise. BHP will monitor and provide support."

During interview, LCSW H (b)(6); (b)(7)(C) confirmed she saw DE LA ROSA in her office this date and commented the encounter was a "normal session." As always, the detainee was "very pleasant and cooperative." She shared that though always appropriate with her, DE LA ROSA told the other social worker that he was going to take her back to Mexico. She said he understood he would be deported.

As detailed below, detainee DE LA ROSA was discovered hanging by socks tied together from the top bunk bed at 10:33 p.m., approximately 11 hours after his encounter with LCSW (b)(6); (b)(7)(C). The officer assigned to 7B for the preceding shift, 2:00 p.m. to 10:00 p.m., was (b)(6); (b)(7)(C) the officer who relieved him for the 10:00 p.m. to 6:00 a.m. shift was (b)(6); (b)(7)(C). The following description of events is based on review of video surveillance footage from 8:00 p.m., July 10, 2018, to 12:00 a.m. July 11, 2018, written and verbal reports of staff, and entries to the Confinement Watch Log and Confinement Activity Records. Referenced times from are rounded to the nearest minute until moments prior to discovery of detainee DE LA ROSA's suicide.

Video shows Officer (b)(6); (b)(7)(C) made a round and looked in DE LA ROSA's cell at 8:40 p.m.

Note: This was the last round where Officer (b)(6); (b)(7)(C) is seen looking in the detainee's cell before he was discovered hanging by Officer (b)(6); (b)(7)(C) 113 minutes later.

At 9:13 p.m., 9:39 p.m. and 10:04 p.m., Officer (b)(6); (b)(7)(C) made rounds and marked the clipboard at DE LA ROSA's cell. Video evidence shows he did not look in the cell during any of the three rounds. Officer (b)(6); (b)(7)(C) who was assigned to RHU Control during this shift, stated the night light in DE LA ROSA's cell was on during the rounds and remained on throughout the shift. She also reported DE LA ROSA did not attempt contact via intercom during her shift. She received only one intercom call, from another detainee requesting his property.

At 10:05 p.m., Officer (b)(6); (b)(7)(C) is seen arriving on the unit to assume the post. At 10:08 p.m., Officer (b)(6); (b)(7)(C) escorted a nurse to a cell on the opposite side of the dayroom from DE LA ROSA's. At 10:13 p.m., Officer P (b)(6); (b)(7)(C) who was assigned to Pod 7A, is seen on Pod 7B looking through paperwork on the officer's desk and then left. At 10:15 p.m., Officer (b)(6); (b)(7)(C) returned to the center of the unit and at 10:17 p.m., sat at his desk. During interview, he stated he began entering detainee names on Confinement Watch Log and Confinement Activity Records forms for the next day because at midnight, he would need to post them on the clipboards. He stated that

when he escorted the nurse to the cell across the day room, he noticed the last round was recorded at 10:04 p.m. so he had time before another round was required. Officer (b)(6); (b)(7)(C) conducted the first round of his shift at 10:33 p.m., 28 minutes after he assumed the post.

Note: RHU Post Orders state that at the start of each shift, the officer must, “Verify that all cell doors and food tray slots are secure”; SDC Policy 9-13, Count Principles and Procedures, states, “At shift change, the oncoming Correctional Officer will conduct an informal count of all inmates in his/her area of responsibility.” Video evidence indicates Officer (b)(6); (b)(7)(C) did not check cell doors or conduct an informal count. When asked about the officer waiting 28 minutes to conduct a round, Captain (b)(6); (b)(7)(C) stated that it is his expectation that at the beginning of a shift, an officer should do a round and a count before they do anything else.

Officer (b)(6); (b)(7)(C) stated on interview that he started his security round at cell 101, moving to cells 102, 103 and 104 after observing the occupants and making entries to the logs on the clipboard. He recalled that the detainee in cell 102 was using the portable phone and that he moved to cell 103 without signing the log for cell 102. He returned to cell 102 and signed the log before proceeding to cell 103.

Video footage shows Officer (b)(6); (b)(7)(C) approached DE LA ROSA’s cell, 105, at 10:33:52 p.m. He stated on interview that he looked in, moved to record his round, then looked into the cell again. He observed detainee DE LA ROSA standing by the bunk bed with his chin down. In his written report, Officer (b)(6); (b)(7)(C) wrote the detainee, “was standing against the bed with his head in a strange position.” He knocked on the cell door window several times and receiving no response, called medical emergency by radio. He informed the review team that he did not open the cell door because he was trained not to do so alone because the situation “could be a set up.”

Note: SDC RHU Post Orders do not mandate that two officers be present before a cell door is opened in a special management unit. Instead, they state, “Staff members equal to the number of inmates/residents assigned to the cell will be present prior to opening any occupied cell door.” As allowed by the Post Orders, video shows Officer (b)(6); (b)(7)(C) opened cell doors on the previous shift without a second officer present to allow detainees out for showers. Therefore, consistent with the Post Orders and observed practice, Officer (b)(6); (b)(7)(C) could have entered the cell and lifted DE LA ROSA to relieve pressure on his neck and waited for responding staff to bring the cut down tool.

Officer (b)(6); (b)(7)(C) was first to respond, arriving at 10:34:50 per video footage. He acknowledged during interview that this was the second time he left his post, 7A, without being properly relieved, stating that he “shouldn’t have done that.” The video shows Officer (b)(6); (b)(7)(C) looking in DE LA ROSA’s cell, then speaking into his radio. On interview, he said he called “possible hanging” then immediately went to the RHU Control Center to retrieve the cut down tool.

Note: Although (b)(7)(E) were present, they did not enter DE LA ROSA's cell. Not knowing how close other responders were, Officer (b)(6); (b)(7)(C) made a judgment call to retrieve the cutdown tool from RHU Control and return with it to the cell, an action that took him less than one minute.

Officer (b)(6); (b)(7)(C) stated on interview that she was assigned to RHU Control for the first time this date. When she heard the medical emergency call, she turned to look into 7B and saw Officer (b)(6); (b)(7)(C) standing at cell 105, then Officer (b)(6); (b)(7)(C) rapped on the window and asked for the cut down tool. She took the tool from its storage box on the wall and removed it from its pouch. She then placed the tool in the pass through box for Officer (b)(6); (b)(7)(C).

Note: Officer (b)(6); (b)(7)(C) only pertinent entry in the RHU Control Logbook documents a medical emergency in 7B at 11:03 p.m., 30 minutes after DE LA ROSA was discovered hanging. She did not log the radio call or subsequent events related to the emergency, including the arrival and departure of SDC and Emergency Medical Services (EMS) responders. She informed the review team she has since been told she needs to record all activity on the unit during an emergency. Central Control logged the time of the medical emergency at 10:38 p.m.

Officer (b)(6); (b)(7)(C) returned to cell 105 with the cut down tool, accompanied by Lieutenant (b)(6); (b)(7)(C). The video footage shows the cell door was opened at 10:35:56 p.m., two minutes and four seconds after Officer (b)(6); (b)(7)(C) looked into the cell. The cell light was turned on. Officer (b)(6); (b)(7)(C) stated on interview that he and the lieutenant lifted DE LA ROSA upward while Officer (b)(6); (b)(7)(C) cut through the socks around the detainee's neck. Officer (b)(6); (b)(7)(C) informed the review team that he had been trained in the use of the cut down tool and had no trouble cutting through the socks. At 10:36:16 p.m. the detainee was placed on the floor with his feet by the toilet/sink fixture as another officer entered the unit. Officer (b)(6); (b)(7)(C) stated he immediately began cardio pulmonary resuscitation (CPR), remarking that he "wanted to do something" because he recalled officers did not start CPR when a detainee was discovered hanging a year ago. The dayroom lights were turned on at 10:37:05 p.m.

Lieutenant (b)(6); (b)(7)(C) stated on interview that he knew of DE LA ROSA before the emergency because he had been on suicide watch a few months prior and had made a "flirty comment" to a female officer. He was not far from 7B when he heard the emergency call and he encountered Officer (b)(6); (b)(7)(C) retrieving the cut down tool. They entered the pod together as Officer (b)(6); (b)(7)(C) stood outside the cell. Lieutenant (b)(6); (b)(7)(C) instructed Officer M (b)(6); (b)(7)(C) to open the cell door and the three entered. He commented that upon entry, he noticed DE LA ROSA's feet were flat on the floor and that he was drooling. He confirmed Officer (b)(6); (b)(7)(C) held the detainee up while Officer Blue cut through the socks, then they lowered the detainee to the floor and Officer (b)(6); (b)(7)(C) began CPR. Lieutenant (b)(6); (b)(7)(C) stated that he took over CPR for Officer (b)(6); (b)(7)(C) who had relieved Officer (b)(6); (b)(7)(C) when he tired.

The video shows Officer (b)(6); (b)(7)(C) arrived with a handheld camera at 10:37:11 p.m. She stated on interview that she heard the medical emergency call while working in Central Control, then grabbed a camera and ran to 7B. She reported she began filming upon arrival at DE LA ROSA's cell, continuing until EMS responders wheeled the detainee off the unit on a gurney. Video from the handheld camera is 20 minutes and 54 seconds in duration. Officer (b)(6); (b)(7)(C) stated that at one point, she sat on the sink in the cell in order to record activities without getting in the way of responders.

Because video taken by Officer (b)(6); (b)(7)(C) includes audio and provides detailed coverage of actions and events within the cell, the following timeline is based primarily on handheld camera footage, supplemented by information reported by staff and documented in a hard copy Chronological Record of Medical Care written by RN (b)(6); (b)(7)(C). According to HSA (b)(6); (b)(7)(C), the document was produced because eCW was down following the medical emergency. Central Control Logbook entries and the report of the Stewart County EMS Fire-Rescue are also referenced.

Note: The time stamp from the handheld camera video appears to be two minutes behind the time stamp on video from the fixed dayroom camera. Times reflected below are adjusted to match the timestamp on the stationary camera footage. Even with the adjustments, times from other sources do not always correspond. The discrepancies are minor and deemed inconsequential by reviewers. They may be explained by different timepieces and completion of documentation after the fact.

10:37:14 p.m. The video opens with Officer (b)(6); (b)(7)(C) kneeling next to detainee DE LA ROSA who is prone on the floor. Officer (b)(6); (b)(7)(C) is seen performing chest compressions, then gives one rescue breath mouth to mouth without a breathing mask or CPR mouth shield. Lieutenant (b)(6); (b)(7)(C) is heard asking Officer (b)(6); (b)(7)(C) if he is tired, and Officer (b)(6); (b)(7)(C) replied, "A little bit." Officer (b)(6); (b)(7)(C) then took over chest compressions.

Note: During interview, Officer (b)(6); (b)(7)(C) showed the review team the pouch on his belt containing a CPR mask, stating he forgot about it in the midst of the emergency.

Note: The reviewer observed Officer (b)(6); (b)(7)(C) initially performed chest compressions properly; however, his hand position moved downward, off the chest.

10:37:32 p.m. Nursing staff arrived on the unit pushing a gurney. Atop the gurney was a backboard and two emergency bags, one blue and one orange. RN (b)(6); (b)(7)(C) is seen looking into the cell, then returned to the emergency bags on the gurney. She stated, "Where is my AED?" Lieutenant (b)(6); (b)(7)(C) entered the cell with the backboard.

The Chronological Record of Medical Care documents RNs (b)(6); (b)(7)(C) arrived at 10:38 p.m. The document states, "Detainee was found lying on cell floor unresponsive and not breathing. Detainee skin was pale and cool to touch. Horizontal bruising was noted to neck area. Core Civic officer (b)(6); (b)(7)(C) was giving chest compressions. Began to place ambu mask to open airway to give rescue breaths. Vomitus/Emesis from mouth noted."

10:38:20 p.m. RN (b)(6); (b)(7)(C) is heard on video stating, "I need an oxygen tank STAT." She then stated, "Tell them to bring a crash cart down and call EMS now." Another nurse entered the cell 19 seconds later.

Note: An oxygen tank was already present; however, it was not usable because a regulator was disconnected. According to HSA (b)(6); (b)(7)(C) the regulator was in the emergency bag but RN (b)(6); (b)(7)(C) could not locate it.

The Chronological Record of Medical Care documents, "(b)(6); (b)(7)(C) (Core Civic) was told to activate EMS" at 10:39 p.m. The Stewart County EMS Fire-Rescue report documents 10:39 was the time a unit was dispatched. The Central Control Logbook documents the time of EMS activation was 10:42 p.m., three minutes after the EMS report documents a unit was dispatched.

10:39:05 p.m. Lieutenant (b)(6); (b)(7)(C) took over CPR.

10:39:11 p.m. (b)(6); (b)(7)(C) stated, "There was nothing on my cart" and that she needed an automated external defibrillator (AED) and additional nurses to be sent from Intake. She also requested the crash cart from medical.

During interview of Captain (b)(6); (b)(7)(C) he stated he followed Lieutenant (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) responding to the scene. When he arrived, medical staff were asking for equipment they did not have. He stated he sent one officer to medical to retrieve the AED and then sent a second officer to medical to retrieve an oxygen tank.

10:40:15 p.m. Officer (b)(6); (b)(7)(C) entered the cell with an AED, followed within seconds by two nurses. During interview, Officer (b)(6); (b)(7)(C) stated she was in intake when medical emergency was announced and was directed by Captain (b)(6); (b)(7)(C) to retrieve AED from medical and bring it to 7B.

The Chronological Record of Medical Care documents the AED and an oxygen tank were brought into the cell by RN (b)(6); (b)(7)(C) at 10:41 p.m.

Note: The Chronological Record of Medical Care does not address the fact that the AED was not initially brought to the scene, nor was the oxygen tank usable because the regulator had been disconnected and RN (b)(6); (b)(7)(C) could not find it in the emergency bag. HSA (b)(6); (b)(7)(C) informed the review team that there was a medical emergency earlier in the day, after which all necessary emergency equipment, including AED, was not returned to the gurney. The reviewers' analysis of the video footage found discovery of missing items added to a response that appeared somewhat disorganized and chaotic.

10:41:25 p.m. The video shows AED pads were applied to DE LA ROSA. A nurse took over CPR.

The Chronological Record of Medical Care documents placement of the AED pads at 10:42 p.m. "[Oxygen] at 15 liters placed to ambu bag. CPR continues with (b)(6); (b)(7)(C) interchanging chest compressions. AED continues to say 'no shock advised. Continue CPR.'"

10:45:46 p.m. A voice off camera announced, "EMS is here."

Per the EMS Fire-Rescue report, the vehicle arrived at the facility at 10:42 p.m. and the responders were at the patient at 10:47 p.m.

10:47:41 p.m. Video shows EMS responders entering the cell. An EMS staffer stated, "We're about to get an airway." 10:47 p.m. is also the time of arrival documented in the Chronological Record of Medical Care and Central Control logbook.

10:47:52 p.m. An EMS responder is seen removing the SDC's AED pads from DE LA ROSA.

10:48:03 p.m. EMS responders dragged the detainee from the cell and to the dayroom by his arm. The Chronological Record of Medical Care documents, "Detainee pulled from cell" at 10:48 p.m.

10:49:13 p.m. An EMS responder applied AED pads to the detainee.

10:49:40 p.m. An EMS responder laid on his stomach at the head of the detainee to intubate him.

10:50:25 p.m. The EMS responder stated, "I'm in."

The Chronological Record of Medical Care documents the detainee was intubated by EMS at 10:50 p.m. "CPR continues. AED monitor exchanged to EMS cardiac monitor/defibrillator."

10:54:16 p.m. Detainee DE LA ROSA was lifted onto the gurney by EMS responders.

10:55:31 p.m. EMS responders wheeled the gurney off the unit.

10:56:59 p.m. An EMS responder is heard saying, “He’s clinically dead right now. We’re doing everything we can to reverse that.”

10:57:03 p.m. DE LA ROSA is placed in the ambulance. Video from the handheld camera ends.

Per the written incident report of Captain (b)(6); (b)(7)(C) the AFOD and contract monitor were notified of the medical emergency at 10:45 p.m.

Officer (b)(6); (b)(7)(C) were assigned to the hospital detail, Officer (b)(6); (b)(7)(C) in the ambulance and Officer (b)(6); in the chase vehicle. Officer (b)(6); informed the review team that when informed of the assignment, he reported to intake and boarded the ambulance with the logbook. He stated there was no room in the back of the vehicle so he sat in the front seat next to the driver. According to his logbook entry, the ambulance left SDC at 11:05 p.m. The EMS report documents the time of departure was 11:06 p.m. Officer (b)(6); told the review team he was unable to observe what was going on in the back of the ambulance and kept his eyes on the road because the ambulance was traveling at a high rate of speed. Officer (b)(6); (b)(7)(C) reported the ambulance immediately activated lights and siren and she followed it as best she could while maintaining posted speed limits. She stated she could see EMS responders performing CPR through the rear windows of the ambulance. The EMS report states that while in route to the hospital, the responders “called for orders to terminate CPR due to efforts being deemed futile”, noting there was no response from the patient, his skin was cool to the touch, and his pupils were fixed and unresponsive. The request was denied by a nurse practitioner (not named) so CPR was continued.

DE LA ROSA was taken to Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, GA, 22.4 miles from SDC. The time of arrival was 11:25 p.m. per both the EMS report and logbook entry. Officer (b)(6); stated that upon arrival at the emergency room (ER), the detainee was taken to a curtained area and hospital staff performed CPR and used an AED. Physicians then checked him and pronounced death. The time of death entered in the logbook was 11:35 p.m.; however, in a later entry Officer (b)(6); documented that (b)(6); (b)(7)(C) informed him that “due to a misunderstanding”, the time was corrected to 11:29 p.m. Officer (b)(6); (b)(7)(C) who arrived in the ER after CPR was terminated, said she notified Captain (b)(6); (b)(7)(C) by telephone as soon as death was pronounced.

Video footage from the 7B dayroom camera shows that at 11:43 p.m., Lieutenant (b)(6); (b)(7)(C) used black tape to apply a large X on DE LA ROSA’s cell, covering the frame and hinges. At 11:51

p.m., he returned and removed the taped X, replacing it with tape covering only the cell door lock. On interview, Lieutenant (b)(6); (b)(7)(C) stated that after he placed the X on the door, he thought about how it might be perceived and that it might “rile up other detainees”, so he returned and removed it.

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Per hospital logbook entries, Deputy Coroner (b)(6); (b)(7)(C) arrived at 1:30 a.m. and exited with the body at 1:46 a.m. Officers (b)(6); (b)(7)(C) confirmed during interview that they remained in the emergency room with the body until it was removed by the Deputy (b)(6); (b)(7)(C). At 1:49 a.m., they left the hospital to return to SDC. They arrived at 2:16 a.m. and wrote their incident statements.

Post-Death Actions

- Incident reports were collected from all involved staff immediately following the medical emergency. Officer (b)(6); (b)(7)(C) initially wrote a two line incident report, explaining that she did not realize a detailed report was necessary because she had never been involved in a hanging. Per instruction of the facility investigator, she wrote a second report on July 23, 2018 providing more detail.
- Officer (b)(6); (b)(7)(C) stated he was never offered employee assistance services. He commented to the review team that the death was “hard to watch” and he has had difficulty getting the images out of his head. Reviewers encouraged him to contact the human resources department or his supervisor. Officer (b)(6); (b)(7)(C) stated he was offered employee assistance services but did not receive a return call after his initial contact.
- Captain (b)(6); (b)(7)(C) stated that upon notification of DE LA ROSA’s death, he spoke with Warden Peterson who instructed him to notify the Sheriff’s Department. Per report of the Stewart County Sheriff’s Office, Sheriff (b)(6); (b)(7)(C) was dispatched to SDC and arrived at 12:30 a.m. on July 11, 2018. He spoke with the Warden and interviewed Officer (b)(6); (b)(7)(C), then contacted the Georgia Bureau of Investigation (GBI). Sheriff (b)(6); (b)(7)(C) report states that GBI arrived on the scene at 1:15 a.m. and the investigation was turned over to two agents from the GBI Americus office.

Captain (b)(6); (b)(7)(C) informed the review team that he escorted one of the GBI agents to DE LA ROSA’s cell. When told he would be awhile, he left the agent with an officer. The GBI report was not available at the time of the site visit.

- On July 11, 2018, Warden (b)(6); (b)(7)(C) assigned facility investigator (b)(6); (b)(7)(C) to review events surrounding detainee DE LA ROSA’s suicide. She submitted a written report to the Warden on August 6, 2018. She informed the review team that her

investigation involved review of written reports, interviews with security and medical staff, and extensive review of video footage. Her review did not include analysis of actions taken by medical personnel. As discussed below, HSA (b)(6); (b)(7)(C) conducted an after action review involving CoreCivic and IHSC personnel.

(b)(6); (b)(7)(C) analysis of video footage included use of the zoom feature to better see DE LA ROSA inside his cell on the day of his suicide. Her analysis ended at 8:04 p.m., approximately two and a half hours before he was discovered, when he turned off the light and could no longer be seen in camera footage. According to (b)(6); (b)(7)(C) report, detainee DE LA ROSA climbed onto the toilet three times between 8:20 a.m. and 8:25 a.m. He attended recreation and was observed playing basketball and speaking to other detainees. After he returned to his cell, he again climbed on top of the toilet twice. He later went to medical and after his return again climbed on top of the toilet at 12:34 p.m. After this he received his lunch meal. Rounds were conducted throughout the afternoon and DE LA ROSA again climbed atop the toilet at 7:07 p.m., getting down a minute later when he saw staff approaching his cell. He received dinner at 7:09 p.m., climbed on the toilet at 7:23 p.m. and had his food tray picked up by Officer (b)(6); (b)(7)(C) at 7:36 p.m. At 8:04 p.m., detainee DE LA ROSA was seen with his hand on the cell light switch, then turned the light off. This is the last time detainee DE LA ROSA was viewed from the pod camera until the cell was entered at 10:36 p.m.

During (b)(6); (b)(7)(C) interview of Officer (b)(6); (b)(7)(C) he commented that detainee DE LA ROSA was always smiling and asking for the time and date. He said the detainee spoke about how beautiful the nurses were but he was never disrespectful and Officer (b)(6); (b)(7)(C) told him to keep his comments to himself. Officer (b)(6); (b)(7)(C) reported he made his last round at 10:04 p.m. and although the lights were off in DE LA ROSA's cell, he saw the detainee with his peripheral vision sitting on the bed smiling at him. As noted, the video evidence does not support Officer (b)(6); (b)(7)(C) statement. (b)(6); (b)(7)(C) drew the same conclusion, finding that Officer (b)(6); (b)(7)(C) did not look into cell 105 during rounds conducted after 8:40 p.m. By document titled CoreCivic Facility Employee Problem Solving Notice dated July 26, 2018, Officer (b)(6); (b)(7)(C) was terminated by Warden (b)(6); (b)(7)(C) for failing "to properly observe the detainee inside of his cell (7B/105) while conducting his rounds..."

- HSA (b)(6); (b)(7)(C) reported an After Action Review was conducted with CoreCivic and IHSC "to determine what they missed and lessons to be learned." He acknowledged that the review determined several things were missed "from the get go." The findings he verbally shared included the following:
 - Nurses improperly documented that detainees in RHU were "no shows" for medication administration. HSA (b)(6); (b)(7)(C) stated nurses have been retrained on the requirement to go to each cell and that video footage is now periodically reviewed to ensure compliance.

- The emergency cart was not set back up after the medical emergency earlier in the day.
- Medical responders seemed flustered during the emergency.
- RN (b)(6); did not offer detainee DE LA ROSA medication even though she documented that she did. She made other errors observed on video such as placing medications in her bare hands, signing the MAR prior to distributing the medication and not identifying detainees prior to giving medications. HSA (b)(6); (b)(7)(C) remarked that in fact, “We couldn’t find anything she did right on the video.” Her employer separated her from service.
- Officer (b)(6); gave rescue breaths without a mask.
- Officer (b)(6); used proper technique when he began CPR, but “walked down the abdomen” and at the end was giving CPR “over the spleen.”
- No one counted chest compressions so the required 30 compressions and two breaths were not consistently applied. In addition, staff did not rotate every two minutes or after five cycles.
- Neither SDC medical staff nor EMS responders did a C Spine immobilization⁴⁷ which should be done after a fall or a hanging. Instead of the head tilt, a jaw thrust should have been used, and EMS dragged the detainee out of the cell and placed him on the gurney without securing his head.

HSA (b)(6); (b)(7)(C) commented that although concerning, none of these issues contributed to DE LA ROSA’s death.

- Photographs of cell 105 taken by the GBI were made available to the review team. Graffiti present on the walls translated from Spanish by ERO staff (b)(6); (title and last name unknown) included a reference to Honduras and “Everyday is more important”. Attribution to detainee DE LA ROSA is not possible, although it is assumed the graffiti referencing Honduras was not his since he was from Mexico.
- Disposition of Property and Inmate Account Summary reports document DE LA ROSA’s property was inventoried on July 11, 2018 and was turned over to ERO staff along with the \$0.31 remaining in the detainee’s account. Photographs of the property were taken by GBI agents and provided to the review team.

⁴⁷ C-spine immobilization refers to procedures and equipment which limit the movement of the vertebrae and prevent serious injury to the spinal column, such as with use of cervical collars and long backboards.

CONCLUSIONS

Healthcare

During intake screening, detainee DE LA ROSA disclosed he was diagnosed with schizophrenia and treated at a mental health facility while serving a federal sentence. He also disclosed that his treatment included psychiatric medications he had stopped taking three months earlier because they affected his sleep. He was appropriately referred for expedited initial physical examination and mental health evaluation during which he again disclosed his mental health history. Because he was asymptomatic, no change to his housing in general population was indicated. DE LA ROSA was scheduled for four-week mental health follow up based on his history but before the appointment, was charged with a disciplinary incident involving inappropriate remarks to a female officer. He was cleared for segregation and referred to a mental health provider due to his history. The provider found DE LA ROSA had no active symptoms and SMI criteria were not met; therefore, his status remained segregation without added mental health observation requirements.

During the detainee's 15 day stay in segregation, nurses documented completion of required daily rounds using template language. Their notes were devoid of subjective information reflecting DE LA ROSA's remarks in response to queries as the SOAP format calls for. LCSWs made two segregation rounds as required, on both occasions documenting SMI criteria were not met. In between the rounds an LCSW conducted a follow up assessment, documenting DE LA ROSA said he hears from God every day and that "voices give him peace because they are there with him." This was the third time the medical record documents the detainee reported hearing from God; the first during intake when he told the nurse God talks to him and can control his mind; the second during the initial mental health assessment when he more vaguely said God speaks to him. The LCSW's offer of evaluation for medication therapy was refused by DE LA ROSA.

Six days following the detainee's return to general population housing, he was evaluated by PMHNP (b)(6); (b)(7)(C) for auditory hallucinations. DE LA ROSA said again that he was able to speak with and was answered by God; also, that he is the anti-Christ and that he would be dead in three days. He was offered and refused medications. PMHNP (b)(6); (b)(7)(C) ordered constant observation suicide watch, which, due to lack of space in the medical housing unit, was effectuated in the RHU. On the third day following DE LA ROSA's placement on suicide watch, PMHNP (b)(6); (b)(7)(C) referred him for hospitalization at CRCC on the basis of continued fixed delusions and continued refusal to accept treatment despite education and encouragement. He was transferred to CRCC when space became available, a week following referral. While on suicide watch pending transfer, DE LA ROSA was seen by providers and nurses an average of four times a day, and nurses documented subjective information reflecting interaction with him. However, there were three occasions when documented healthcare rounds were completed outside the required eight-hour timeframe, and multiple others when positive determination was not possible because providers do not enter the times of their encounters. In addition, on three occasions, nurses did not document vital signs associated with their rounds. DE LA ROSA's blood pressure was occasionally found

elevated, including during seven assessments when the American Heart Association threshold for stage one hypertension was exceeded.

DE LA ROSA was hospitalized at CRCC for approximately six weeks. CRCC records document antihypertensive medication amlodipine was given when his blood pressure was elevated, and that he was started on psychiatric medications Haldol and Zyprexa to treat schizophrenia. The records indicate Zyprexa by injection was authorized if he refused the medication, but do not document whether involuntary administration occurred. The CRCC record indicates he was “generally compliant” with treatment.

A nurse screened DE LA ROSA again when he returned to SDC, to include review of discharge documentation from CRCC. The Clinical Director was notified and ordered the three medications started at CRCC. Their administration was not attempted until the second day after ordered, possibly due to timing of the order vis-à-vis pharmacy hours and availability of the psychiatric medications. MARs reflect DE LA ROSA took his psychiatric medications on three days; however, one of the entries was determined false and the others are highly suspect. In fact, the preponderance of the evidence suggests he took no doses of amlodipine or psychiatric medications. No Show entries were made on the MAR on eight days for amlodipine and 12 days for the psychiatric medication, including seven days when he was in segregation and could not voluntarily report to the medication nurse. At no time did nurses who entered No Show document that they sought the detainee out to confirm he refused his medications and educate him as to the risks. Refusals were documented for all other doses; however, nurses did not complete refusal forms or notify a provider on a consistent basis. Although nurses did refer him to NP (b)(6); (b)(7)(C) 17 times, the provider never saw him. An LCSW was notified twice and in her encounter notes, documented DE LA ROSA maintained he did not need medication. PMHNP (b)(6); (b)(7)(C) incorrectly documented the detainee was compliant with treatment in his own encounter notes, stating during interview that DE LA ROSA reported that he was taking his medications and because he was doing well, the detainee’s assertion was not questioned. At no time was the Clinical Director informed DE LA ROSA was not taking any of his medications.

Detainee DE LA ROSA’s return to segregation took place six days after he was discharged from CRCC and was the result of making inappropriate remarks to a second female officer. His suicide occurred three weeks after placement in the RHU. He was cleared for segregation and nurses made required rounds, again using only template language in their medical record entries. The detainee was seen by mental health providers four times for segregation rounds, twice by LCSW (b)(6); (b)(7)(C) and twice by PMHNP (b)(6); (b)(7)(C). PMHNP (b)(6); (b)(7)(C) documented SMI criteria were not met; LCSW documented SMI criteria were met but added that the detainee had no active psychiatric symptoms. Her determination that DE LA ROSA met SMI criteria and at the same time, had no active symptoms is contradictory. In her encounter note for the morning of DE LA ROSA’s suicide, she wrote that he presented as “pleasantly delusional” and that the content of the delusions was spiritual in nature. She also wrote that he denied having thoughts of suicide or believing that

he was going to die. She concluded he did not present a danger to himself or others at the time of the encounter.

Approximately 11 hours later, an officer discovered DE LA ROSA hanging and immediately called medical emergency. Responding security personnel started CPR without delay, although one officer appeared to inadvertently move his hands to an improper position during performance of chest compressions. The first nurse arrived within four minutes of the medical emergency announcement and directed that EMS be called; however, because emergency equipment was not returned to its designated location after an emergency earlier in the day, the AED was not initially brought to the scene and the oxygen tank was missing its regulator. Although swift, the response was somewhat chaotic.

In summary, detainee DE LA ROSA was monitored by mental health professionals throughout the detention period and hospitalization at a mental health facility was arranged when providers determined he was suicidal. Psychiatric medications were offered and declined multiple times before his hospitalization at CRCC and upon DE LA ROSA's return, medications were ordered. As is his right, DE LA ROSA refused. The record includes 21 refusal forms documenting he was informed by nurses of risks associated with not taking his medications, and LCSW encounter notes indicate the detainee maintained he did not need medications. The Clinical Director or a prescribing mental health provider were not notified he refused to take medications; however, the midlevel provider responsible for following up on medication refusals was, 17 times, and did not see him. Although she failed to do so, PMHNP (b)(6); (b)(7)(C) saw DE LA ROSA twice during segregation rounds in the weeks preceding his suicide and, unaware the detainee was not taking medications, nonetheless determined he did not meet SMI criteria. The LCSW who also saw DE LA ROSA in the weeks preceding his suicide was aware he was refusing his medications, but up to and including the day of his suicide, determined his continued delusions were of a spiritual nature and did not put him at current risk of harming himself. Mental health encounter notes entered in the weeks before DE LA ROSA's suicide were co-signed by IHSC Behavioral Health Unit professionals who concurred with documented plans to continue monitoring.

Based on the evidence, reviewers conclude providers identified no signs of suicidal ideation or intent following DE LA ROSA's return from CRCC; also, that because he exhibited no active psychiatric symptoms, his refusal of psychiatric medications raised no flags. Assessing provider judgment is beyond the scope of the healthcare reviewer's credentials and the scope of this analysis; therefore, the following findings and concerns relate to process, only.

Compliance Findings

Creative Corrections cites the following deficiencies in the ICE PBNDS 2011, 2016 revisions, governing healthcare.

Medical Care, section (V)(U)(4), which states, “Distribution of medications shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medications given to or refused by detainees shall be maintained. All prescribed medication and medically necessary treatments shall be provided to detainees on schedule and without interruption absent exigent circumstances.”

- Video evidence shows an RN falsely recorded refusal of psychiatric medications on the night of DE LA ROSA’s suicide, July 10, 2018. The RN’s entries documenting successful administration of the medications on June 27, 28, and 30, 2018 are also assumed to be false.
- There were two illegible entries on the MAR for amlodipine (June 14 and 17, 2018); therefore, there is no documentation the medication was either given or refused. In addition, entries of No Show were entered 20 times between June 14 and 26, 2018, including 15 after he was placed in segregation and could not voluntarily report to receive medications. Entries of No Show, especially in segregation, do not constitute affirmative documentation that medications were refused as required by the standard.

Medical Care, section (V)(AA)(1), which states, “Upon admission at the facility, documented informed consent shall be obtained for the provision of health care services.

- A consent form was not signed by the detainee when first admitted to SDC. He signed consent for tele-psychiatry services on March 16, 2018, and general consent for treatment when readmitted after hospitalization on June 12, 2018.

Medical Care, section (V)(AA)(4), which states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects, shall be obtained.”

- There is no documentation DE LA ROSA was asked to sign a separate consent for Haloperidol and Olanzapine when ordered on June 12, 2018.

Medical Care, section (V)(AA)(9-11), which states, “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 treatments. The Clinical Medical Authority and facility administrator shall look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding. Facilities should make efforts to involve trusted individuals such as clergy or family members should a detainee refuse treatment.”

- The MAR documents DE LA ROSA refused his medications 29 times. No refusal forms were completed for eight of the 29. In addition, as noted in the above deficiency, nurses entered No Show on the MAR 20 times. There is no documentation any effort was made to confirm the detainee was, in fact, refusing medications on these 20 occasions, explain the risks, and complete refusal forms.

- The Clinical Director was not notified the detainee was refusing medications and therefore, did not follow up. Nurses did, however, send 17 telephone encounters to NI(b)(6) the midlevel provider responsible for following up on medication refusal. The provider did not see DE LA ROSA, claiming scheduled appointments were postponed. No documentation of scheduling was produced.

Significant Self-harm and Suicide Prevention and Intervention, Medical Care, section (V)(E), which states, “All suicidal detainees placed in an isolated confinement setting will receive on-to-one monitoring welfare checks at least every eight hours conducted by a qualified clinician.

- The eight-hour timeframe was not met on at least three occasions. There was a 12 and half hour gap between a healthcare round at 8:55 p.m. on April 26, 2018 and the next round at 9:30 a.m. on April 27, 2018; a ten hour gap between a healthcare round at 10:30 p.m. on April 28, 2018 and the next round at 8:45 a.m. on April 29, 2018; and ten hours between a round at 2:29 p.m. on April 29, 2018 and 12:30 a.m. on April 30, 2018. Because providers do not enter the times they see patients, reviewers were unable to positively identify other occasions when the eight-hour timeframe may have been exceeded. However, timing of vital signs and provider sign-off suggests there may have been multiple, particularly when a round was due on midnight shift.

Significant Self-harm and Suicide Prevention and Intervention, section (V)(K), which states, “A critical incident debriefing shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident.”

- Officer (b)(6) who rode in the ambulance, stated he was not offered a critical incident debriefing or supportive counseling services. In addition, Officer (b)(6) who discovered DE LA ROSA hanging and participated in the emergency response, stated the employee assistance program did not call him back following his request for services.

Areas of Concern

The following expands upon above-cited deficiencies and identifies areas of concern not addressed in the detention standards.

- Nurses used template language programmed in eCW to document segregation rounds when DE LA ROSA was in the RHU for disciplinary reasons. All notes are virtually identical and do not include subjective information reflecting DE LA ROSA’s remarks in answer to queries. Subjective information is the first element in the SOAP note format and fundamentally, supports objective findings. In DE LA ROSA’s case, nurses’ findings that there was no evidence of hallucinatory and delusional thoughts would have been far better supported had they documented subjective information. Reviewers recognize that nurses enter segregation rounds in eCW well after completion and including subjective information would require careful note-taking. However, to assure that segregation rounds

serve the intended purpose of verifying detainee health and welfare, reviewers recommend that nurses be required to include adequate, individualized subjective content in their notes.

- An elevated blood pressure of 152/92 recorded on April 30, 2018 was not followed up or reported to a provider for evaluation to determine possible monitoring and treatment needs. HSA (b)(6); (b)(7)(C) stated nurses are to notify providers of elevated blood pressure readings following thresholds sent in IHSC Directive 03-10, Intake Screening and Intake Reviews. This directive states providers are to be notified if the systolic blood pressure is 150 or higher.
- As noted in the fourth deficiency, nurses sent 17 telephone encounters to NP (b)(6); (b)(7)(C) notifying her DE LA ROSA was refusing his medications. She never saw him. She stated during interview that she consulted mental health professionals, which, if she did, may have resulted in confirmation that he was stable from a mental health perspective. However, the fact remained that a detainee with diagnosed schizophrenia, previously on suicide watch and hospitalized, was not taking prescribed psychiatric medications. Regarding antihypertensive medication amlodipine, the NP's failure to evaluate DE LA ROSA meant his blood pressure was not checked, except by happenstance when he was cleared for segregation. In fact, his blood pressure fell within American Heart Association parameters for stage one hypertension 21 times and stage two hypertension eight times during the detention period. Whether or not the detainee's refusal of medications was impactful on either his physical or mental health, NP (b)(6); (b)(7)(C) as a prescribing provider, was obliged to act upon nurses' referrals, including educating the detainee on the risks.
- Also addressed in the deficiency are nurses' No Show entries on the MAR, including on seven consecutive days after DE LA ROSA was placed in segregation. An entry of No Show implies the detainee did not report to the nurse to receive his medications which, in segregation, is not possible. If nurses did, in fact, go to his cell and offer medications, they should have documented refusal, educated him as to risks, and completed refusal forms. Although the evidence suggests that DE LA ROSA would have refused medications if offered at his cell, entries of No Show do not properly document attempts to administer ordered medications.
- RN (b)(6); (b)(7)(C) the first medical responder to arrive at DE LA ROSA's cell, brought emergency equipment with her; however, an AED was not available and the oxygen tank was missing a regulator. The explanation provided to reviewers was that emergency equipment was not replenished following a medical emergency earlier in the day. Although unlikely to have made a difference in DE LA ROSA's case, ensuring necessary emergency equipment is available and operable is critical to an effective medical emergency response.

Safety and Security

Detainee DE LA ROSA was in general population for approximately three weeks until charged the first time with Making Sexual Proposals to an officer. He was placed in RHU pending disciplinary hearing; however, one copy of the Confinement Record erroneously documented he was assigned to disciplinary segregation status prior to adjudication of the charge. The hearing was held approximately 50 hours after the investigation was completed, two hours later than the mandated 48 hours. The detainee admitted to committing the offense and received a sanction of 30 days disciplinary segregation. Per unilateral order of the Security Chief, DE LA ROSA was returned to general population after 15 days. DE LA ROSA committed the same offense against another officer later during his detention. The Confinement Record placing him in the RHU again erroneously assigned him to disciplinary segregation status before the charge was adjudicated. At his disciplinary hearing he admitted to the offense and was sanctioned with 30 days disciplinary segregation. He was serving the sanction at the time of his suicide.

In between the disciplinary incidents, detainee DE LA ROSA submitted an incident statement in which he alleged he was being threatened by his cellmate. The statement does not document when or by whom it was received. Three days after the date of statement, a memorandum and Confinement Record document the detainee's placement on the status for protective custody. The Confinement Record also documents placement by healthcare staff for constant observation suicide watch. The detainee was strip searched without documentation of specific reasonable suspicion that he was secreting contraband. On the third day of the suicide watch, a mental health provider referred him to a mental health facility for advanced care. He was transferred when a bed became available, a week following referral. The detainee returned to SDC and was in general population for approximately one week before the second infraction for Making Sexual Proposals to an officer. During DE LA ROSA's three periods in segregation, status reviews were sometimes missed or late, and none document that he was interviewed.

At approximately 10:33 p.m. on July 10, 2018, the officer assigned to the RHU, Officer (b)(6); (b)(7)(C) observed DE LA ROSA hanging by socks from the upper bunk bed in his cell. Officer (b)(6); (b)(7)(C) made the discovery during his first security round, 28 minutes after he assumed the post. The detainee was presumably last seen alive at 8:40 p.m. by the officer on the previous shift, Officer (b)(6); (b)(7)(C). Although Officer (b)(6); (b)(7)(C) recorded security rounds at 9:13 p.m., 9:39 p.m. and 10:04 p.m., video evidence does not corroborate that he looked into the cell to personally observe detainee DE LA ROSA during any of these rounds.

Officer (b)(6); (b)(7)(C) immediately called a medical emergency when he observed detainee DE LA ROSA hanging. He did not enter the cell pending the arrival of additional security personnel, although facility policy allowed him to do so. Officer (b)(6); (b)(7)(C) was first to respond, leaving his post without being properly relieved, then retrieved a cut down tool from the RHU control center. Approximately two minutes after Officer (b)(6); (b)(7)(C) discovered detainee DE LA ROSA hanging, he

an (b)(7)(E) entered the cell, cut the detainee down, and Officer (b)(6); (b)(7)(C) began chest compressions.

The first nurse arrived in less than four minutes of the medical emergency call, although without AED, and immediately directed calling EMS. Other nurses and security staff rotated performance of chest compressions and once brought to the scene, the AED was applied and advised no shock. EMS responders arrived approximately eight minutes after DE LA ROSA's suicide was discovered, took over care, and transported him to a hospital 22 miles away. Detainee DE LA ROSA was pronounced dead at 11:29 p.m.

Incident reports were collected from all involved staff. Employee assistance services were offered to Officer N (b)(6); (b)(7)(C) but not to the officer who was in the ambulance and present when death was pronounced. Officer (b)(6); (b)(7)(C) stated he contacted the employee assistance program but did not receive a return call.

Compliance Findings

Creative Corrections cites the following deficiencies in relevant components of the ICE PBNDS 2011, 2016 revisions, governing safety and security.

Custody Classification System, section (V)(H)(3), which states, "Special Reclassification Assessments "Staff shall complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU), following an incident of abuse or victimization, and at any other time when warranted based upon the receipt of additional, relevant information, such as after a criminal act, or if a detainee wins a criminal appeal, is pardoned or new criminal information comes to light."

- A reclassification review was not completed within the 24 hours preceding DE LA ROSA's release from disciplinary segregation on April 18, 2018. A reclassification review factoring the disciplinary conviction was, however, conducted eight days earlier.

Disciplinary System, section (V)(A)(6), which states, "When a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior." Also, **Section (V)(A)(8)**, which states, "If a detainee has a mental disability or mental illness but is competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. A mental health professional should also be consulted as to whether certain types of sanctions, (e.g.,

placement in disciplinary segregation, loss of visits, or loss of phone calls) may be inappropriate because they would interfere with supports that are a part of the detainee's treatment or recovery plan."

- There is no documentation that a mental health professional was consulted prior to disciplinary hearings on April 6 and June 21, 2018, or that the hearing officer considered the degree to which DE LA ROSA's mental illness may have contributed to his behavior.

Disciplinary System, section (V)(H)(2), which states detainees in IDP proceedings have the right to due process which includes the right to "have an IDP hearing within 48 hours after the conclusion of the investigation or the conclusion of the UDC hearing." Also, section (V)(H)(4), setting requirements for the IDP. The component states, "In cases where a hearing is delayed, the reason(s) must be documented (e.g., a continuing investigation of facts, unavailability of one or more essential witnesses, etc.) and, unless the detainee has requested the delay, approved by the facility administrator."

- The investigation for the April 3, 2018 disciplinary incident was concluded at 10:52 a.m. on April 4, 2018. The IDP hearing commenced at 12:42 p.m. on April 6, 2018, more than 48 hours after the conclusion of the investigation. The hearing officer did not document the reason for the delay.

Searches of Detainees, section (V)(D)(2)(b), which states, "Staff may conduct a strip search where there is reasonable suspicion that contraband may be concealed on the person. 'Reasonable suspicion' means suspicion based on specific and articulable facts that would lead a reasonable officer to believe that a specific detainee is in possession of contraband. It is a more permissive (lower) standard than probable cause, but it is more than a mere hunch. It must be based on specific and articulable facts—along with reasonable inferences that may be drawn from those facts—that the officer shall document in Form G-1025 or equivalent."

- The form documenting the strip search of DE LA ROSA on April 24, 2018 states "Suicide Watch" and does not document the specific facts that led the officer to believe that detainee DE LA ROSA was in possession of contraband.

This also violates SDC RHU Post Orders, Section (III)(C)(1)(b), which states, "ICE detainees will not be strip searched unless there is 'reasonable suspicion' that the detainee is concealing a weapon or contraband, A frisk search shall be performed in lieu of a strip search."

Special Management Units, section (V)(A)(3)(a)(1) which states, "All facilities shall implement written procedures for the regular review of all detainees held in administrative segregation, consistent with the procedures specified below. A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. The review shall include an interview with the detainee." Also, section (V)(A)(3)(b), which states, "A supervisor shall conduct an identical review after the detainee has

spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter, at a minimum.”

- There is no documentation DE LA ROSA was interviewed during administrative segregation status reviews on April 26, 2018 and May 3, 2018.
- The May 3, 2018 status review was delinquent. Per the standard, it was due on May 1, 2018 after DE LA ROSA had been in segregation for seven days.

Special Management Units, section (V)(B), which states, “A detainee may be placed in disciplinary segregation only by order of the IDP, or its equivalent, after a hearing in which the detainee has been found to have committed a prohibited act and only when alternative dispositions may inadequately regulate the detainee’s behavior.”

- The orders placing DE LA ROSA in segregation on April 3 and June 19, 2018 documented his status was disciplinary segregation. The charges had not been adjudicated.

Special Management Units, section (V)(B)(3)(a), which states, “All facilities shall implement written procedures for the regular review of all disciplinary segregation cases, consistent with the following procedures: A security supervisor, or the equivalent, shall interview the detainee and review his/her status in disciplinary segregation every seven days to determine whether the detainee: 1) Abides by all rules and regulations; and, 2) Is provided showers, meals, recreation and other basic living standards, as required by this detention standard. b. The supervisor shall document his/her findings after every review, by completing a disciplinary segregation review (Form I-887).”

- There is no documentation DE LA ROSA was interviewed or reviewed during his placement in disciplinary segregation from April 6 to April 18, 2018.
- There is no documentation DE LA ROSA was interviewed during disciplinary segregation status reviews on June 22 and July 3, 2018.
- The July 3, 2018 status review was delinquent. Per the standard, it was due on June 29, 2018, seven days after the previous status review completed on June 22, 2018.

Special Management Units, section (V)(B)(3)(b)(1) and (2), which state, “All facilities shall implement written procedures for the regular review of all disciplinary segregation cases, consistent with the following procedures: The supervisor may recommend the detainee’s early release from the SMU upon finding time in disciplinary segregation is no longer necessary to regulate the detainee’s behavior. An early-release recommendation must have the facility administrator’s approval before the detainee may be returned to the general population.”

- On April 18, 2018, Security Chief Dethrow directed DE LA ROSA’s release to general population after he served 15 days of the first 30 day disciplinary segregation sanction. The early release is noted on the Confinement Record only, without documented rationale. Chief Dethrow did not complete a status review documenting interview of the detainee and a recommendation for early release based on determination disciplinary segregation was no longer necessary. In addition, facility administrator approval was not obtained. The

ICE detention standards do not address suspension of the balance of a disciplinary segregation sanction outside the status review process.

Special Management Units, section (V)(M), which states, “Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule.”

- Because logs were not available for April 4, April 17 or July 3, 2018, completion of 30 minute rounds could not be verified.
- On July 10, 2018, the day of the detainee’s suicide, Officer (b)(6); (b)(7)(C) logged security rounds at 9:13 p.m., 9:39 p.m. and 10:04 p.m. While the video footage shows him signing documents on the clipboard next to the detainee’s cell, he did not look in the cell to personally observe DE LA ROSA.

This also violates **SDC Restricted Housing Unit Post Orders, section (III)(B)(1)**, which states, “Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule”; and, **SDC Restricted Housing Unit Post Orders, section (III)(B)(1)(i)** which requires the observation of detainees during rounds to include, “looking in each cell to ensure that no unusual or unauthorized activities are occurring.”

Special Management Units, section (V)(D)(1), which states, “A permanent log shall be maintained in the SMU to record all activities concerning SMU detainees (e.g., meals served, recreational time, visitors, etc.).”

- There was no record of whether the lunch meal was served or refused on April 5, April 6, April 29, and June 22, 2018.

Special Management Units, section (V)(R), which states, “In accordance with standard “4.5 Personal Hygiene,” detainees in SMU may shave and shower at least three times weekly.”

- Confinement Activity Records document the detainee was not offered showers three times weekly during the weeks of April 1, April 8, April 15, and July 1, 2018.

This also violates SDC RHU Post Orders, section (III)(L)(5), which states, “Inmates/residents will be offered the opportunity to shower and shave at least three (3) times per week. In the event an inmate/resident refuses to shower for an entire one (1) week period, notify the Shift Supervisor/Unit Manager.”

- There is no documentation that a supervisor was notified when detainee DE LA ROSA did not shower during the period from April 3 to April 18, 2018.

The following additional violations of SDC policy are cited:

SDC Policy 9-13, Count Principles and Procedures, which states, “At shift change, the oncoming Correctional Officer will conduct an informal count of all inmates in his/her area of

responsibility”; and, **SDC RHU Post Orders, section (II)(G), Start of Shift** which states, “Verify that all cell doors and food tray slots are secure.”

- Officer (b)(6); [REDACTED] did not conduct a count or make a round to verify all cell doors and food tray slots were secure at the start of his shift at 10:00 p.m. on July 10, 2018. He did not make his first round until he had been on the post for 28 minutes.

SDC RHU Post Orders, Section (IV), which states, “Never leave your post for any reason unless properly relieved by an assigned officer or the Shift Supervisor.”

- Officer (b)(6); [REDACTED] left his post on two occasions between the hours of 10:00 p.m. and 10:40 p.m. on July 10, 2018.

Areas of Concern

The following expands upon above-cited deficiencies and identifies areas of concern not addressed in the detention standards.

- As noted in the above Disciplinary System deficiency, a mental health provider was not consulted prior to disciplinary hearings on April 6 and June 21, 2018. Reviewers acknowledge that DE LA ROSA’s mental illness was likely not known to security personnel at the time of the first hearing because patient diagnoses are confidential and per the medical record, he was asymptomatic. DE LA ROSA’s second hearing was conducted nine days following his return from psychiatric hospitalization, prior to which he was on suicide watch for ten days. If this information was known to the hearing officer, consultation with health care staff before proceeding with the disciplinary hearing was called for. Available evidence indicates DE LA ROSA was not, however, exhibiting signs of active mental illness after he returned from CRCC. If the hearing officer was unaware the detainee was on suicide watch for ten days and hospitalized at CRCC, the requirement to consult healthcare staff may not have been considered. Reviewers recommend that healthcare and security personnel review the standard and consider ways it may be met without violating patient confidentiality.
- DE LA ROSA submitted an incident statement dated April 21, 2018 in which he asked to be moved to segregation because his life was threatened by his cellmate. There is no documentation indicating when the statement was received or what action was taken pursuant to the claim. Absent a record of when DE LA ROSA’s statement was received, the date of submission must be assumed to be accurate. No action was taken for three days when a memorandum documents the detainee was placed on administration segregation status pending investigation for protective custody. The segregation order references both protective custody and placement on suicide watch per direction of healthcare staff, the latter status continuing until he was transferred to CRCC. Although placement on protective custody apparently overlapped with suicide watch, documentation relating to

protective custody was poor, including information explaining the three days delay following DE LA ROSA's request. If the detainee accurately dated his incident statement, three days to respond to the allegation that his life was threatened by his cellmate is excessive and put the detainee at risk. Reviewers recommend implementation of procedures that include documenting when requests are received, by whom, and actions taken. Reviewers also recommend prompt action when detainees allege they are at risk.

- As noted in above deficiencies, segregation reviews did not document interview of DE LA ROSA. While document review to assess the basis for continued segregation assignment and provision of mandated basic living conditions is important, so too is interviewing the detainee. Interviews are an additional welfare check, and allow the detainee the opportunity to confirm or refute that basic services are being provided. If the latter is alleged, further review of documentation would be called for. In DE LA ROSA's case, available evidence indicates he preferred to be segregated and except for showers and some meals, documentation reflects he was provided with mandated services.
- DE LA ROSA was last observed almost two hours before his suicide was discovered. As recognized by CoreCivic in terminating Officer (b)(6); (b)(7)(C) employment, failing to make security rounds is an egregious dereliction of duty, compounded by his false entries to the log. Officer (b)(6); (b)(7)(C) also failed to make a security round when he first assumed the post and instead, timed his first round based on Officer (b)(6); (b)(7)(C) last false entry before leaving. Conducting rounds in accordance with the standard and facility policy, specifically, verifying detainee welfare through direct observation at least every 30 minutes on an irregular schedule, serves a fundamental and critical safety and security purpose in restricted housing. Reviewers recommend retraining officers in conducting security rounds and periodic checks of video by supervisors to verify that officers are conducting rounds properly.
- After finding DE LA ROSA hanging and calling medical emergency, Officer (b)(6); (b)(7)(C) did not enter the cell until other officers arrived. As the reason, he said he was trained to not open a cell door in the RHU unless another officer is present. However, SDC policy does not mandate that at least two officers be present before cells are opened. In fact, the officer on the previous shift is seen on video opening cell doors without another officer present to allow cell occupants out for showers. Reviewers recommend review of the policy and retraining officers as to expectations.
- The Classification Supervisor did not review and approve the detainee's initial classification until 16 days after it was applied. The ICE detention standard does not set a specific timeframe for supervisory review, but does state that the purpose of the review is to check "for accuracy and completeness and ensure that each detainee is assigned to the appropriate housing unit." Although in this case, detainee DE LA ROSA's classification

and housing assignment were appropriate, the purpose of supervisory review cannot be achieved if review of classification decisions is not timely.

- There were multiple illegible signatures with no accompanying printed names on documents in the detention file. Absent legible names, accountability for actions and decisions cannot be ascribed. Reviewers recommend that persons who sign forms be required to also print their names and titles.

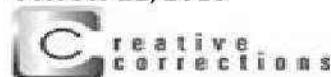
APPENDIX 1

Medical staff documented the following vital signs in DE LA ROSA's medical record. Per American Heart Association parameters, systolic blood pressure of 120 to 129 and diastolic blood pressure less than 80 signifies **Elevated blood pressure**; systolic blood pressure of 130 to 139 or diastolic blood pressure of 80 to 89 signifies **Stage One hypertension**; and systolic blood pressure of at least 140 or diastolic of at least 90 is **Stage Two hypertension**. Detainee DE LA ROSA's blood pressure was within parameters for Elevated blood pressure on six occasions, Stage One Hypertension on 21 occasions, and Stage Two on eight occasions.

DATE	TEMPERATURE	PULSE	RESPIRATIONS	BLOOD PRESSURE	WEIGHT
March 14, 2018	98.5	80	18	119/80	137
March 15, 2018	98.3	71	18	113/80	138
April 3, 2018	98.8	89	18	128/89	136
April 24, 2018	98.1	88	16	135/88	130
	98.6	92	18	123/78	130
April 25, 2018	98.7	85	16	132/87	130
	98.4	96	16	147/83	131
April 26, 2018	98.3	87	18	124/77	135
	98.2	88	18	137/88	135
	98.2	88	18	137/88	135
April 27, 2018	98.1	81	16	122/71	135
	98.6	97	18	148/90	135
	98.6	97	18	148/90	
	98.6	71	18	146/86	135
April 28, 2018	98.4	89	18	124/80	135
	98.4	89	18	124/80	135
	99.1	95	18	124/76	
April 29, 2018	98.6	100	16	124/79	135
	98.8	86	17	139/88	135
	98.8	90	17	139/88	135
	98.6	98	18	125/86	
April 30, 2018	97.8	83	16	145/88	135
	98.0	69	16	142/80	
	98.4	73	16	152/92	
May 1, 2018	98.4	81	18	139/81	135
	98.6	81	18	139/81	135
May 2, 2018	98.6	77	18	137/89	
	98.6	77	18	137/89	135
	98.8	98	16	128/88	
May 3, 2018	98.9	86	18	137/89	
	98.3	66	18	141/101	135

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	98.3	104	18	121/89	135
May 4, 2018	98.6	80	18	135/80	135
June 12, 2018	98.9	94	16	115/73	140
June 13, 2018	98.5	85	18	123/77	140
June 19, 2018	98.7	92	20	132/86	144

SYNOPSIS

On July 10, 2018, Efrain DE LA ROSA (DE LA ROSA), a forty-year-old citizen of Mexico, died while in custody of U.S. Immigration and Customs Enforcement (ICE) at the Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, Georgia (GA). DE LA ROSA's preliminary cause of death is self-induced strangulation. The Georgia Bureau of Investigation (GBI), Associate Medical Examiner, documented DE LA ROSA's cause of death as suicide by hanging.¹

DE LA ROSA was detained at Stewart Detention Center (SDC) in Lumpkin, GA, from March 13, 2018 until his death on July 10, 2018. SDC is a dedicated facility governed by an Intergovernmental Service Agreement, owned and operated by CoreCivic (CC), and is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011. ICE Health Services Corp (IHSC) provides medical care at SDC and is supported by contract company InGenesis; InGenesis subcontracts with STG International, Maxim Healthcare Services, Prestige Healthcare, and Akahi Associates to ensure adequate levels of care are provided at SDC. At the time of DE LA ROSA's death, SDC housed approximately 1,835 male detainees of all classification levels for periods in excess of 72 hours.

DETAILS OF REVIEW

From August 14 to 16, 2018, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited SDC to review DE LA ROSA's detention and the circumstances surrounding his death while in ICE custody. ERAU was assisted in its review by contract subject matter experts (SME) in correctional healthcare and security, who are employed by Creative Corrections, a national management and consulting firm.² As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to DE LA ROSA, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis (to include subcontractors), and ICE Office of Enforcement and Removal Operations (ERO) staff.

During the review, the ERAU review team took note of any deficiencies observed in the facility's compliance with the relevant detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in the report should not be construed in any way as indicating the deficiency contributed to the death of the detainee. ERAU determined the following timeline of events, from the time of DE LA ROSA's encounter with ERO, through his detention at SDC, and his eventual death at the SGRMC.

¹ See Exhibit 1: Georgia Bureau of Investigation, Division of Forensic Sciences Autopsy, Official Report, dated October 2, 2018.

² See Exhibit 2: Creative Corrections Detainee Death Review Healthcare and Security Analysis.

IMMIGRATION AND CRIMINAL HISTORY

In the year 2000, at an unknown date and time, DE LA ROSA claimed to have illegally entered the United States near the U.S.-Mexico border near Arizona, without being admitted or paroled by an immigration official.³

On July 8, 2004, the Circuit Court of Fairfax County, Virginia (VA), convicted DE LA ROSA of driving while intoxicated, sentenced him to 30 days' confinement⁴ and suspended his driver's license for 12 months.

On July 22, 2004, the Circuit Court of the City of Alexandria, VA, convicted DE LA ROSA of possession of burglary tools and sentenced him to two years' confinement, with the possibility of one and one-half years suspended for good behavior, and two years' probation.⁵

On August 30, 2004, the Circuit Court of the City of Alexandria, VA, convicted DE LA ROSA of carjacking and sentenced him to 20 years' confinement, with the possibility of 12 years suspended for good behavior, and five years' probation.⁶

On October 13, 2004, the Circuit Court of Fairfax County, VA, convicted DE LA ROSA of carjacking and sentenced him to 15 years' confinement, with the possibility of nine years and six months suspended for good behavior, and five years' probation.⁷

On October 25, 2004, the Circuit Court of Fairfax County, VA, convicted DE LA ROSA of receiving stolen property, and sentenced him to six months' confinement and six months' supervised probation.⁸

On November 22, 2004, the Commonwealth of Virginia Department of Corrections (VADOC) booked DE LA ROSA into the Alexandria City Jail.⁹

On December 6, 2004, the Fairfax County General District Court, Fairfax, VA, convicted DE LA ROSA of escape without force and sentenced him to 30 days' confinement with 30 days suspended.¹⁰

³ See Enforce Alien Removal Module (EARM) Narrative, dated May 10, 2017.

⁴ Initially, the Circuit Court of Fairfax County suspended all 30 days of the jail sentence, contingent upon his good behavior for one year. On February 10, 2005, the Circuit Court of Fairfax County determined DE LA ROSA violated the terms of his release and ordered him to serve the remainder of his previous 30 days' confinement. See Circuit Court of Fairfax County Final Order, dated February 10, 2005.

⁵ See Circuit Court of the City of Alexandria Sentencing Summary, dated October 1, 2004.

⁶ See Circuit Court of the City of Alexandria Sentencing Summary, dated October 29, 2004.

⁷ See Circuit Court of Fairfax County Sentencing Order, dated January 11, 2005.

⁸ See Circuit Court of Fairfax County Sentencing Order, dated January 7, 2005.

⁹ See Commonwealth of Virginia Department of Corrections DE LA ROSA Transfer Dates Report, dated November 22, 2004 - July 11, 2018.

¹⁰ See United States Department of Justice Criminal Record, dated February 9, 2018.

On January 11, 2005, VADOC transferred DE LA ROSA from Alexandria City Jail to Fairfax County Adult Detention Center. From this date through January 15, 2013, VADOC transferred DE LA ROSA to five separate facilities.¹¹

On January 15, 2013, VADOC transferred DE LA ROSA to Marion Correctional Treatment Center (MCTC).¹²

On April 5, 2017, ERO Washington encountered DE LA ROSA at the Virginia Department of Behavioral Health and Developmental Service (DBHDS), MCTC,¹³ pursuant to a referral from the VADOC. The DBHDS detained DE LA ROSA at MCTC as he suffered from schizophrenia and was found to be mentally incompetent and was therefore unable to participate in his criminal proceedings.¹⁴

On August 29, 2017, ERO Washington issued DE LA ROSA a Notice to Appear, Form I-862, charging removability pursuant to Sections 212(a)(6)(A)(i),¹⁵ 212(a)(2)(A)(i)(I),¹⁶ and 212(a)(2)(B)¹⁷ of the Immigration and Nationality Act (INA).¹⁸

On September 8, 2017, ERO Washington lodged an Immigration Detainer – Notice of Action, Form I-247A, with the MCTC; however, on this same date, based on the recommendation of the Washington ICE Office of Chief Counsel (OCC), ERO Washington lifted the detainer pursuant to 8 CFR 236.2(b).¹⁹

On September 11, 2017, MCTC released DE LA ROSA.²⁰

On February 9, 2018, a designated immigration officer (DIO) from the Wake County 287(g) program encountered DE LA ROSA at the Wake County Detention Center (WCDC) in Raleigh, North Carolina (NC), following his arrest for larceny. The DIO lodged a Form I-247A with the WCDC.²¹

¹¹ See Commonwealth of Virginia Department of Corrections DE LA ROSA Transfer Dates Report, dated November 22, 2004 - July 11, 2018.

¹² *Id.*

¹³ MCTC is a behavioral health unit (BHU) licensed for acute care, outpatient, and residential mental health services. It houses male offenders determined in need of care outside the scope of services available in prisons.

¹⁴ See EARM Narrative, dated May 10, 2017; See ICE Significant Incident Report, dated July 11, 2018.

¹⁵ An alien present in the United States without being admitted or paroled, or who arrived in the United States at any time or place other than as designated by the Attorney General.

¹⁶ An alien who has been convicted of, or who admits having committed, or who admits committing acts which constitute the essential elements of a crime involving moral turpitude (other than a purely political offense) or an attempt or conspiracy to commit such a crime.

¹⁷ An alien who has been convicted of two or more offenses (other than purely political offenses) for which the aggregate sentences to confinement were five years or more.

¹⁸ See DHS Form I-862, Notice to Appear, dated August 29, 2017.

¹⁹ An alien confined due to mental instability in an institution shall not be accepted into physical custody by the service until an order of removal has been entered. See ICE Significant Incident Report, dated July 11, 2018.

²⁰ See Commonwealth of Virginia Department of Corrections DE LA ROSA Transfer Dates Report, dated November 22, 2004 - July 11, 2018.

²¹ See DHS Form I-247A, Immigration Detainer – Notice of Action, dated February 9, 2018.

On March 9, 2018, the Wake County District Court in Raleigh, NC, convicted DE LA ROSA of larceny and sentenced him to 28 days' confinement with 28 days' credit for time served.²²

On March 12, 2018, WCDC released DE LA ROSA to the custody of ERO Atlanta.²³

On March 13, 2018, ERO Atlanta transferred DE LA ROSA to SDC.²⁴

On March 22, 2018, the Atlanta OCC filed a motion with the Executive Office for Immigration Review (EOIR) to change the venue of DE LA ROSA's removal proceedings from Arlington, VA, to Lumpkin, GA.²⁵ On this same date, the ICE Office of the Principal Legal Advisor (OPLA) submitted a request for mental health reviews with IHSC.²⁶

On April 18, 2018, EOIR granted the motion for a change of venue.²⁷

On June 28, 2018, IHSC provided OPLA with DE LA ROSA's medical records, which indicated a history of schizophrenia. On this same date, Atlanta OCC filed a motion for consideration of medical/mental health records with EOIR.²⁸

On July 3, 2018, an Immigration Judge in Lumpkin, GA, ordered DE LA ROSA removed from the United States to Mexico.²⁹

NARRATIVE

On March 13, 2018, at approximately 1:07 p.m.,³⁰ SDC admitted DE LA ROSA. At an unknown time, Officer (b)(6); (b)(7)(C) completed DE LA ROSA's initial ICE Custody Classification Worksheet and appropriately classified DE LA ROSA as high; a supervisor did not approve the classification until March 29, 2018.³¹

At 10:55 p.m.,³² (b)(6); (b)(7)(C), Registered Nurse (RN), completed DE LA ROSA's pre-screening and documented DE LA ROSA denied having any current health problems or taking any medications.³³ RN (b)(6); (b)(7)(C) also noted that DE LA ROSA appeared alert, with normal

²² See Raleigh/Wake City-County Bureau of Identification Criminal Disposition Inquiry, dated March 11, 2018.

²³ See EARM Custody Actions & Decisions, dated March 12, 2018.

²⁴ See EARM Custody Actions & Decisions, dated March 13, 2018.

²⁵ See Department of Justice EOIR Immigration Court, Motion to Change Venue, dated March 22, 2018.

²⁶ See IHSC, OPLA Request for Medical Records, dated March 22, 2018.

²⁷ See ICE Significant Incident Report, dated July 11, 2018.

²⁸ See DHS Motion for Consideration of Medical/Mental Health Records, dated June 28, 2018.

²⁹ See Order of the Immigration Judge, July 3, 2018.

³⁰ See Inmate Information Sheet, dated March 13, 2018.

³¹ See ICE Custody Classification Assessment, dated March 13, 2018. ERAU notes Officer (b)(6); (b)(7)(C) omitted any notes regarding special vulnerabilities (i.e., mental illness) on the assessment form.

³² ERAU approximated timing of medical events as best as possible. Medical times catalogued within the report are prioritized based on the time medical staff indicated a round time, vital signs, or electronically signed their note.

³³ See eClinicalWorks (eCW) Progress Note by RN (b)(6); (b)(7)(C) dated March 13, 2018. RN (b)(6); (b)(7)(C) Progress Note documented DE LA ROSA's time of arrival as 10:30 p.m., which is inconsistent with the Inmate Information Sheet.

behavior and appearance, and exhibited no noticeable restrictions or difficulties in movement or breathing.

On March 14, 2018, at 1:51 a.m.,³⁴ Officer (b)(6); (b)(7)(C) booked DE LA ROSA into SDC.³⁵

At 2:45 a.m., RN (b)(6); (b)(7)(C) completed DE LA ROSA's medical and mental health screening and documented the following:³⁶

- RN (b)(6); (b)(7)(C) conducted the screening in the detainee's native language of Spanish, although DE LA ROSA reported he spoke fluent English.
- DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 119/80.³⁷
- DE LA ROSA disclosed a history of drug (cocaine), alcohol, and tobacco use, with last consumption in January 2018, December 2017, and February 2018, respectively.
- DE LA ROSA reported feeling good and denied pain, medical or dental problems, withdrawal or tuberculosis (TB) symptoms.
- DE LA ROSA stated that while incarcerated in Virginia, the MCTC treated him for schizophrenia.³⁸ DE LA ROSA also reported taking eight different medications but stated he ceased use approximately three months before he arrived at SDC because he could not sleep.
- In response to the question, "Do you ever hear voices that others do not hear?" DE LA ROSA responded he hears God talk to him.
- In response to the question, "Do you believe someone can control your mind?" DE LA ROSA stated, "No, only God."
- DE LA ROSA appeared to have normal speech, comprehension, focus, physical characteristics, and emotional attributes.
- DE LA ROSA arrived with a Transfer Summary³⁹ from WDCD, discussed below.

³⁴ It is unknown why the booking time differs from the March 13, 2018, 1:07 p.m. admission time noted on Inmate Information Sheet.

³⁵ See Detainee Commitment Summary, dated March 14, 2018.

³⁶ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated March 14, 2018.

³⁷ A normal temperature is considered 98.6; the normal range for a pulse is 60 to 100 beats per minute; the normal range for respirations is 12 to 20 breaths per minute; and, a normal blood pressure is 120/80 or less. According to the American Heart Association (AHA), this blood pressure reading indicates stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or a diastolic reading of 80 to 89.

³⁸ Schizophrenia is a chronic mental health disorder that affects how a person thinks, feels, and behaves, often losing touch with reality. It is characterized by possible auditory and visual hallucinations (apparent perception of something not present), delusions (belief that is firmly maintained despite being contradicted by reality), depression, self-harm and harm to others.

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³⁹ See WDCD Medical Summary (4 pages), reviewed by RN (b)(6); (b)(7)(C) March 13, 2018.

According to the WDC Transfer Summary,⁴⁰ DE LA ROSA was not currently taking medication and per a purified protein derivative (PPD)⁴¹ test completed on February 10, 2018, was negative for TB. The Problem List⁴² included seven items; legible entries included a scar to the dorsal⁴³ side of the right hand, prior incarceration in the VADOC, and schizophrenia.

Based on her findings, RN (b)(6); (b)(7)(C) documented the following:⁴⁴

- The mental health screening was negative for suicidal or homicidal ideation.
- RN (b)(6); (b)(7)(C) explained the TB test and chest x-ray to DE LA ROSA and completed the process with appropriate shielding.⁴⁵
- As DE LA ROSA had an abnormal intake screening, the RN referred him to a medical provider.
- RN (b)(6); (b)(7)(C) cleared DE LA ROSA for custody.

ERAU notes that during DE LA ROSA's first detention period at SDC, medical staff did not obtain a signed IHSC Medical Consent Form for general treatment from DE LA ROSA.

At 4:50 a.m., Office (b)(6); (b)(7)(C) completed a risk classification assessment and documented answers of "No" to all questions.⁴⁶ At 10:02 a.m., SDC assigned DE LA ROSA to general population unit 6, pod A, cell 110.⁴⁷

On March 15, 2018, at 9:30 a.m. (b)(6); (b)(7)(C) Nurse Practitioner (NP), conducted DE LA ROSA's initial physical assessment, and documented the following:⁴⁸

- DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 113/80.
- DE LA ROSA denied a history of chronic medical conditions and dental problems.
- DE LA ROSA reported a history of schizophrenia and hospitalization for the disease in 2004 and 2010.
- DE LA ROSA could not recall the names of his past medications and stated he ceased use of them after informing a doctor in NC that he could not sleep.

⁴⁰ *Id.*

⁴¹ A PPD skin test is a solution injected into the skin to determine whether a person has been infected with tuberculosis.

⁴² A Problem List is a running list of a patient's medical problems. Problem Lists are maintained in the medical record to support continuity of care during patient encounters.

⁴³ Dorsal refers to the top side.

⁴⁴ See eCW Progress Note by (b)(6); (b)(7)(C) RN, dated March 14, 2018.

⁴⁵ ERAU notes the SDC medical record was void of a chest x-ray report. Creative Corrections advised if completed, the reason is unclear as the WDC Transfer Summary documented TB clearance through PPD testing just one month earlier and the ICE PBNDS 2011 standard, *Medical Care*: TB Management states, "For detainees that have been in continuous law enforcement custody, symptom screening plus documented TB screening within one year of arrival may be accepted for intake screening purposes."

⁴⁶ See Assessment Questionnaire Form: Initial Screening Tool, dated March 14, 2018. The assessment questionnaire is utilized to screen for victimization and predatory history/risk, among other factors to be considered when evaluating housing options for a detainee.

⁴⁷ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

⁴⁸ See eCW Progress Note by (b)(6); (b)(7)(C), dated March 15, 2018.

- DE LA ROSA again stated hearing voices from God, the last time in September 2017.
- DE LA ROSA denied suicidal or homicidal ideations.
- DE LA ROSA was not currently exhibiting symptoms of a serious mental disorder or cognitive impairment.

NP (b)(6) advised DE LA ROSA to continue daily activities even if he did not feel like it, regularly exercise, and notify an officer or nurse if he started having thoughts of harming himself or others or hearing voices.⁴⁹ Additionally, (b)(6); (b)(7)(C) referred DE LA ROSA to mental health. (b)(6); (b)(7)(C) Clinical Director, co-signed the note on March 17, 2018.

On March 16, 2018, at 5:25 p.m., IHSC (b)(6); (b)(7)(C) psychologist, signed off on a mental health assessment conducted pursuant to NP (b)(6); (b)(7)(C) referral and documented the following:⁵⁰

- (b)(6); (b)(7)(C) conducted the assessment in English.
- During discussion of his past schizophrenia diagnosis, DE LA ROSA adamantly denied suicidal or homicidal ideations, gestures, or plan.
- DE LA ROSA mentioned God told him he would speak in the lands of Israel, Iraq, and “Arabia” and would go to Heaven in the future.
- DE LA ROSA reported a history of drugs and alcohol.
- DE LA ROSA reported a conviction of driving under the influence of alcohol and going to prison in 2004, and then to a mental health prison years later.
- DE LA ROSA stated he had friends to talk to for support, including his brother, and that he speaks to God.
- (b)(6); (b)(7)(C) described DE LA ROSA as appropriately dressed and future-oriented.
- (b)(6); (b)(7)(C) also noted DE LA ROSA showed no abnormalities in psychomotor activity or body movement and his affect,⁵¹ mood, speech, insight, thought content, and judgement were normal.

(b)(6); (b)(7)(C) determined there were no current symptoms of a serious mental disorder or condition, but in the treatment section of the notes, he listed treatment planning and supportive psychotherapy intervention. The plan included multiple elements that focused on DE LA ROSA’s general wellness, coping and stress management skills, and direction/understanding that he would notify staff if he had any issues or felt unsafe with himself. (b)(6); (b)(7)(C) documented discussing this plan with DE LA ROSA, who verbalized understanding and agreed to follow the plan. (b)(6); (b)(7)(C) discussed information on progressive muscle relaxation, meditation, and positive thinking; DE LA ROSA stated he would use the techniques when necessary. (b)(6); (b)(7)(C) also noted staff scheduled DE LA ROSA for a psychiatry evaluation and a mental health follow-up. DE LA ROSA consented to receiving tele-psychiatry services.⁵²

⁴⁹ *Id.*

⁵⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated March 16, 2018.

⁵¹ Affect refers to the emotional tone a person expresses, which can be appropriate or inappropriate in relationship to the situation.

⁵² See IHSC Consent to Receive Tele-Psychiatry Services (Form 792), dated March 16, 2018.

On April 3, 2018, at 5:45 p.m., Officer (b)(6); (b)(7)(C) reported to Case Counselor (b)(6); (b)(7)(C) and Unit Manager (b)(6); (b)(7)(C) that DE LA ROSA exhibited inappropriate behavior towards her.⁵³ Security staff removed DE LA ROSA from the pod and Unit Manager (b)(6); (b)(7)(C) instructed him to stop making inappropriate comments to staff; however, DE LA ROSA did not comply. Unit Manager (b)(6); (b)(7)(C) recalled that she counseled DE LA ROSA regarding his actions after (b)(7)(E) reported to her that DE LA ROSA was being inappropriate. When DE LA ROSA failed to listen, Unit Manager (b)(6); (b)(7)(C) instructed the officers to submit their reports.⁵⁴ Officer (b)(6); (b)(7)(C) and the second officer, Officer (b)(6); (b)(7)(C) proceeded to document their separate interactions with DE LA ROSA.⁵⁵ Officer (b)(6); (b)(7)(C) completed an Incident of Prohibited Acts and Notice of Charges document and cited DE LA ROSA for Making Sexual Proposals or Threats.⁵⁶ Subsequently, Shift Supervisor (b)(6); (b)(7)(C) ordered DE LA ROSA's placement in disciplinary segregation.⁵⁷

At 8:20 p.m., (b)(6); (b)(7)(C) RN, completed DE LA ROSA's segregation clearance assessment.⁵⁸ RN (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 128/89. RN (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal or homicidal ideations and visual or auditory hallucinations. RN (b)(6); (b)(7)(C) also noted DE LA ROSA did not appear to have any acute or unresolved medical conditions which might worsen in segregation. RN (b)(6); (b)(7)(C) educated DE LA ROSA on how to access medical, mental, and dental care while in segregation and cleared him for housing.

At 8:52 p.m., security staff placed DE LA ROSA into restricted housing unit (RHU)⁵⁹ Pod 7A, cell 205.⁶⁰ Security staff created and accurately completed the Confinement Activity Record (CAR)⁶¹ and Confinement Watch Log (CWL)⁶² for this date.⁶³

At 10:15 p.m., RN (b)(6); (b)(7)(C) submitted a telephone encounter to the Mental Health Unit stating she cleared DE LA ROSA for housing in segregation.⁶⁴

⁵³ See Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2018.

⁵⁴ ERAU interview with Unit Manager (b)(6); (b)(7)(C) dated August 15, 2018.

⁵⁵ See Incident Statement by Officer (b)(6); (b)(7)(C) and Incident Statement by Officer (b)(6); (b)(7)(C) dated April 3, 2018.

⁵⁶ See Incident of Prohibited Acts and Notice of Charges, dated April 3, 2018.

⁵⁷ See Confinement Record, dated April 3, 2018.

⁵⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 3, 2018.

⁵⁹ The SDC RHU is a special management unit (SMU) as defined in the ICE detention standards.

⁶⁰ See Cellmate Housing History Report, dated March 13, 2018 – May 4, 2018.

⁶¹ The CAR is a multi-purpose form posted on a clipboard outside each cell within segregation and details which meals, recreation, visits, and other activities the detainee partook in that day. RNs also sign this record during their rounds.

⁶² As SDC does not have an electronic system for recording rounds, officers manually record the time of their rounds on the CWL. Additionally, each shift supervisor is required to sign the form, and RNs are required to document the time of their rounds, as well as morning, noon, and/or evening delivery of medication, when applicable.

⁶³ ERAU notes during DE LA ROSA's placements in segregation, multiple CARs and CWLs were void of entries or signatures, or were missing altogether. ERAU identifies missing records within the narrative, while Appendix 1 documents specifics regarding refused activities and meals recorded on DE LA ROSA's CARs during his placements in segregation.

⁶⁴ See Telephone Encounter by RN (b)(6); (b)(7)(C) dated April 3, 2018.

On April 4, 2018, at 10:43 a.m., Sergeant (Sgt.) (b)(6); (b)(7)(C) initiated an investigation related to DE LA ROSA's offense.⁶⁵ Sgt. (b)(6); (b)(7)(C) interviewed DE LA ROSA, during which he admitted to the offenses charged. Sgt. (b)(6); (b)(7)(C) noted referral to the Institution Disciplinary Panel (IDP).⁶⁶ At 10:48 a.m., (b)(6); (b)(7)(C) issued DE LA ROSA his Detainee Rights at the IDP Hearing,⁶⁷ which DE LA ROSA signed as having received.⁶⁸

At 11:27 a.m., (b)(6); (b)(7)(C) RN, completed an initial segregation round.⁶⁹ For questions related to thoughts of suicide, medical complaints or requests, and referral for health care services, RN (b)(6); (b)(7)(C) made no changes to the pre-populated answers of "No." Additionally, the pre-populated segregation evaluation template language remained unedited in the Examination section. Therefore, RN (b)(6); (b)(7)(C) entry failed to include subjective findings reflecting an individualized assessment of DE LA ROSA.⁷⁰

ERAU further notes that during DE LA ROSA's multiple segregation placements, RNs completed daily medical segregation rounds but all entries contained the same template language with no supplemental information reflecting an individualized assessment of the detainee.⁷¹

At 3:17 p.m., (b)(6); (b)(7)(C) Licensed Clinical Social Worker (LCSW), signed off on DE LA ROSA's clinical segregation assessment pursuant to RN (b)(6); (b)(7)(C)'s referral and documented the following:⁷²

- DE LA ROSA's thoughts, mood, and affect were consistent with previous reports.
- DE LA ROSA stated he was fine and adjusting well to being in segregation.
- DE LA ROSA denied having suicidal and homicidal ideations, intent, or plan.
- DE LA ROSA's dress was appropriate and his grooming and hygiene were adequate.

⁶⁵ See Investigation Report, dated April 4, 2018. Sgt. Haynes concluded the investigation at 10:52 a.m.

⁶⁶ An IDP is a higher-level disciplinary panel that adjudicates detainee incident reports. The panel is comprised of either three individuals appointed by the facility administrator or one single disciplinary hearing officer.

⁶⁷ See Detainee Rights at the IDP Hearing, dated April 4, 2018.

⁶⁸ See Incident of Prohibited Acts and Notice of Charges, dated April 3, 2018.

⁶⁹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 4, 2018. ERAU notes RN (b)(6); (b)(7)(C) did not sign his note until April 9, 2018, at 8:23 a.m., five days after the round. Although ERAU did not interview RN (b)(6); (b)(7)(C) regarding this delay, during RN (b)(6); (b)(7)(C) interview on August 16, 2018, she explained nurses handwrite their notes during rounds and enter them in eCW following return to the clinic. She further stated, although nurses are expected to make all entries prior to the end of their shift, occasionally some are missed.

⁷⁰ Per IHSC Directive 03-06, Health Evaluation of Detainees in Special Management Units, Section 5.2: On-going Medical Rounds in the SMU, "(a) The RN or medical provider conducts daily rounds in the SMU; (b) The RN or medical provider queries each individual regarding medical, dental and behavioral health concerns or requests. Particular consideration is given to the possibility of suicidal ideations or attempts; and (c) The RN or medical provider documents the medical rounds in the SMU log book and in the patient's health record. The progress note is in the SOAP (Subjective, Objective, Assessment, Plan) format and summarizes the patient's disposition (to include whether the patient is stable; has no medical or psychiatric concerns voiced or homicidal or suicidal plan or intent; and if the patient will continue to receive monitoring daily while in the SMU)."

⁷¹ Unless a significant event occurred related to a daily medical segregation round, completion of medical segregation rounds and the use of template language are not discussed further within the report.

⁷² See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 4, 2018. LCSW (b)(6); (b)(7)(C) utilized SOAP format within her note.

- DE LA ROSA was receiving mental health treatment by way of talk therapy.⁷³
- LCSW (b)(6); (b)(7)(C) instructed and reminded DE LA ROSA of the process to request mental health services if he had any issues.

LCSW (b)(6); (b)(7)(C) noted mental health providers were to follow up on a weekly basis, continue to monitor, and report any changes. LCSW (b)(6); (b)(7)(C) determined DE LA ROSA did not meet serious mental illness (SMI) criteria; therefore, he was stable enough to remain in segregation.⁷⁴ IHSC Lieutenant (Lt.) Commander (LCDR (b)(6); (b)(7)(C)) LCSW, co-signed the note on April 19, 2018, concurring with LCSW (b)(6); (b)(7)(C) conclusions regarding SMI and segregation. LCSW (b)(6); (b)(7)(C) further recommended continuity of care needs as medically indicated to address coordination of chronic care management.

SDC was unable to produce a CWL for this date.

On April 5, 2018, at an unknown time, SDC security staff issued DE LA ROSA a Notice of IDP Hearing with a documented hearing date of April 6, 2018.⁷⁵

On April 6, 2018, at 12:42 p.m., the IDP conducted a disciplinary hearing at which DE LA ROSA again admitted to making inappropriate statements.⁷⁶ The IDP sentenced DE LA ROSA to 30 days of segregation; Shift Supervisor (b)(6); (b)(7)(C) first name unknown) signed off on the sanction the same day.⁷⁷ Assistant Shift Supervisor (b)(6); (b)(7)(C) (first name unknown) delivered a copy of the IDP Report to DE LA ROSA three days later.⁷⁸

On April 10, 2018, at an unknown time, Office (b)(6); (b)(7)(C) completed a special classification review using the ICE Custody Classification Worksheet.⁷⁹ Office (b)(6); (b)(7)(C) added

⁷³ Talk therapy, also referred to as psychotherapy, involves an encounter by a mental health professional to help patients cope with their feelings, problem solve, and change behavior patterns that might contribute to their symptoms.

⁷⁴ IHSC Directive 07-05, *Serious Mental Disorders or Conditions*, states, “Detainees with SMI need to be monitored closely to ensure consistent and adequate care. The Behavioral Health Unit at IHSC Headquarters monitors detainees with significant psychiatric impairments. The Behavioral Health Provider (BHP) at the facility completes and submits a weekly report to BHU for notification and continued monitoring of their seriously mentally ill detainees. SMI determination is based on significant psychiatric impairment of the detainee. The detainee must meet one or more of the following criteria based on the evaluation completed by the mental health care provider: (a) One or more active psychiatric symptoms: disorganization of thought or behavior, active hallucinations or delusions, catatonia, severe depressive symptoms, suicidal ideation, homicidal ideation, severe exacerbation of manic symptoms and marked anxiety and impulsivity; (b) History of more than two psychiatric hospitalization in the past three months and still presenting moderate to severe symptoms; (c) Presently taking psychiatric medications and still presenting active moderate to severe symptoms; (d) Continues to display harm to self or others in spite of psychiatric treatment and/or psychiatric hospitalizations; and (e) Serious limitations in mental functioning (communicating, taking care of activities of daily living, social skill, etc.) due to mental disability or severe medical conditions impairing mental function i.e. dementia or traumatic brain injury.”

⁷⁵ See Notice of IDP Hearing, dated April 5, 2018.

⁷⁶ See IDP Report, dated April 6, 2018.

⁷⁷ *Id.*; see also Disciplinary Segregation Order, dated April 6, 2018.

⁷⁸ See IDP Report, dated April 9, 2018.

⁷⁹ See ICE Custody Classification Assessment, dated April 10, 2018.

two additional points for the disciplinary infraction, maintaining the current classification level of high; a supervisor approved the classification the next day.

On April 11, 2018, at 11:46 a.m., IHSC (b)(6); (b)(7)(C) LCSW, completed the weekly mental health segregation round.⁸⁰ LCSW (b)(6); (b)(7)(C) noted that she perceived DE LA ROSA to be calm, cooperative, and with no suicidal or homicidal potential. LCSW (b)(6); (b)(7)(C) utilized the eCW Clinical Segregation Assessment checklist and determined DE LA ROSA did not meet SMI criteria. LCSW (b)(6); (b)(7)(C) co-signed the note on April 19, 2018, and noted concurrence with LCSW (b)(6); (b)(7)(C) conclusions regarding SMI.

On April 13, 2018, in accordance with the ICE PBNDS 2011, a security supervisor or equivalent was due to conduct an interview with DE LA ROSA as part of a seven-day review of his status in disciplinary segregation. There is no record in DE LA ROSA's detention file indicating the review occurred.

On April 16, 2018, at approximately 12:00 p.m., LCSW (b)(6); (b)(7)(C) documented a mental health follow-up.⁸¹ LCSW (b)(6); (b)(7)(C) noted that DE LA ROSA denied auditory or visual hallucinations and stated he only hears the voice of God; he denied thoughts of self-harm and any content that was commanding, threatening or stressful in nature. DE LA ROSA also stated he began to hear voices in 2005 while in prison, and that the voices give him peace because they are there with him. DE LA ROSA refused evaluation for medication stating he did not need medication and signed a refusal form.⁸² The refusal form included standard language concerning the potential health consequences of refusing treatment or procedure and a hand-written note from LCSW (b)(6); (b)(7)(C) explaining the consequences of his refusal.

LCSW (b)(6); (b)(7)(C) determined DE LA ROSA was not a danger to himself or others. ERAU notes LCSW (b)(6); (b)(7)(C) did not utilize the eCW Clinical Segregation Assessment checklist; therefore, she did not complete the data checklist that specifically addressed whether DE LA ROSA met SMI criteria. LCSW (b)(6); (b)(7)(C) note also did not include any change to DE LA ROSA's current treatment plan and on April 25, 2018, (b)(6); (b)(7)(C) documented confirmatory sign-off of LCSW (b)(6); (b)(7)(C) pte without further comment.

SDC was unable to produce a CWL for **April 17, 2018**.

On April 18, 2018, at 10:58 a.m., LCSW (b)(6); (b)(7)(C) signed off on a mental health segregation round⁸³ and noted that DE LA ROSA presented in a calm manner with no signs of ineffective coping or acute emotional distress. LCSW (b)(6); (b)(7)(C) utilized the eCW Clinical Segregation Assessment checklist and determined DE LA ROSA did not meet SMI criteria. LCSW (b)(6); (b)(7)(C)

⁸⁰ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 11, 2018.

⁸¹ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 16, 2018. LCSW (b)(6); (b)(7)(C) electronically signed the note on April 17, 2018, but included a comment stating the encounter was a late entry and occurred on April 16, 2018. ERAU concluded the encounter occurred around 12:00 p.m. as the refusal form documents this time.

⁸² See Refusal Form, dated April 16, 2018. The form was signed by LCSW (b)(6); (b)(7)(C) and witnessed by LCSW (b)(6); (b)(7)(C).

⁸³ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 18, 2018.

made no change to DE LA ROSA's assessment or treatment plan; there was no confirmatory sign-off by another provider on the note.⁸⁴

At 6:10 p.m., SDC transferred DE LA ROSA to general population unit 7B, cell 113.⁸⁵ Neither the Confinement Record nor the Disciplinary Segregation Order forms provided specific reasoning as to why SDC released DE LA ROSA 15 days into his 30 days of disciplinary segregation.⁸⁶ According to the Confinement Record, which he signed two days later, Security Chief (b)(6); (b)(7)(C) ordered DE LA ROSA's release from segregation, but no documentation provided supports that the facility administrator approved the early release.⁸⁷ Furthermore, security staff did not complete a special re-classification for DE LA ROSA within 24 hours prior to his release from segregation.⁸⁸

On this date, DE LA ROSA's medical record included an initial psychiatry appointment progress note by (b)(6); (b)(7)(C) but the contents of the note were blank.⁸⁹ (b)(6); (b)(7)(C) did not sign her note until July 19, 2018, nine days after DE LA ROSA's death. As discussed later in the report, the next time a prescribing mental health provider assessed DE LA ROSA was on April 24, 2018, during an initial suicide risk assessment.

On April 19, 2018, at 12:41 p.m., SDC transferred DE LA ROSA to unit 5B, cell 212, where he remained until facility staff placed him in protective custody on April 24, 2018.⁹⁰

On April 21, 2018, DE LA ROSA dated an incident statement, completed in Spanish with his name at the top but unsigned, which requested transfer to another cell as he alleged his cellmate told him he was going to kill him.⁹¹ There is no response or follow-up action from SDC documented on the form. According to the SDC Cellmate Housing History record, DE LA ROSA had one cellmate on this date, who SDC moved on April 23, 2018.⁹²

⁸⁴ ERAU notes although the ICE PBNDS 2011 Standards and IHSC or SDC policy do not require confirmatory sign-offs by another provider in these instances, observations related to a confirmatory sign-off, or the lack of one, are detailed within the report for consistency purposes. Furthermore, Creative Corrections advised that review and sign-off by another mental health professional supports quality mental health and suicide prevention management.

⁸⁵ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

⁸⁶ See Confinement Record, dated April 3, 2018; See Disciplinary Segregation Order, dated April 6, 2018.

⁸⁷ See Confinement Record, dated April 3, 2018. In accordance with the ICE PBNDS 2011 Standard, *Security Management Units*, Section (V)(B)(3), "The supervisor may recommend the detainee's early release from the SMU upon finding time in disciplinary segregation is no longer necessary to regulate the detainee's behavior; an early release recommendation must have the facility administrator's approval before the detainee may be returned to the general population."

⁸⁸ In accordance with the ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3), "Staff shall complete a special reclassification within 24 hours before a detainee leaves the SMU..."

⁸⁹ See eCW Progress Note by (b)(6); dated April 18, 2018.

⁹⁰ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

⁹¹ See Incident Statement, dated April 21, 2018. Multiple other areas on the form were void of information, to include answers to injury and medical questions.

⁹² See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018.

On April 24, 2018, at 10:23 a.m., SDC re-assigned DE LA ROSA to RHU pod 7A, cell 201, pending investigation for protective custody.⁹³ At approximately 10:51 a.m.,⁹⁴ Commander (b)(6); (b)(7)(C) Psychiatric Mental Health Nurse Practitioner (PMHNP), conducted a mental health assessment and noted the reason for the assessment was auditory hallucinations.⁹⁵ PMHN (b)(6); (b)(7)(C) documented the following:

- DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 135/88.
- DE LA ROSA was calm, cooperative, and fully oriented, and his affect was broad but with some inappropriate laughter⁹⁶ at times.
- DE LA ROSA had no loose associations⁹⁷ or flight of ideas.⁹⁸
- DE LA ROSA made multiple statements about being the Antichrist but also being filled with the Holy Spirit.
- DE LA ROSA stated he would be dead within three days, that he might die three times, and that he wanted to be alone and relax.
- DE LA ROSA denied low mood, anxiety, and suicidal or homicidal ideations, plans, or intent.
- DE LA ROSA declined medication treatment.

PMHN (b)(6); (b)(7)(C) requested LCSW (b)(6); (b)(7)(C) join the interview due to her previous encounters with DE LA ROSA (b)(6); (b)(7)(C) noted DE LA ROSA was vague in his responses but repeated the same statements about dying and being the Antichrist to LCSW (b)(6); (b)(7)(C) PMHN (b)(6); (b)(7)(C) and LCSW (b)(6); (b)(7)(C) collectively determined DE LA ROSA was a potential danger to himself and others. PMHN (b)(6); (b)(7)(C) completed an initial suicide risk assessment⁹⁹ and determined DE LA

⁹³ *Id.*; see also CoreCivic memorandum re: Pending Investigation, dated April 24, 2018.

⁹⁴ Certain vital signs are time stamped at 10:51 a.m., while others are time stamped at 1:33 p.m. PMHN (b)(6); (b)(7)(C) did not document a specific encounter time within the note and did not electronically sign-off on the note until 4:40 p.m.

⁹⁵ See eCW Progress Note by PMHN (b)(6); (b)(7)(C) dated April 24, 2018. ERAU notes there was no documentation of a referral by healthcare or security staff for evaluation for auditory hallucinations.

⁹⁶ Inappropriate laughter is laughter that is unexpected due to dissociation from the topic or circumstance.

⁹⁷ Loose associations occur when a patient's responses are not relative to the questions being posed to him.

⁹⁸ Flight of ideas refers to disconnected rambling or a rapid shifting of ideas with only superficial associated connection between them.

⁹⁹ See eCW Progress Note by PMHN (b)(6); (b)(7)(C) dated April 24, 2018. The suicide risk assessment includes risk and protective factors and mental status examination elements.

ROSA was at “Moderate Acute Risk”¹⁰⁰ for suicide; he ordered one-on-one suicide watch¹⁰¹ and scheduled mental health follow-up for the next day.

At 1:45 p.m., PMHNP (b)(6); (b)(7)(C) approved a Special Needs Form completed by LCSV (b)(6); (b)(7)(C) which directed DE LA ROSA’s placement on suicide watch in a safety cell.¹⁰² LCSV (b)(6); (b)(7)(C) included handwritten instructions for security to maintain one-on-one visuals and allow only a smock, blanket, and finger foods.

At 2:37 p.m., Shift Supervisor (b)(6); (b)(7)(C) documented DE LA ROSA’s placement on suicide watch per medical.¹⁰³ According to a memorandum submitted by Unit Manager (b)(6); (b)(7)(C) to Chief of Unit Management (b)(6); (b)(7)(C) SDC placed DE LA ROSA in segregation pending investigation for protective custody.¹⁰⁴ This memorandum was also signed by DE LA ROSA.

At 2:48 p.m., Officer (b)(6); (b)(7)(C) conducted a strip search of DE LA ROSA.¹⁰⁵ The documented reason for the search was suicide watch and Shift Supervisor (b)(6); (b)(7)(C) signed the form.

At 4:45 p.m., security placed DE LA ROSA into RHU 7A, cell 112, where he remained until transfer to Columbia Regional Care Center (CRCC) on May 4, 2018.¹⁰⁶ Security staff initiated a

¹⁰⁰ According to the IHSC Significant Self-Harm and Suicide Prevention and Intervention Operations Memorandum (OM 16-002), moderate acute risk would require one-on-one suicide watch. Consideration for moderate acute risk include, but are not limited to, the presence of suicidal ideation with vague plan and/or intent in the presence of multiple risk factors and high acute distress.

¹⁰¹ According to OM 16-0002, suicide watch always involves continuous visual observation of one detainee by one security staff member (one-to-one). All detainees on suicide watch must be housed individually in a cell deemed safe by custody staff and medical staff. Custody staff collaborate with on-site medical staff to review the cell housing a suicide watch detainee and ensure the cell is as suicide resistant as possible (e.g., no protrusions of any kind that would enable hanging or inflicting self-harm). Suicide watch detainees have their belongings and issued clothing removed, wear a suicide smock, use a suicide blanket, have a mattress to sleep on the floor or on a fixed bed, and are given food that can be consumed without the use of utensils (i.e., finger foods). Custody staff document welfare checks every 15 minutes, and a health care provider (RN or higher) document a welfare check at least every 8 hours.

¹⁰² See Special Needs Form, dated April 24, 2018.

¹⁰³ See Confinement Record, dated April 24, 2018.

¹⁰⁴ See Memorandum Re: Pending Investigation, dated April 24, 2018. ERAU was unable to confirm if DE LA ROSA’s placement in segregation pending investigation for protective custody is related to his April 21, 2018, incident statement or a separate event altogether.

¹⁰⁵ See Record of Search, dated April 24, 2018.

¹⁰⁶ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018. During ERAU’s interview with IHSC Commander (b)(6); (b)(7)(C), Health Services Administrator (HSA), on August 14, 2018, he explained SDC utilized the RHU as medical health overflow, to include suicide watch. At the time of DE LA ROSA’s detention, renovations in the Medical Health Unit (MHU) were underway, therefore observation cells were limited, and DE LA ROSA was placed in RHU. He acknowledged although those cells are not anti-ligature, detainees placed on suicide watch in these cells are on one-on-one observation.

Suicide Observation Checklist¹⁰⁷ for this date and documented welfare checks every 15 minutes.¹⁰⁸

At 5:45 p.m., RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment¹⁰⁹ and documented DE LA ROSA denied pain and was compliant with the assessment.¹¹⁰ RN (b)(6); (b)(7)(C) noted that DE LA ROSA's comments remained consistent and he denied suicidal and homicidal ideations or auditory and visual hallucinations. RN (b)(6); (b)(7)(C) also documented security staff placed DE LA ROSA in a suicide smock and blanket and initiated suicide watch. RN (b)(6); (b)(7)(C) noted medical rounds, to include the completion of vital signs each shift, and mental health rounds would occur each day.

On April 25, 2018, at 1:00 a.m., RN (b)(6); (b)(7)(C) completed a suicide watch nursing assessment and documented DE LA ROSA was compliant with the assessment.¹¹¹ RN (b)(6); (b)(7)(C) noted that DE LA ROSA denied auditory and visual hallucinations and suicidal ideation but stated he had conversations with God. Additionally, it was noted that DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 132/87.

At 9:45 a.m. (b)(6); (b)(7)(C) RN, completed a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 147/83.¹¹² RN (b)(6); (b)(7)(C) noted that DE LA ROSA reported hearing voices the previous night but felt better since he was able to sleep through the night.

At 1:16 p.m. (b)(6); (b)(7)(C) signed off on DE LA ROSA's mental health assessment and documented that DE LA ROSA denied suicidal or homicidal ideations but stated God was trying to kill him.¹¹³ (b)(6); (b)(7)(C) also documented DE LA ROSA's vital signs were all within normal limits, except for an elevated blood pressure of 147/83. (b)(6); (b)(7)(C) determined medical staff would continue to monitor DE LA ROSA in MHU for concern of suicidal ideations.

At an unknown time, LCSW (b)(6); (b)(7)(C) documented a follow-up suicide risk assessment and noted that DE LA ROSA continued to discuss his relationship with God, that he had already died, and

¹⁰⁷ The Suicide Observation Checklist is utilized to record the detainee's activity every 15 minutes, such as sleeping, walking, or standing at the door. Security also maintains a CAR during suicide watch.

¹⁰⁸ See Suicide Observation Checklist, dated April 24, 2018. Unless ERAU discovered a significant issue related to future Suicide Observation Checklists, they are not further discussed within the report.

¹⁰⁹ Per the ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section F: Housing and Monitoring, "All suicidal detainees placed in an isolated confinement setting will receive...welfare checks at least every 8 hours conducted by clinical staff;" and IHSC OM 16-002, Section 5: Policies and Procedures, g. Housing and Monitoring, "While on-site, a health care provider (RN or higher) must perform rounds and document observations in the health record at least every eight hours." The eCW form used by RNs to document suicide watch rounds is not the same one used for segregation rounds. The suicide watch form includes vital signs and SOAP elements.

¹¹⁰ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 24, 2018.

¹¹¹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 25, 2018.

¹¹² See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 25, 2018. According to the AHA, this blood pressure reading indicates stage two hypertension; stage two hypertension is characterized by a systolic reading of at least 140 or a diastolic reading of at least 90.

¹¹³ See eCW Progress Note by D (b)(6); (b)(7)(C) dated April 25, 2018.

if he died again he would be raised from the dead.¹¹⁴ LCSW (b)(6); (b)(7)(C) documented that DE LA ROSA stated he wanted to return to Mexico and see females and did not want to be in general population as he did not want to fight with people. LCSW (b)(6); (b)(7)(C) assessed DE LA ROSA's level of insight and judgement as poor and noted that he would remain on suicide watch due to delusions, hallucinations, and fixations with death. LCSW Cannon co-signed the note on April 30, 2018, and noted concurrence with LCSW (b)(6); (b)(7)(C) assessment and treatment plan.

On April 26, 2018, at approximately 9:00 a.m., a Supervisory Immigration and Enforcement Agent (SIEA), or equivalent, conducted an Administrative Segregation Review (ICE Form I-885) of DE LA ROSA.¹¹⁵ The ICE Form I-885 documented "Yes" responses for the questions, "Does the reason for initial placement remain valid" and, "Is the detainee unwilling or unable to live in general population." Although the ICE Form I-885 directions state, "If any of the above factors are marked 'Yes,' the detainee must continue his/her existing status, unless the Officer in Charge (OIC) determines otherwise," the reviewer recommended DE LA ROSA's removal from protective custody. Furthermore, if the reviewer interviewed DE LA ROSA, the reviewer did not document so on the ICE Form I-885 or elsewhere in the detention file.¹¹⁶ The Field Office Director, or representative, signature line and date is blank but the box "Continue Status" is checked.

At 9:50 a.m.,¹¹⁷ (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/88.¹¹⁸ RN (b)(6); (b)(7)(C) noted DE LA ROSA had no complaints and denied experiencing suicidal/homicidal ideations or hallucinations.

At 10:43 a.m.,¹¹⁹ (b)(6); (b)(7)(C) conducted a mental health assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/88.¹²⁰ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal or homicidal ideations and stated no one was trying to kill him. (b)(6); (b)(7)(C) made no changes to DE LA ROSA's treatment or follow-up plans. When asked about DE LA ROSA's repeatedly elevated blood pressure readings (b)(6); (b)(7)(C) stated DE LA ROSA's blood pressure was abnormal on an irregular basis, so she believed it was potentially anxiety related versus a medical issue.¹²¹

¹¹⁴ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 25, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until April 26, 2018, at 4:14 p.m. but documented within the progress note that it was a late entry for April 25, 2018.

¹¹⁵ See Administrative Segregation Review, dated April 26, 2018. The form includes a name and signature on the SIEA or equivalent line but both are illegible. SDC was unable to confirm the signatory; therefore, ERAU was unable to interview the individual about the form details.

¹¹⁶ ERAU notes ICE Form I-885 does not include a designated section to document completion of an interview with the detainee, although the ICE PBNDS 2011, *Special Management Units* standard requires documentation of one.

¹¹⁷ ERAU notes there are multiple instances where compliance with the eight-hour healthcare rounds cannot be confirmed due to unknown round times.

¹¹⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 26, 2018.

¹¹⁹ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when Dr. Owusu documented DE LA ROSA's vital signs.

¹²⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 26, 2018.

¹²¹ ERAU interview with (b)(6); (b)(7)(C) dated August 14, 2018.

At 6:00 p.m. (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA denied homicidal/suicidal ideations or hallucinations.¹²² (b)(6); (b)(7)(C) did not record vital signs.

At 8:55 p.m. (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except an elevated blood pressure of 124/77.¹²³ (b)(6); (b)(7)(C) noted DE LA ROSA was cooperative with the examination.

At an unknown time, (b)(6); (b)(7)(C), RN, conducted a nursing assessment.¹²⁴ RN (b)(6); (b)(7)(C) utilized the segregation evaluation rather than the suicide watch assessment, did not document vital signs, and did not sign her note until July 19, 2018.¹²⁵

At an unknown time, LCSW (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment.¹²⁶ LCSW (b)(6); (b)(7)(C) documented DE LA ROSA did not want to harm himself but believed he would die three horrible deaths. It was also noted that DE LA ROSA denied auditory or visual hallucinations but stated he heard things and did not want to be around others because of that. LCSW (b)(6); (b)(7)(C) documented assessment findings of delusional disorder and schizophrenia. DE LA ROSA remained on suicide watch.

On this date only, security staff documented 15-minute rounds on the Mental Health Observation Checklist form rather than the Suicide Observation Checklist form.¹²⁷

On April 27, 2018, at 8:51 a.m.,¹²⁸ PMHNP (b)(6); (b)(7)(C) completed a follow-up suicide risk assessment and documented DE LA ROSA's vital signs were all within normal limits except an elevated blood pressure of 122/71.¹²⁹ PMHNP (b)(6); (b)(7)(C) noted that although DE LA ROSA continued to deny suicidal ideation, plan, or intent to harm himself, he again stated he would soon die three horrible deaths and be resurrected three times. PMHNP also noted that DE LA ROSA continued to express grandiose beliefs that he was the Antichrist but believed that God was using him as an instrument of change to save the world. According to the assessment, DE LA ROSA reported speaking directly to God and being answered by God and DE LA ROSA continued to refuse

¹²² See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 26, 2018.

¹²³ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 26, 2018. According to the AHA, this blood pressure reading indicates an elevated blood pressure; an elevated blood pressure is characterized by a systolic reading of 120 to 129 and a diastolic reading of less than 80.

¹²⁴ See eCW Program Note by RN (b)(6); (b)(7)(C) dated April 26, 2018.

¹²⁵ ERAU was unable to interview (b)(6); (b)(7)(C) regarding this nursing assessment as she was no longer employed by SDC at the time of the site visit. During interviews of (b)(6); (b)(7)(C) on August 14 and 15, 2018, respectively, they explained nurses who conduct rounds in the RHU have a roster that identifies detainees on mental health observation and suicide watch status.

¹²⁶ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 26, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until April 27, 2018, at 11:00 a.m. but documented within the progress note that it was a late entry for April 26, 2018. There was no confirmatory sign-off by another provider.

¹²⁷ See Mental Health Observation Checklist, dated April 26, 2018. ERAU notes upon comparison, the forms require documentation of the same information.

¹²⁸ ERAU notes PMHNP (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when PMHNP (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹²⁹ See eCW Progress Note by PHMNP (b)(6); (b)(7)(C) dated April 27, 2018.

treatment and stated he did not need medication. PMHNP (b)(6); (b)(7)(C) determined DE LA ROSA was a danger to himself and potentially to others. PMHNP (b)(6); (b)(7)(C) discussed the case with LCSW (b)(6); (b)(7)(C) and determined medical staff would refer DE LA ROSA to CRCC for inpatient hospitalization.¹³⁰ LCSW (b)(6); (b)(7)(C) documented confirmatory sign-off and concurrence with the plan on May 2, 2018.

At 9:30 a.m. (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA denied hallucinations or homicidal/suicidal ideations.¹³¹ RN (b)(6); (b)(7)(C) did not record vital signs or sign the note until July 19, 2018, nine days after DE LA ROSA's death.

At 12:40 p.m.,¹³² RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vitals were all within normal limits except for an elevated blood pressure of 148/90.¹³³ RN (b)(6); (b)(7)(C) noted DE LA ROSA was asymptomatic relative to his elevated blood pressure and that she made (b)(6); (b)(7)(C) aware.

At 2:39 p.m.,¹³⁴ (b)(6); (b)(7)(C) conducted a mental health observation assessment.¹³⁵ Dr. (b)(6); (b)(7)(C) documented DE LA ROSA's vitals were all within normal limits except for an elevated blood pressure of 148/90. (b)(6); (b)(7)(C) noted DE LA ROSA was generally unchanged in overall presentation, and medical staff would continue to follow up with mental health until medical staff determined proper placement.

At 10:30 p.m., (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 146/86.¹³⁶ (b)(6); (b)(7)(C) noted DE LA ROSA was sitting on his bed, alert, and fully oriented and not experiencing auditory or visual hallucinations.

On April 28, 2018, at 8:40 a.m.,¹³⁷ (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 124/80.¹³⁸

¹³⁰ During interview with ERAU on August 14, 2018, HS (b)(6); (b)(7)(C) informed ERAU that ICE has a contract with CRCC for care of detainees who require psychiatric services outside the facility's scope. SDC transfers detainees once a bed becomes available at CRCC.

¹³¹ See eCW Progress Note by RN (b)(6); (b)(7)(C), dated April 27, 2018, electronically signed July 19, 2018.

¹³² ERAU notes RN (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when RN (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹³³ See eCW Progress Note by RN Shepherd, dated April 27, 2018, electronically signed April 27, 2018.

¹³⁴ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹³⁵ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 27, 2018.

¹³⁶ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 27, 2018.

¹³⁷ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹³⁸ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 28, 2018. ERAU notes medical conducted the last healthcare round more than 10 hours earlier.

At 8:45 a.m., (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 124/80.¹³⁹ RN (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

At 4:39 p.m., RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 124/76.¹⁴⁰

On April 29, 2018, at 12:50 a.m. (b)(6); (b)(7)(C) RN, conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits.¹⁴¹

At 7:11 a.m.,¹⁴² (b)(6); (b)(7)(C) NP, conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/88.¹⁴³ NP (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

At 8:15 a.m., RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/88.¹⁴⁴

At 2:29 p.m., RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 125/86.¹⁴⁵ RN (b)(6); (b)(7)(C) noted that DE LA ROSA continued to deny suicidal and homicidal ideations or hallucinations.

On April 30, 2018, at 12:30 a.m., RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 145/88.¹⁴⁶

At 8:25 a.m., RN (b)(6); (b)(7)(C) conducted a suicide watch nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 152/92.¹⁴⁷ RN (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

¹³⁹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 28, 2018 at 8:45 a.m.

¹⁴⁰ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 28, 2018 at 4:39 p.m.

¹⁴¹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 29, 2018.

¹⁴² ERAU notes NP (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when NP Bush documented DE LA ROSA's vital signs.

¹⁴³ See eCW Progress Note by NP (b)(6); (b)(7)(C) dated April 29, 2018.

¹⁴⁴ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 29, 2018.

¹⁴⁵ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 29, 2018.

¹⁴⁶ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 30, 2018.

¹⁴⁷ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated April 30, 2018.

At 12:29 p.m.,¹⁴⁸ (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 142/80.¹⁴⁹ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

At an unknown time, LCSW (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment and documented DE LA ROSA continued to present with fixed delusions and consistently declined medication.¹⁵⁰ LCSW (b)(6); (b)(7)(C) further described DE LA ROSA's appearance and affect as odd. LCSW Harvey believed DE LA ROSA was at risk of being a danger to himself and others and he remained focused on the concept of death. DE LA ROSA again declined to be treated with medication. As of this date, referral to CRCC remained pending.

On May 1, 2018, at 8:43 am., RN (b)(6); (b)(7)(C) conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/81.¹⁵¹ RN (b)(6); (b)(7)(C) noted that DE LA ROSA voiced no suicidal/homicidal ideations.

At 12:09 p.m.,¹⁵² (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 139/81.¹⁵³ (b)(6); (b)(7)(C) noted that DE LA ROSA denied suicidal/homicidal ideations or physical complaints.

At 3:37 p.m., LCSW (b)(6); (b)(7)(C) signed off on a wellness check and noted DE LA ROSA continued to present with fixed delusions and focused on concepts of death.¹⁵⁴ LCSW (b)(6); (b)(7)(C) noted DE LA ROSA felt hopeless, helpless, and like he was a burden to others. In response to further questioning on these risk factors, DE LA ROSA stated he sometimes felt bad because he was in jail and he was a burden to others because he was the Antichrist and rejected Jesus Christ. LCSW (b)(6); (b)(7)(C) noted CRCC accepted DE LA ROSA and travel arrangements were pending. There was no confirmatory sign-off by another provider.

At 4:00 p.m., (b)(6); (b)(7)(C) RN, conducted a suicide risk nursing assessment but did not record vital signs.¹⁵⁵ RN (b)(6); (b)(7)(C) documented DE LA ROSA denied suicidal/homicidal ideations or hallucinations.

¹⁴⁸ ERAU not (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁴⁹ See eCW Progress Note by (b)(6); (b)(7)(C) dated April 30, 2018.

¹⁵⁰ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated April 30, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until May 1, 2018 at 3:11 p.m. but documented within the progress note that it was a late entry for April 30, 2018. There was no confirmatory sign-off by another provider.

¹⁵¹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated May 1, 2018.

¹⁵² ERAU not (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁵³ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 1, 2018.

¹⁵⁴ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated May 1, 2018.

¹⁵⁵ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated May 1, 2018.

On May 2, 2018, at 8:45 a.m.,¹⁵⁴ (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/89.¹⁵⁷

At 9:03 a.m.,¹⁵⁸ RN (b)(6); (b)(7)(C) conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 128/88.¹⁵⁹

At 9:30 p.m., (b)(6); (b)(7)(C) RN, conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/89.¹⁶⁰ When RN (b)(6); (b)(7)(C) asked DE LA ROSA how he was doing, he responded everything was fine.

At an unknown time, LCSW (b)(6); (b)(7)(C) conducted a follow-up suicide risk assessment.¹⁶¹ LCSW noted DE LA ROSA continued to present with inappropriate laughter and believed he would die three terrible deaths soon. When asked about suicidal ideations, DE LA ROSA smiled while replying, "No, not right now." At this time, DE LA ROSA's transfer to CRCC remained pending. There was no confirmatory sign-off by another provider.

On May 3, 2018, at 9:57 a.m., (b)(6); (b)(7)(C) conducted a mental health observation assessment and document DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 141/101.¹⁶³

At 12:40 p.m., an SIEA, or equivalent, conducted an Administrative Segregation Review (ICE Form I-885) of DE LA ROSA.¹⁶⁴ Findings were identical to the April 26, 2018, segregation review, but this time the reviewer recommended DE LA ROSA remain in protective custody. Once again, the reviewer did not document an interview of DE LA ROSA on the ICE Form I-885 or elsewhere in the detention file. On the same date, the Field Office Director, or representative, checked the "Continue Status" box and signed the form.

¹⁵⁶ ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁵⁷ See eCW Progress Note by (b)(6); (b)(7)(C), dated May 2, 2018.

¹⁵⁸ ERAU notes RN (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when RN Shepherd documented DE LA ROSA's vital signs.

¹⁵⁹ See eCW Progress Note by R (b)(6); (b)(7)(C), dated May 2, 2018.

¹⁶⁰ See eCW Progress Note by RN (b)(6); (b)(7)(C), dated May 2, 2018.

¹⁶¹ See eCW Progress Note by LCSW (b)(6); (b)(7)(C), dated May 2, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until May 3, 2018, at 7:33 a.m. but documented within the progress note that it was a late entry for May 2, 2018. There was no confirmatory sign-off by another provider.

¹⁶² ERAU notes (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁶³ See eCW Progress Note by (b)(6); (b)(7)(C), dated May 3, 2018.

¹⁶⁴ See Administrative Segregation Review, dated May 3, 2018. The form includes a name and signature on the SIEA or equivalent line but both are illegible. SDC was unable to confirm the signatory; therefore, ERAU was unable to interview the individual about the form details.

At 3:19 p.m.,¹⁶⁵ (b)(6); (b)(7)(C) RN, conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 121/89 and an elevated pulse rate of 104.¹⁶⁶ (b)(6); (b)(7)(C) noted that DE LA ROSA denied any pain.

At 3:54 p.m., LCSW (b)(6); (b)(7)(C) signed off on a follow-up suicide risk assessment and documented similar findings to the previous day's encounter.¹⁶⁷ When asked about suicidal ideations, DE LA ROSA replied, "I already told you." There was no confirmatory sign-off by another provider and the transfer to CRCC remained pending.

At 9:40 p.m., RN (b)(6); (b)(7)(C) conducted a suicide risk nursing assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 137/89.¹⁶⁸ RN (b)(6); (b)(7)(C) noted that DE LA ROSA denied any suicidal/homicidal ideations or hallucinations.

On May 4, 2018, at 12:57 a.m. (b)(6); (b)(7)(C) RN, signed off on DE LA ROSA's transfer summary to CRCC and documented a diagnosis of schizophrenia, delusional disorder, and suicidal ideations.¹⁶⁹ RN (b)(6); (b)(7)(C) cleared DE LA ROSA for travel.

At an unknown time (b)(6); (b)(7)(C) conducted a mental health observation assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 135/80.¹⁷⁰ (b)(6); (b)(7)(C) noted that DE LA ROSA appeared calm and cooperative with the exam and denied any physical complaints (b)(6); (b)(7)(C) also noted CRCC would admit DE LA ROSA on this date.

Prior to DE LA ROSA's departure from SDC, Officer (b)(6); (b)(7)(C) attempted to obtain DE LA ROSA's signature on the Release section of the Detainee Forwarding Address Form¹⁷¹ and Discharge Checklist section of the Receiving & Discharge Checklist,¹⁷² but DE LA ROSA refused to sign the forms.

At approximately 7:32 a.m., SDC released DE LA ROSA into the care of CRCC for mental health treatment, where he remained until June 12, 2018.¹⁷³

¹⁶⁵ ERAU notes RN (b)(6); (b)(7)(C) did not document the precise time of the assessment; therefore, this time reflects when RN (b)(6); (b)(7)(C) documented DE LA ROSA's vital signs.

¹⁶⁶ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁷ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated May 3, 2018.

¹⁶⁹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated May 4, 2018.

¹⁷⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated May 4, 2018. Although (b)(6); (b)(7)(C) recorded vital signs at 9:44 a.m., the SDC Cellmate Housing History and CoreCivic Offender Management System information support DE LA ROSA departed SDC for CRCC around 7:32 a.m.; therefore, the exact time of the assessment is unknown.

¹⁷¹ See Detainee Forwarding Address Form, dated May 4, 2018.

¹⁷² See SDC Receiving & Discharge Checklist, dated May 4, 2018.

¹⁷³ See SDC Cellmate Housing History, dated March 13, 2018 – May 4, 2018. SDC did not provide documentation related to DE LA ROSA's transport to CRCC.

At 2:00 p.m., DE LA ROSA signed a Treatment Agreement and Consent form in Spanish.¹⁷⁴

At 2:29 p.m., (b)(6); (b)(7)(C) CRCC RN, signed off on DE LA ROSA's Nursing Assessment.¹⁷⁵ RN (b)(6); (b)(7)(C) documented DE LA ROSA was able to read and speak English but that his primary language was Spanish and that his vital signs were all within normal limits except for an elevated blood pressure of 160/97. RN (b)(6); (b)(7)(C) noted that DE LA ROSA stated he did not know why he was being admitted to the hospital other than people thinking he was crazy. RN (b)(6); (b)(7)(C) also noted his behavior was cooperative, friendly, and that he demonstrated appropriate interaction. RN (b)(6); (b)(7)(C) further documented DE LA ROSA's thought process (b)(6); (b)(7)(C) were within normal limits. In addition to an admitting diagnosis of schizophrenia,¹⁷⁶ RN (b)(6); (b)(7)(C) checked the boxes beside "Depression with Suicidal Ideations" and "Psychosis" in the assessment form.

At approximately 3:48 p.m., CRCC placed DE LA ROSA under suicide precautions for 24 hours, which included suicide apparel and restricted movement at the facility.¹⁷⁷

On May 5, 2018, at 7:58 a.m., (b)(6); (b)(7)(C) (first name unknown), CRCC RN, documented DE LA ROSA had an elevated blood pressure. RN (b)(6); (b)(7)(C) did not document any other concerns but further noted an MD directed nursing staff to observe DE LA ROSA's blood pressure and notify the MD if his blood pressure remained high.

At approximately 9:45 a.m., RN (b)(6); (b)(7)(C) conducted a Suicide Shift Assessment form in which she documented DE LA ROSA denied suicidal or homicidal ideations or hearing voices commanding he hurt himself.¹⁷⁸

At 11:33 a.m., DE LA ROSA signed a Neuroleptic (Antipsychotic) Medication Consent Form in English.¹⁷⁹ According to the CRCC Order Record History, medical staff prescribed DE LA ROSA the antipsychotic medications Haldol and Zyprexa while hospitalized at CRCC.¹⁸⁰

At approximately 4:46 p.m., CRCC staff discontinued DE LA ROSA's suicide precautions.¹⁸¹

On May 7, 2018, at 12:29 p.m., (b)(6); (b)(7)(C) psychiatrist, signed off on DE LA ROSA's initial psychiatric evaluation.¹⁸² According to the notes, DE LA ROSA stated while in prison, he was previously diagnosed with schizophrenia because he told staff he heard the voice of God. He further stated (b)(6); (b)(7)(C) take medication at SDC because he believed there was nothing wrong with him. (b)(6); (b)(7)(C) noted DE LA ROSA believed God spoke to him regularly, as do many other religious individuals. As such (b)(6); (b)(7)(C) noted CRCC staff would need to continue observation of DE LA ROSA to determine if signs and symptoms of schizophrenia

¹⁷⁴ See CRCC Treatment Agreement and Consent form, dated May 4, 2018.

¹⁷⁵ See CRCC Nursing Assessment, dated May 4, 2018.

¹⁷⁶ See CRCC Provider Treatment Order, dated May 3, 2018.

¹⁷⁷ See CRCC Provider Treatment Order – Verbal/Telephone, dated May 4, 2018.

¹⁷⁸ See CRCC Suicide Shift Assessment, dated May 5, 2018.

¹⁷⁹ See CRCC Neuroleptic (Antipsychotic) Medication Consent Form, dated May 5, 2018.

¹⁸⁰ See CRCC Order Record History, dated May – July, 2018.

¹⁸¹ See CRCC Provider Treatment Order – Verbal/Telephone, dated May 5, 2018.

¹⁸² See CRCC Initial Psychiatric Evaluation, dated May 7, 2018.

were present (b)(6); (b)(7)(C) documented DE LA ROSA's thought form and content were coherent and appropriate, respectively.

On May 9, 2018, at 9:16 a.m., (b)(6); (b)(7)(C), Social Worker, signed off on DE LA ROSA's initial psychosocial assessment and documented DE LA ROSA had a history of hypertension.¹⁸³

On May 12, 2018, at 12:08 p.m., (b)(6); (b)(7)(C), psychiatrist, documented DE LA ROSA had told staff he was the Antichrist and would die in three days.¹⁸⁴ (b)(6); (b)(7)(C) noted that DE LA ROSA stated God spoke with him on a daily basis, using the voice of his own father, and communicated with him through the television. DE LA ROSA stated he would be killed by someone soon in a horrible way but could not tell (b)(6); (b)(7)(C) when. DE LA ROSA added he would be resurrected and then used by God to rid the world of everything else evil. Dr. (b)(6); (b)(7)(C) also noted that DE LA ROSA said he had previously been killed and resurrected but would not go into additional detail. DE LA ROSA claimed to look forward to death but did not intend to harm himself because God would take care of that by having someone else kill him.

May 20, 2018, at 2:53 p.m., (b)(6); (b)(7)(C) noted DE LA ROSA continued to believe he was the Antichrist and that he would be killed and resurrected.¹⁸⁵ According to (b)(6); (b)(7)(C) notes, DE LA ROSA stated he knew the date this would occur but could not share that information with (b)(6); (b)(7)(C). DE LA ROSA also reported hearing the voice of God, who told him good and bad things, but denied having suicidal or homicidal thoughts.

On June 5, 2018, at 11:49 a.m., (b)(6); (b)(7)(C) noted DE LA ROSA had shown significant improvement and was compliant with his psychotropic medication, even though DE LA ROSA did not think it was necessary.¹⁸⁶ (b)(6); (b)(7)(C) noted DE LA ROSA continued to express he was the Antichrist and that at some point he would be killed and then resurrected. (b)(6); (b)(7)(C) also noted DE LA ROSA steadfastly maintained he was not suicidal and had no thoughts of harming himself or others. (b)(6); (b)(7)(C) further documented DE LA ROSA had reached the maximum benefit of being at CRCC but recommended continued psychiatric treatment upon discharge.

On June 10, 2018, at 4:15 p.m., (b)(6); (b)(7)(C) documented that although DE LA ROSA continued to have the delusion that he was the Antichrist and that he would be killed and resurrected, he was not suicidal.¹⁸⁷ (b)(6); (b)(7)(C) again noted DE LA ROSA had reached the maximum benefit of being at CRCC and recommended continued psychiatric treatment upon discharge; she further commented that CRCC completed DE LA ROSA's discharge summary.

CRCC's psychiatric discharge summary of DE LA ROSA's care documented the following:¹⁸⁸

¹⁸³ See CRCC Psychosocial Initial Assessment, dated May 9, 2018.

¹⁸⁴ See CRCC Psychiatrist Progress Note, dated May 12, 2018.

¹⁸⁵ See CRCC Psychiatrist Progress Note, dated May 20, 2018.

¹⁸⁶ See CRCC Psychiatrist Progress Note, dated June 5, 2018.

¹⁸⁷ See CRCC Psychiatrist Progress Note, dated June 10, 2018.

¹⁸⁸ See CRCC Psychiatric Discharge Summary, dated June 5, 2018. Although the date of service notes June 5, 2018, the provider signed off on the document on July 13, 2018 at 5:12 p.m., three days after DE LA ROSA's death. It is unclear if SDC received the discharge summary prior to DE LA ROSA's death.

- On admission to CRCC, DE LA ROSA reported he was able to hear the voice of God. Medical staff initially thought the patient's beliefs about communicating with God could have been part of his religious belief system, rather than evidence of psychosis. However, as DE LA ROSA became more comfortable discussing his experiences, it became clear the patient had delusions. DE LA ROSA also believed he was the Antichrist and that he had been killed twice before and arisen from the dead. He also said he believed he would be killed again shortly but commented he was not permitted by God to disclose when that would happen.
- DE LA ROSA denied suicidal thoughts while at CRCC, and there was no evidence he was suicidal while hospitalized.
- DE LA ROSA was initially resistant to taking medication but by the time of discharge he was compliant.
- Although (b)(6); (b)(7)(C) described DE LA ROSA Haldol¹⁸⁹ and Zyprexa,¹⁹⁰ he continued to be delusional but was less guarded and interacted better with other patients; he also participated in group activities.
- DE LA ROSA stated he would consider taking medication after discharge although he did not feel he needed it.
- DE LA ROSA's insight and judgment were chronically impaired.
- Laboratory tests performed were non-contributory and his condition was stable for discharge, having reached the maximum hospital benefit.
- CRCC listed DE LA ROSA's discharge medications as Zyprexa (20 mg) and Haldol (5 mg).

Although not reflected in the CRCC discharge summary, the CRCC medical record documents medical staff ordered DE LA ROSA amlodipine in response to his elevated blood pressure.¹⁹¹ Additionally, the Medication Reconciliation for Discharge/Transfer lists Norvasc,¹⁹² along with Zyprexa and Haldol, as discharge medications.¹⁹³

On June 11, 2018, prior to DE LA ROSA's return to SDC, Officer (b)(6); (b)(7)(C) completed DE LA ROSA's ICE Custody Classification Worksheet.¹⁹⁴ Officer (b)(6); (b)(7)(C) assigned a custody level of high, and a supervisor approved the rating on June 13, 2018.¹⁹⁵

On June 12, 2018, at 2:20 a.m., (b)(6); (b)(7)(C) CRCC RN, added a nursing progress note stating DE LA ROSA was with the security officer for discharge.¹⁹⁶ At 8:30 a.m., upon DE LA ROSA's return from CRCC to SDC, RN (b)(6); (b)(7)(C) conducted DE LA ROSA's medical pre-screening.¹⁹⁷ RN (b)(6); (b)(7)(C) documented receipt of a medical transfer summary from CRCC. At

¹⁸⁹ Haldol is an antipsychotic medication used to treat mental disorders, including schizophrenia.

¹⁹⁰ Zyprexa is an antipsychotic medication used to treat mental disorders, including schizophrenia.

¹⁹¹ See CRCC Order Record History – Medication Orders, dated May – June 2018.

¹⁹² Norvasc is a brand name for amlodipine, which is an antihypertensive medication.

¹⁹³ See CRCC Medication Reconciliation for Discharge/Transfer List, dated July 8, 2018.

¹⁹⁴ See ICE Custody Classification Worksheet, dated June 11, 2018. ERAU notes the special vulnerabilities section omitted mention of any serious mental illness.

¹⁹⁵ ERAU notes both the officer's and supervisor's signatures were illegible.

¹⁹⁶ See CRCC Nursing Progress note, dated June 12, 2018.

¹⁹⁷ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated June 12, 2018.

9:00 a.m., RN (b)(6); (b)(7)(C) conducted DE LA ROSA's medical intake screening and documented the following:¹⁹⁸

- DE LA ROSA's vital signs were all within normal limits.
- DE LA ROSA reported a history of schizophrenia, hypertension, and alcohol abuse.
- DE LA ROSA was taking the medications Haldol (5 mg), Norvasc (10 mg), and Zyprexa (20 mg).

RN (b)(6); (b)(7)(C) cleared DE LA ROSA for custody but designated the intake screening as abnormal and referred him to a provider. DE LA ROSA also signed an IHSC Medical Consent Form for general treatment.¹⁹⁹

At 9:44 a.m., Office (b)(6); (b)(7)(C) re-booked DE LA ROSA into SDC.²⁰⁰ At 10:17 a.m., SDC assigned him to general population unit 7, pod B, cell 104.²⁰¹

At an unknown time, LCSW (b)(6); (b)(7)(C) conducted a mental health assessment due to DE LA ROSA's return from CRCC.²⁰² LCSW (b)(6); (b)(7)(C) documented that DE LA ROSA stated he was given medication at CRCC, taking his last dose the prior evening, but did not feel it helped. DE LA ROSA also mentioned he did not want to continue to take his medication as he did not need them. Although he again discussed his future deaths and resurrections, DE LA ROSA stated he would not harm himself. LCSW (b)(6); (b)(7)(C) noted she discussed medication compliance and reoccurrence of symptoms with DE LA ROSA.

At 3:09 p.m., (b)(6); (b)(7)(C) submitted a telephone order for amlodipine (10 mg) in the morning and olanzapine²⁰³ (20 mg) and haloperidol²⁰⁴ (5 mg), both in the evening, for DE LA ROSA to keep-on-person (KOP).²⁰⁵ ERAU notes there were no signed consent forms for the two psychotropic medications, olanzapine and haloperidol.

On June 13, 2018, at 9:00 a.m., (b)(6); (b)(7)(C) NP, conducted an abbreviated physical examination as medical staff last examined DE LA ROSA at SDC on March 15, 2018.²⁰⁶ The examination revealed that DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 123/77. Additionally, DE LA ROSA denied any pain. (b)(6); (b)(7)(C) completed an Abnormal Involuntary Movement Scale (AIMS) test to determine if DE LA ROSA

¹⁹⁸ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated June 12, 2018.

¹⁹⁹ See IHSC Medical Consent Form, dated June 12, 2018.

²⁰⁰ See Commitment Summary, dated June 12, 2018.

²⁰¹ See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018.

²⁰² See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 12, 2018. LCSW (b)(6); (b)(7)(C) did not sign her note until July 11, 2018, at 2:41 p.m. but documented within the progress note that it was a late entry for June 12, 2018 and that the note was locked on July 11, 2018. There was no confirmatory sign-off by another provider.

²⁰³ Olanzapine is generic Zyprexa.

²⁰⁴ Haloperidol is generic Haldol.

²⁰⁵ See Telephone Encounter by (b)(6); (b)(7)(C) dated June 12, 2018. Although (b)(6); (b)(7)(C) ordered these three medications on this date, per the MAR, medical did not start them until June 14, 2018. The cause of the delay is unknown.

²⁰⁶ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 13, 2018.

was experiencing side effects from psychotropic medications; the score was zero. NP (b)(6); (b)(7)(C) noted a follow-up would occur in two weeks.²⁰⁷

On June 14, 2018, at an unknown time, Office (b)(6); (b)(7)(C) completed the remainder of DE LA ROSA's intake process back into SDC.²⁰⁸ At 1:36 p.m., SDC moved DE LA ROSA to general population unit 5, pod A, cell 213.²⁰⁹

On this date, SDC medical staff began attempts to administer the medication (b)(6); (b)(7)(C) had ordered for DE LA ROSA on June 12, 2018.²¹⁰ DE LA ROSA refused all medications up to and including the day of his suicide; documentation and follow-up by medical staff related to his refusals were limited. Although there were many occasions medical staff documented on his Medication Administration Record (MAR) that DE LA ROSA did not present for pill call, medical staff did not document any efforts to account for DE LA ROSA to confirm if his failure to report for pill call constituted a refusal of his medications. As such, medical staff could have educated him on the associated risks and had him sign a refusal form. Furthermore, as discussed later in the report, security staff placed DE LA ROSA in segregation again, during which time medical staff repeatedly documented DE LA ROSA did not present for pill call, although medical staff administered medications directly to the detainee through their cell door while in segregation. Additionally, medical staff did not consistently notify providers DE LA ROSA was not taking his prescribed medications and, when notified, a provider did not follow up consistently. Exhibit 2 details specifics related to refusals, referrals to providers, and provider follow-ups, unless a significant event tied to medication administration occurred.²¹¹

On June 15, 2018, at 2:38 p.m. (b)(6); (b)(7)(C), Licensed Practical Nurse (LPN), notified NP (b)(6); (b)(7)(C) that DE LA ROSA refused his morning amlodipine dose.²¹² Three days later, in the Action Taken section, (b)(6); (b)(7)(C) documented "noted." This is the first of 17 telephone encounters nurses sent (b)(6); (b)(7)(C) notifying her of DE LA ROSA's refusals.²¹³ At no time after DE LA ROSA's return from CRCC on June 12, 2018, did NP (b)(6); (b)(7)(C) see him. NP (b)(6); (b)(7)(C) stated she conferred with mental health personnel and reviewed DE LA ROSA's chart, and medical staff scheduled him for follow-up appointments.²¹⁴ (b)(6); (b)(7)(C) added that medical staff rescheduled these follow-up appointments due to staffing issues. Except for an encounter on June 19, 2018, there was no documentation provided to confirm medical staff scheduled or postponed the appointments. (b)(6); (b)(7)(C) advised that the Mortality Review Committee

²⁰⁷ ERAU notes there is no documentation a medical provider followed up within two weeks.

²⁰⁸ See SDC Intake Documents, dated June 14, 2018. ERAU notes DE LA ROSA signed all intake processing documents on this date. It is unknown why security did not complete the remainder of DE LA ROSA's intake process until two days later.

²⁰⁹ See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018.

²¹⁰ See MAR.

²¹¹ See Exhibit 2: Creative Corrections Detainee Death Review Healthcare and Security Analysis.

²¹² See Telephone Encounter by LPN (b)(6); (b)(7)(C) dated June 15, 2018.

²¹³ As mentioned above, specifics regarding all 17 refusals of medication and subsequent referrals to providers by way of telephone encounters are detailed in Exhibit 2 and are not further discussed within the report unless a significant event occurred related to it.

²¹⁴ ERAU interview with NP (b)(6); (b)(7)(C) dated August 14, 2018.

identified this issue and recommended providers document why appointments are not carried out in the future.²¹⁵

On June 18, 2018, at approximately 4:51 a.m., (b)(6); (b)(7)(C) Licensed Vocational Nurse (LVN), notified NP (b)(6); (b)(7)(C) and LCSW (b)(6); (b)(7)(C) that DE LA ROSA refused his previous night's Haldol and Zyprexa doses.²¹⁶ NP (b)(6); (b)(7)(C) responded that the mental health provider was informed and LCSW (b)(6); (b)(7)(C) responded that medical staff scheduled an appointment with DE LA ROSA for June 19, 2018.

On June 19, 2018, at 10:55 a.m., LCSW (b)(6); (b)(7)(C) signed off on her assessment of DE LA ROSA in response to his medication refusals.²¹⁷ She documented DE LA ROSA stated he did not need medication but still believed he was the Antichrist. LCSW (b)(6); (b)(7)(C) also documented that DE LA ROSA denied any thoughts of self-harm or hearing any voices. LCSW (b)(6); (b)(7)(C) provided medication education, explained the importance of compliance, and instructed DE LA ROSA to report to staff immediately should he begin to have thoughts of self-harm or command auditory hallucinations. (b)(6); (b)(7)(C) psychologist, reviewed and concurred with LCSW (b)(6); (b)(7)(C) encounter note seven days later. He further noted the BHU would continue to monitor DE LA ROSA's continuity of care needs and mental status examination in consult with the mental health team and (b)(6); (b)(7)(C) IHSC's Chief Psychiatrist. (b)(6); (b)(7)(C) also directed staff to notify BHU if a higher level of care became necessary.

At 4:52 p.m., Office (b)(6); (b)(7)(C) documented an incident with DE LA ROSA and cited him for the prohibited act of making a sexual proposal.²¹⁸

At 5:10 p.m., (b)(6); (b)(7)(C) RN, completed DE LA ROSA's segregation clearance assessment and documented DE LA ROSA's vital signs were all within normal limits except for an elevated blood pressure of 132/86.²¹⁹ R (b)(6); (b)(7)(C) noted DE LA ROSA was in no acute distress and within normal limits of behavior, affect and cognitive functioning and cleared him for segregation.²²⁰

At 6:05 p.m., Office (b)(6); (b)(7)(C) ordered DE LA ROSA's placement in disciplinary segregation²²¹ and security moved DE LA ROSA to RHU unit 7, pod A, cell 107.²²²

²¹⁵ ERAU interview with (b)(6); (b)(7)(C) dated August 14, 2018.

²¹⁶ See Telephone Encounters by LV (b)(6); (b)(7)(C) dated June 17, 2018; see also MAR. Medical staff notified LCSW (b)(6); (b)(7)(C) DE LA ROSA's medication refusals and follow-up telephone encounter sent to NP (b)(6); (b)(7)(C) on one other occasion, June 29, 2019. All other notifications by medical staff regarding DE LA ROSA's medication refusals were routed only to NP (b)(6); (b)(7)(C). Creative Corrections further advised that although medical staff notified LCSW (b)(6); (b)(7)(C) of DE LA ROSA's medication refusal on these two occasions, she was not a prescribing provider; therefore, NP (b)(6); (b)(7)(C) could have been the provider to take action.

²¹⁷ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 19, 2018.

²¹⁸ See Incident of Prohibited Acts and Notice of Charges, dated June 19, 2018.

²¹⁹ See Progress Note by RN (b)(6); (b)(7)(C) dated June 19, 2018.

²²⁰ RN (b)(6); (b)(7)(C) was no longer employed at SDC during the time of the site visit; therefore, ERAU was unable to confirm if RN (b)(6); (b)(7)(C) viewed DE LA ROSA's medical record or was aware of his ongoing issues related to mental illness and medication refusals.

²²¹ See Confinement Record, dated June 19, 2018.

²²² See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018.

At 6:43 p.m., Case Counselor (b)(6); (b)(7)(C) initiated an investigation related to DE LA ROSA's offense.²²³ Case Counselor (b)(6); (b)(7)(C) documented DE LA ROSA was very calm and admitted to approaching the officer. Case Counselor (b)(6); (b)(7)(C) subsequently referred the incident to the IDP and issued DE LA ROSA his Detainee Rights at the IDP Hearing.²²⁴

On June 20, 2018, at 12:31 p.m., security moved DE LA ROSA to RHU unit 7, pod B, cell 105, where he remained until his death.²²⁵

At 4:13 p.m., LCSW H (b)(6); (b)(7)(C) signed off on a mental health assessment.²²⁶ LCSW (b)(6); (b)(7)(C) discussed DE LA ROSA's placement in segregation with him and, when questioned about his behavior, DE LA ROSA stated the officer was beautiful, and he liked her. LCSW (b)(6); (b)(7)(C) documented DE LA ROSA continued to deny the need for medication. DE LA ROSA indicated he did not have any concerns related to housing in segregation or thoughts of self-harm. LCSW (b)(6); (b)(7)(C) noted DE LA ROSA met SMI criteria due to "one or more psychiatric symptoms, presently taking psychiatric medications and still presenting active moderate to severe symptoms. Serious limitations in mental functioning." She also noted that he would benefit from a higher level of care. Contradictory to this statement, however, LCSW (b)(6); (b)(7)(C) documented a "No" answer in response to the questions, "Does the detainee present any active symptoms" and "Is the detainee compliant with his/her treatment?" She provided no explanation for the conflicting information.

During her interview, LCSW (b)(6); (b)(7)(C) stated she advised IHSC Headquarters via e-mail that SDC was not an appropriate placement for DE LA ROSA, but neither she nor HSA (b)(6); (b)(7)(C) produced a copy of the e-mail.²²⁷ Furthermore, LCSW (b)(6); (b)(7)(C) documented completion of an IHSC Form 883, but one was not located in DE LA ROSA's medical file or provided during the on-site review.²²⁸ (b)(6); (b)(7)(C) concurred with LCSW (b)(6); (b)(7)(C) encounter note and entered the same narrative as the June 19, 2018 encounter.

At an unknown time, SDC informed DE LA ROSA his disciplinary hearing would occur on June 21, 2018, at 10:10 a.m.²²⁹ The form documented DE LA ROSA did not request staff representation or witnesses present at the hearing.

²²³ See Investigation Report, dated June 19, 2018.

²²⁴ See Detainee Rights at the IDP Hearing, dated June 19, 2018.

²²⁵ See Cellmate Housing History Report, dated June 12, 2018 – July 10, 2018. Warden (b)(6); (b)(7)(C) explained security moved all detainees from RHU Pod A to 7B due to an air conditioner malfunction.

²²⁶ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 20, 2018.

²²⁷ ERAU interview with LCSW (b)(6); (b)(7)(C) dated August 14, 2018. Per IHSC Directive 07-05, "Once a detainee is identified as having significant psychiatric impairment utilizing the SMI criteria, the BHP will immediately notify the HSA and document the following into the Patient Report spreadsheet which he or she submits to BHU at IHSC headquarters on a weekly basis: (a) Name, (b) Alien #, (c) Facility, (d) Status (e.g., hospitalized, medical housing unit, general population, etc.), (e) Diagnosis, (f) Current Symptoms, and (g) Updates/Treatment Plan." Furthermore, the BHP must complete a Mental Health Review Form (IHSC Form 883) for every patient on the Patient Report spreadsheet at the inclusion of the patient on the list and once a month thereafter as long as the detainee remains on the list which is determined by the evaluation completed by the mental health care provider."

²²⁸ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated June 20, 2018.

²²⁹ See Notice of IDP Hearing, dated June 20, 2018.

On June 21, 2018, at 10:55 a.m., the IDP conducted a disciplinary hearing for DE LA ROSA's violation.²³⁰ The hearing officer, Assistant Shift Supervisor (b)(6); (b)(7)(C) documented DE LA ROSA admitted to the charges. A supervisor reviewed and concurred with the findings the following day. Assistant Shift Supervisor (b)(6); (b)(7)(C) sentenced DE LA ROSA to 30 days' segregation.²³¹

On June 22, 2018, at 10:00 a.m., an SIEA, or equivalent, completed an ICE Form I-887.²³² The ICE Form I-887 documented "Yes" answers to multiple factors, which required DE LA ROSA to continue his segregation status, unless the OIC determined otherwise. Again, the reviewer did not document an interview of DE LA ROSA on the ICE Form I-887 or elsewhere in the detention file.²³³ The SIEA recommended DE LA ROSA remain in disciplinary segregation and the (Acting) Assistant Field Office Director (AFOD) agreed to continue the status.

At an unknown time, Assistant Shift Supervisor (b)(6); (b)(7)(C) delivered a copy of the IDP Report to DE LA ROSA.²³⁴

On June 27, 2018, at 4:11 p.m., PMHNP (b)(6); (b)(7)(C) signed off on a mental health assessment and documented DE LA ROSA had no active symptoms and did not meet SMI criteria.²³⁵ PMHNP (b)(6); (b)(7)(C) reported DE LA ROSA's mood was happy, his affect was appropriate, his behavior pleasant and cooperative, and his judgment was insightful. PMHNP (b)(6); (b)(7)(C) noted DE LA ROSA was receiving psychotropic medications and talk therapy for treatment, and that (b)(6); (b)(7)(C) as compliant with his medication. When asked to elaborate on the latter, PMHNP (b)(6); (b)(7)(C) explained that DE LA ROSA reported he was taking his medication, and he assumed DE LA ROSA was being truthful since he seemed much better.²³⁶ Additionally, PMHNP (b)(6); (b)(7)(C) noted that DE LA ROSA continued to deny thoughts of self-harm. (b)(6); (b)(7)(C) concurred with PMHNP (b)(6); (b)(7)(C) encounter note two days later and entered the same narrative as previous encounters.

According to the MAR (b)(6); (b)(7)(C), RN, administered night doses of Haldol and olanzapine and DE LA ROSA complied.²³⁷ ERAU was unable to discuss either this medication administration or two additional administrations of night medications on June 28 and 29, 2018, with RN (b)(6); (b)(7)(C) as her employer, InGenesis, separated her from service at SDC on August 10, 2018.²³⁸ HSA (b)(6); (b)(7)(C) explained that InGenesis separated RN (b)(6); (b)(7)(C) from service after they discovered she falsified a July 10, 2018, entry on DE LA ROSA's MAR.²³⁹ HSA (b)(6); (b)(7)(C)

²³⁰ See IDP Report, dated June 21, 2018.

²³¹ See Disciplinary Segregation Order, dated June 21, 2018.

²³² See Disciplinary Segregation Review, dated June 22, 2018. All signatures on this form were illegible.

²³³ Similar to the ICE Form I-885, it does not include a designated section to document completion of an interview with the detainee.

²³⁴ See IDP Report, dated June 22, 2018.

²³⁵ See eCW Progress Note by PMHNP (b)(6); (b)(7)(C) dated June 27, 2018.

²³⁶ ERAU interview with PMHNP (b)(6); (b)(7)(C) dated August 15, 2018.

²³⁷ See MAR.

²³⁸ ERAU interview with HSA (b)(6); (b)(7)(C) dated August 14, 2018; See email from (b)(6); (b)(7)(C) at Prestige Staffing, dated August 10, 2018.

²³⁹ ERAU interview with HSA (b)(6); (b)(7)(C) dated August 14, 2018. In this instance, RN (b)(6); (b)(7)(C) documented DE LA ROSA refused his medication but analysis of video footage revealed she did not approach his cell.

concluded, considering this information and DE LA ROSA's consistent non-compliance with medication treatment, these successful entries were highly unlikely.

A Confinement Review Committee reviewed DE LA ROSA's placement in SMU and determined that he should remain removed from the general population for disciplinary reasons.²⁴⁰ Other than an EARM entry, there was no other documentation provided to support this review occurred.

On July 2, 2018, SDC staff notified ERO Atlanta of DE LA ROSA's scheduled return to general population on July 18, 2018.²⁴¹

On July 3, 2018, at 9:32 a.m., Security Chief (b)(6); (b)(7)(C) completed an ICE Form I-887.²⁴² He concluded the reason for DE LA ROSA's placement remained valid but proceeded to check the box to recommend DE LA ROSA's removal from disciplinary segregation. Security Chief (b)(6); (b)(7)(C) did not document an interview of DE LA ROSA on the ICE Form I-887 or elsewhere in the detention file. The Field Office Director, or representative, signed the same day but did not document their determination of DE LA ROSA's segregation status. DE LA ROSA remained in segregation.

SDC was unable to produce a CWL for this date.

On July 4, 2018, at 12:24 p.m., PMHNP (b)(6); (b)(7)(C) signed off on a mental health assessment and documented the same findings as his previous assessment, to include DE LA ROSA's compliance with medication.²⁴³ Again, (b)(6); (b)(7)(C) concurred with PMHNP (b)(6); (b)(7)(C) encounter note and entered the same narrative as previous encounters.

July 10, 2018 – Day of Death

At 1:04 p.m., LCSW (b)(6); (b)(7)(C) signed off on a mental health assessment and again documented DE LA ROSA met SMI criteria.²⁴⁴ LCSW (b)(6); (b)(7)(C) stated DE LA ROSA presented as pleasantly delusional and the content of his delusions were spiritual in nature. LCSW (b)(6); (b)(7)(C) noted that DE LA ROSA denied hearing any voices or thoughts of self-harm and expressed no desire to take medications as he did not believe he needed them. LCSW (b)(6); (b)(7)(C) reminded DE LA ROSA of the benefits of medication compliance, but DE LA ROSA smiled and stated, "I don't need them." LCSW (b)(6); (b)(7)(C) confirmed she conducted the assessment in her office and reported the encounter was normal.²⁴⁵ LCSW (b)(6); (b)(7)(C) documented completion of an IHSC Form 883 again, but one was not located in DE LA ROSA's medical file or provided during the on-site review.

²⁴⁰ See EARM entry for DE LA ROSA, dated July 2, 2018.

²⁴¹ See EARM entry for DE LA ROSA, dated July 2, 2018.

²⁴² See Disciplinary Segregation Review, dated July 3, 2018.

²⁴³ See eCW Progress Note by PMHNP (b)(6); (b)(7)(C) dated July 4, 2018.

²⁴⁴ See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated July 10, 2018.

²⁴⁵ ERAU interview with LCSW (b)(6); (b)(7)(C) dated August 14, 2018.

(b)(6); (b)(7)(C) concurred with LCSW (b)(6); (b)(7)(C) note and entered the same narrative as previous encounters.²⁴⁶

At 8:40 p.m., Officer (b)(6); (b)(7)(C) conducted a security round and looked into DE LA ROSA's cell.²⁴⁷ At 9:12 p.m., 9:41 p.m., and 10:04 p.m., Officer (b)(6); (b)(7)(C) logged conducting additional rounds on a clipboard outside of DE LA ROSA's cell; however, video surveillance footage confirmed Officer (b)(6); (b)(7)(C) did not look in DE LA ROSA's cell at these times.²⁴⁸

At 10:05 p.m., Officer (b)(6); (b)(7)(C) entered Pod 7B to assume the 3rd shift post.²⁴⁹ At 10:08 p.m., Officer (b)(6); (b)(7)(C) escorted a nurse to a cell on the opposite side of the room from DE LA ROSA. At 10:13 p.m., Officer (b)(6); (b)(7)(C) signed to Pod 7A, entered 7B, looked through paperwork at the officer's desk, and then left the pod. At 10:15 p.m., Officer (b)(6); (b)(7)(C) returned to the center of the unit and at 10:17 p.m., moved to his desk. Officer (b)(6); (b)(7)(C) stated when he assumed post, he started to fill out the detainee information on each CAR and CWL for the following day because at midnight, he would need to post the new ones on their clipboards.²⁵⁰ Officer (b)(6); (b)(7)(C) added that while escorting a nurse to another detainee's cell, he noticed the last recorded security round conducted by Officer (b)(6); (b)(7)(C) as at 10:04 p.m.; therefore, he believed he had time before the next required security round to start paperwork needed for the following day during his shift.

At 10:33 p.m., Officer (b)(6); (b)(7)(C) conducted his first security round.²⁵¹ He approached DE LA ROSA's cell, looked in, moved to record his round, and then looked in the cell again after he observed DE LA ROSA standing by the bunk with his chin down.²⁵² Officer (b)(6); (b)(7)(C) knocked on the cell door several times, and after he received no response, called for medical emergency by radio. Officer (b)(6); (b)(7)(C) noted he saw multiple socks wrapped around the top bunk rail.²⁵³ Officer (b)(6); (b)(7)(C) explained he did not open the door and enter the cell himself as he was trained not to do so alone.²⁵⁴

At 10:34 p.m., Officer (b)(6); (b)(7)(C) assigned to Pod 7A, responded to the medical emergency.²⁵⁵ Officer (b)(6); (b)(7)(C) approached DE LA ROSA's cell, looked in, and spoke into his radio. Officer (b)(6); (b)(7)(C)

²⁴⁶ See Progress Note by LCSW (b)(6); (b)(7)(C) dated July 10, 2018. ERAU notes D (b)(6); (b)(7)(C) confirmatory signed off on July 11, 2018, the day after DE LA ROSA expired.

²⁴⁷ See Pod 7B video surveillance footage, dated July 10, 2018. On this date, Officer (b)(6); (b)(7)(C) was 2nd Shift Officer (2:00 p.m. – 10:00 p.m.), assigned to Pod 7B.

²⁴⁸ See CWL, dated July 10, 2018; see also Pod 7B video surveillance footage, dated July 10, 2018. ERAU was unable to interview Officer (b)(6); (b)(7)(C)'s SDC terminated Officer (b)(6); (b)(7)(C) July 26, 2018 for failing to properly observe DE LA ROSA while conducting his rounds.

²⁴⁹ At SDC, 3rd Shift times are 10:00 p.m. – 6:00 a.m.

²⁵⁰ ERAU interview with Officer (b)(6); (b)(7)(C), dated August 14, 2018.

²⁵¹ See Pod 7B video surveillance footage, dated July 10, 2018.

²⁵² ERAU interview with Officer (b)(6); (b)(7)(C), dated August 14, 2018.

²⁵³ See Incident Report by Officer (b)(6); (b)(7)(C), dated July 10, 2018.

²⁵⁴ ERAU interview with Officer (b)(6); (b)(7)(C), dated August 14, 2018.

²⁵⁵ See Pod 7B video surveillance footage, dated July 10, 2018.

stated he called for a possible hanging over the radio then immediately went to the RHU Control Center to retrieve the cut-down tool.²⁵⁶

Office (b)(6); (b)(7)(C), assigned to the RHU Control Center, stated she heard the medical emergency call and saw Officer (b)(6); (b)(7)(C) standing at DE LA ROSA's cell; then Office (b)(6); (b)(7)(C) pounded on the window and asked for the cut-down tool.²⁵⁷ Officer (b)(6); (b)(7)(C) took the tool from its storage box on the wall, removed it from its pouch, and placed the tool in the pass-through box for Officer (b)(6); (b)(7)(C).

At 10:35 p.m., Officer (b)(6); (b)(7)(C) returned to DE LA ROSA's cell, accompanied by (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) opened the cell door.²⁵⁸ (b)(6); (b)(7)(C) stated upon entry into the cell, he noticed DE LA ROSA's feet were flat on the floor and that he was drooling.²⁵⁹ Officer (b)(6); (b)(7)(C) proceeded to lift DE LA ROSA upward, while Officer (b)(6); (b)(7)(C) cut through the socks tied around his neck.

At 10:36 p.m., the officers placed DE LA ROSA on the floor, and Officer (b)(6); (b)(7)(C) immediately began cardio pulmonary resuscitation (CPR); Captain (b)(6); (b)(7)(C) arrived on the scene shortly after.²⁶⁰

At 10:37 p.m., security turned the dayroom lights on, and Officer (b)(6); (b)(7)(C) arrived with a handheld camera.²⁶¹ Officer (b)(6); (b)(7)(C) stated she was in Central Control when she heard the medical emergency call, located the handheld camera, and then ran to Pod 7B.²⁶² Unless otherwise noted, the following events are based on a review of the handheld video footage²⁶³ captured by Officer (b)(6); (b)(7)(C). Officer (b)(6); (b)(7)(C) gave DE LA ROSA one rescue breath.

²⁵⁶ ERAU interview with Officer (b)(6); (b)(7)(C), dated August 16, 2018. Officer (b)(6); (b)(7)(C) acknowledged he should not have left his post without proper relief and that he made a judgment call to retrieve the cut-down tool versus breaching the cell as he was unsure how close the other responders were to the pod.

²⁵⁷ ERAU interview with Officer (b)(6); (b)(7)(C), dated August 14, 2018.

²⁵⁸ See Pod 7B video surveillance footage, dated July 10, 2018. ERAU notes two minutes and four seconds elapsed from the time when Officer (b)(6); (b)(7)(C) looked into DE LA ROSA's cell to when the officers opened the cell door.

²⁵⁹ ERAU interview with (b)(6); (b)(7)(C), dated August 14, 2018.

²⁶⁰ *Id.*; See also Incident Statement by Officer (b)(6); (b)(7)(C), dated July 10, 2018. Officer (b)(6); (b)(7)(C) performed chest compressions without a breathing mask or CPR mouth shield. During interview, Officer (b)(6); (b)(7)(C) pointed out a CPR mask pouch on his belt and stated he forgot about it during the emergency.

²⁶¹ See Pod 7B video surveillance footage, dated July 10, 2018.

²⁶² ERAU interview with Officer (b)(6); (b)(7)(C), dated August 14, 2018. Officer (b)(6); (b)(7)(C) a member of the SDC Emergency Response Team (ERT).

²⁶³ The time stamp shown in the right-hand corner of the handheld camera footage is approximately an hour and three minutes behind the time stamp shown in SDC's Milestone video surveillance. For instance, the handheld camera footage shows R (b)(6); (b)(7)(C) entered DE LA ROSA's cell at 9:36:37 p.m. In the pod 7B video surveillance footage, it shows R (b)(6); (b)(7)(C) entered DE LA ROSA's cell at 10:39:28 p.m. As such, any event documented in the handheld video camera footage has been adjusted to add one hour and three minutes in this report.

At 10:38 p.m., Officer (b)(6); (b)(7)(C) took over chest compressions for Officer (b)(6); (b)(7)(C) ²⁶⁴ (b)(6); (b)(7)(C) and another nurse arrived in Pod 7B with a gurney, backboard, and two emergency bags. RN (b)(6); (b)(7)(C) looked into DE LA ROSA's cell, returned to the emergency bags, and asked where the automatic external defibrillator (AED) was. (b)(6); (b)(7)(C) then entered the cell with the backboard. In the approximate two minutes of video footage preceding (b)(6); (b)(7)(C) arrival and subsequent ambu bag ²⁶⁵ placement, officers gave DE LA ROSA only one rescue breath.

At 10:39 p.m., (b)(6); (b)(7)(C) stated she needed an oxygen tank, a crash cart, and for someone to call Emergency Medical Services (EMS). ²⁶⁶ At this time, Stewart County Fire & EMS dispatched responders to SDC. ²⁶⁷ (b)(6); (b)(7)(C) took over CPR and (b)(6); (b)(7)(C) again stated she needed an oxygen tank, an AED, additional nurses from Intake, and a crash cart.

At 10:41 p.m., (b)(6); (b)(7)(C) entered the cell with an AED. Two other nurses arrived moments later. ²⁶⁸ (b)(6); (b)(7)(C) applied the AED pads, and another SDC nurse took over CPR.

At 10:42 p.m., Officer (b)(6); (b)(7)(C) arrived at DE LA ROSA's cell with an oxygen tank.

Between 10:42 p.m. and 10:47 p.m., three nurses coordinated CPR efforts; the AED never advised shock. ²⁶⁹ At 10:43 p.m., (b)(6); (b)(7)(C) tilted ²⁷⁰ DE LA ROSA's head back during CPR for the first time.

At 10:48 p.m., an EMS responder entered DE LA ROSA's cell. The EMS responder removed the AED pads from DE LA ROSA's body, then he and an SDC nurse pulled DE LA ROSA into the 7B dayroom. At 10:50 p.m., an EMS responder re-applied AED pads to DE LA ROSA and another then intubated him. At 10:55 p.m., EMS responders lifted DE LA ROSA onto their gurney and a minute later, wheeled him out of the unit. At 10:57 p.m., an EMS responder can be

²⁶⁴ Officer (b)(6); (b)(7)(C) initially performed chest compressions correctly; however, at one point his hand position moved downward, off DE LA ROSA's chest. In the minute and 24 seconds Officer (b)(6); (b)(7)(C) performed CPR before RN (b)(6); (b)(7)(C) arrival and subsequent oxygen mask placement, he never gave DE LA ROSA a rescue breath. While Officer (b)(6); (b)(7)(C) performed chest compressions, (b)(6); (b)(7)(C) attempted to place a CPR mask on DE LA ROSA but a voice stated, "back up a little bit." (b)(6); (b)(7)(C) proceeded to step back, and RN (b)(6); (b)(7)(C) arrived to DE LA ROSA's cell within seconds. (b)(6); (b)(7)(C) moved out of (b)(6); (b)(7)(C) way and did not place the mask on DE LA ROSA.

²⁶⁵ An ambu bag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

²⁶⁶ An oxygen tank was present on the gurney; however, it was nonfunctional due to a disconnected regulator.

During his interview, HS (b)(6); (b)(7)(C) advised that the regulator was in the bag, but during the emergency, RN (b)(6); (b)(7)(C) could not locate it.

²⁶⁷ See Stewart County Fire & EMS Prehospital Care Report, dated July 10, 2018.

²⁶⁸ See Pod 7B video surveillance footage, dated July 10, 2018. ERAU was only able to confirm the identity of one nurse in the video footage as many of the medical staff's incident statements, interviews, and actions in the video footage contradicted one another.

²⁶⁹ See RN (b)(6); (b)(7)(C) Detainee Death e-mail, dated July 11, 2018.

²⁷⁰ Creative Corrections advised that the head tilt method of opening the airway is effective provided the emergency responder properly places his or her hands in performance of the tilt. During HSA (b)(6); (b)(7)(C) After-Action Review with medical staff, he identified that the jaw thrust method would have been preferred, as it effectively and more simply, opens an airway without having to rely on proper hand placement at the neck as one would need to do with the head tilt method.

heard stating DE LA ROSA was clinically dead as they placed him into the ambulance, but that they were going to do everything they could to reverse that. The handheld video footage ends.

At 11:06 p.m., the ambulance left SDC for SGRMC.²⁷¹

Lt. (b)(6); (b)(7)(C) assigned Officer (b)(6); (b)(7)(C) to the hospital detail.²⁷² Officer C (b)(6); (b)(7)(C) rode in the front seat of the ambulance with DE LA ROSA, while Officer (b)(6); (b)(7)(C) followed in the chase vehicle.²⁷³

Officer (b)(6); (b)(7)(C) reported the ambulance immediately activated its lights and siren, and she observed EMS responders performing CPR through the rear windows of the ambulance.²⁷⁴ While en route to the hospital, EMS requested to terminate CPR as DE LA ROSA was not responding, his skin was cool to the touch, and his pupils were fixed and unresponsive; an SGRMC Emergency Room NP (unnamed) denied the request, therefore EMS continued CPR efforts.²⁷⁵

At 11:25 p.m., EMS arrived to SGRMC.²⁷⁶ Officer (b)(6); (b)(7)(C) stated hospital staff took DE LA ROSA to a curtained area and continued to perform CPR.²⁷⁷ At 11:27 p.m., SGRMC RN (b)(6); (b)(7)(C) noted that upon arrival, DE LA ROSA was in full cardiac and respiratory arrest with EMS staff performing bag/mask ventilations; no signs of life were present.²⁷⁸

At 11:29 p.m., SGRMC (b)(6); (b)(7)(C) pronounced DE LA ROSA dead.²⁷⁹

At 11:35 p.m., RN (b)(6); (b)(7)(C) contacted Captain (b)(6); (b)(7)(C) to inform him of DE LA ROSA's death.²⁸⁰

At 11:50 p.m., Captain (b)(6); (b)(7)(C) back and advised her to call the coroner.

On July 11, 2018, at 12:27 a.m., HSA (b)(6); (b)(7)(C) called RN (b)(6); (b)(7)(C) and notified her an autopsy would be required.²⁸¹

At 1:24 a.m., Deputy Coroner (b)(6); (b)(7)(C) arrived at the hospital. Officers (b)(6); (b)(7)(C) and Coleman remained with DE LA ROSA until Deputy (b)(6); (b)(7)(C) arrived to SGRMC.

At 1:46 a.m., Deputy (b)(6); (b)(7)(C) left the hospital with DE LA ROSA.²⁸² At 1:49 a.m., Officer (b)(6); (b)(7)(C) departed SGRMC, and at 2:16 a.m., they returned to SDC.

²⁷¹ See Stewart County Fire & EMS Prehospital Care Report, dated July 10, 2018.

²⁷² ERAU interview with (b)(6); (b)(7)(C) dated August 14, 2018.

²⁷³ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 15, 2018.

²⁷⁴ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 15, 2018.

²⁷⁵ See Stewart County Fire & EMS Prehospital Care Report, dated July 10, 2018.

²⁷⁶ *Id.*

²⁷⁷ ERAU interview with Officer (b)(6); (b)(7)(C) dated August 15, 2018.

²⁷⁸ See SGRMC Emergency Department (ED) Summary Nursing Notes, dated July 10, 2018.

²⁷⁹ See SGRMC ED Visit Note Report, dated July 11, 2018.

²⁸⁰ See SGRMC ED Summary Nursing Notes, dated July 10, 2018. Officer (b)(6); (b)(7)(C) advised ERAU that she informed Captain (b)(6); (b)(7)(C) by telephone of DE LA ROSA's death but was unable to provide documentation to support this.

²⁸¹ *Id.*

²⁸² See Hospital Logbook, dated July 10, 2018.

Post-Death Events

- SDC collected incident reports from all involved staff immediately following the medical emergency. On July 10, 2018, Officer (b)(6); (b)(7)(C) initially wrote only a two-line incident report but, per instruction by (b)(6); (b)(7)(C) Facility Investigator, she wrote a second, detailed report on July 23, 2018.²⁸³ Officer (b)(6); (b)(7)(C) explained that she did not realize a detailed report was necessary, as she had never been involved in a response to a hanging before.
- Captain (b)(6); (b)(7)(C) stated that after DE LA ROSA's death, Warden Peterson instructed him to notify the Sheriff's Department. Sheriff (b)(6); (b)(7)(C) arrived to SDC at 12:30 a.m. on July 11, 2018.²⁸⁴ Sheriff (b)(6); (b)(7)(C) stated he spoke with the Warden and then interviewed Officer (b)(6); (b)(7)(C) following the interview, he contacted the GBI and noted that GBI arrived on the scene at 1:15 a.m. Captain (b)(6); (b)(7)(C) informed the review team that he escorted one of the GBI agents to DE LA ROSA's cell. When told he would be awhile, he left the agent with an officer.
- On July 11, 2018, SDC inventoried DE LA ROSA's property and turned it over to ERO staff, along with the \$0.31 remaining in DE LA ROSA's account.²⁸⁵ At the time of the site visit, ERO had not returned DE LA ROSA's property to his next of kin, as there was an ongoing investigation.
- On July 11, 2018, Warden Peterson assigned Facility Investigator (b)(6); (b)(7)(C) to review the events surrounding DE LA ROSA's suicide. She submitted a written report to the Warden on August 6, 2018.²⁸⁶ Facility Investigator (b)(6); (b)(7)(C) informed ERAU that her investigation involved a review of written reports, interviews with security and medical staff, and extensive review of video footage. Her review did not include analysis of actions taken by medical personnel.
- HSA (b)(6); (b)(7)(C) conducted an After-Action Review with IHSC and CoreCivic medical staff.²⁸⁷

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care SDC provided DE LA ROSA, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found deficiencies in SDC's compliance with certain requirements of the ICE PBNDS 2011 (as revised in 2016).

²⁸³ See Incident Statements by Officer (b)(6); (b)(7)(C) dated July 10, 2018, and July 23, 2018.

²⁸⁴ See Stewart County Sheriff's Office Incident Report, dated July 10, 2018.

²⁸⁵ See Disposition of Non-Allowable Property and Inmate Account Summary, both dated July 11, 2018.

²⁸⁶ See CoreCivic General Counsel Office of Investigations, Investigative Report Form by Facility Investigator (b)(6); (b)(7)(C) dated August 6, 2018.

²⁸⁷ HSA (b)(6); (b)(7)(C) did not advise ERAU of the After-Action Review date.

1. ICE PBNDS 2011, *Medical Care*, Section (V)(U)(4) states, “Distribution of medication (including over the counter) shall be performed in accordance with specific instructions and procedures established by the HSA in consultation with the CMA. Written records of all prescribed medication given to or refused by detainees shall be maintained... All prescribed medications and medically necessary treatments shall be provided to detainees on schedule and without interruption, absent exigent circumstances.”
 - Video evidence showed an RN falsely recorded refusal of psychiatric medications on the night of DE LA ROSA’s suicide, July 10, 2018.
 - ERAU was unable to confirm if the June 14, and 17, 2018, amlodipine administrations were given or refused due to illegible entries on the MAR.
2. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(1) states, “Upon admission at the facility, documented informed consent shall be obtained for the provision of health care services.”
 - DE LA ROSA did not sign a general consent for treatment form when first admitted to SDC.
3. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4) states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects, shall be obtained.”
 - There is no documentation that medical staff requested DE LA ROSA sign a separate consent form for the psychotropic medications haloperidol and olanzapine when ordered on June 12, 2018.
4. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(9) states, “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 treatments.”
 - Medical staff documented DE LA ROSA refused his medications 29 times between June 15 and July 10, 2018, but medical staff completed refusal forms for only 21 of the 29 refusals.
 - Medical staff entered “No-Show” on the MAR 20 times between June 14 and 26, 2018. Fifteen of the 20 no-shows occurred after security placed DE LA ROSA in segregation; therefore, he could not voluntarily report to receive medications. Entries of “No-Show”, especially in segregation, do not constitute affirmative documentation that the detainee refused medications as required by the standard. There is no documentation medical staff confirmed the detainee was refusing medications on these 15 occasions, that they explained the risks associated with these refusals, or that they completed refusal forms.

5. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(10) states, “The clinical medical authority and facility administrator shall look into refusals of treatment to ensure that such refusals are not the result of miscommunication or misunderstanding.”
 - Medical staff did not notify the Clinical Director that DE LA ROSA was refusing medications; therefore, the Clinical Director was unaware of this issue. However, nurses sent 17 telephone encounters to NP (b)(6); (b)(7)(C) the mid-level provider responsible for following-up on medication refusals/no-shows. The NP did not see DE LA ROSA, claiming medical staff postponed scheduled appointments; medical staff were unable to produce documentation supporting scheduling occurred at all.
6. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(F) states, “All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring, welfare checks at least every eight hours conducted by clinical staff, and daily mental health treatment by a qualified clinician.”
 - Medical staff did not meet the eight-hour timeframe on at least three occasions. On April 25, 2018, there was an 8 hour and 45-minute gap between a healthcare round at 1:00 a.m. and the next round at 9:45 a.m. On April 27, 2018, there was a 10 hour and 10-minute gap between a healthcare round at 10:30 p.m. and the next round at 8:40 a.m. on April 28, 2018. On April 29, 2018, there was a 10 hour and 1-minute gap between a round at 2:29 p.m. and the next round at 12:30 a.m. on April 30, 2018. ERAU was unable to positively identify other occasions when medical staff may have exceeded the eight-hour timeframe, as numerous staff members did not enter the exact time of the encounter. Timing of vital signs and medical staff sign-offs suggest there may have been multiple other instances of welfare checks exceeding the eight-hour timeframe, particularly when a round was due on the night shift.
7. ICE PBNDS 2011, *Significant Self-harm and Suicide Prevention and Intervention*, Section (V)(K) states, “A critical incident debriefing following a suicide or serious suicide attempt shall be offered to all affected staff and detainees within 24 to 72 hours after the critical incident.”
 - Although other officers involved in the incident reported getting one, Officer (b)(6); (b)(7)(C) who rode in the ambulance with DE LA ROSA, was not offered a critical incident debriefing or supportive counseling services by SDC.
8. ICE PBNDS 2011, *Custody Classification System*, Section (V)(H)(3) states, “Special Reclassification Assessments: Staff shall complete a special reclassification within 24 hours before a detainee leaves the SMU, following an incident of abuse or victimization, and at any other time when warranted based upon the receipt of additional, relevant information, such as after a criminal act, or if a detainee wins a criminal appeal, is pardoned or new criminal information comes to light.”
 - A reclassification review factoring DE LA ROSA’s disciplinary conviction was conducted on April 10, 2018, following his IDP disciplinary hearing and sentencing

on April 6, 2018. However, security staff did not complete a reclassification review within the 24 hours preceding DE LA ROSA's release from disciplinary segregation on April 18, 2018.

9. ICE PBNDS 2011, *Disciplinary System*, Section (V)(A)(6-8) states, "When a detainee has a diagnosed mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability, a mental health professional, preferably the treating clinician, shall be consulted to provide input as to the detainee's competence to participate in the disciplinary hearing, any impact the detainee's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior... If a detainee has a mental disability or mental illness but is competent, the disciplinary process shall consider whether the detainee's mental disabilities or mental illness contributed to his or her behavior when determining what type of sanction, if any, should be imposed. A mental health professional should also be consulted as to whether certain types of sanctions (e.g., placement in disciplinary segregation, loss of visits, or loss of phone calls) may be inappropriate because they would interfere with supports that are a part of the detainee's treatment or recovery plan."
 - There is no documentation that security staff consulted a mental health professional prior to disciplinary hearings on April 6 and June 21, 2018, or that the hearing officer considered the degree to which DE LA ROSA's mental illness may have contributed to his behavior. ERAU acknowledges that DE LA ROSA's mental illness was likely not known to security personnel at the time of the hearings as patient diagnoses are confidential and, per the medical record, he was asymptomatic. Ultimately, ERAU recommends that healthcare and security personnel review the standard and consider ways they can accomplish this without violating patient confidentiality.
10. ICE PBNDS 2011, *Disciplinary System*, Section (V)(H) states, "The detainee in IDP proceedings shall have the right to due process, which includes the rights to... have an IDP hearing within 48 hours after the conclusion of the investigation or the conclusion of the Unit Disciplinary Committee (UDC) hearing... The IDP shall conduct the hearing within 48 hours after the investigation or the conclusion of the UDC hearing, unless the detainee requests more time to gather evidence or otherwise prepare a defense. In cases where a hearing is delayed, the reason(s) must be documented (e.g., a continuing investigation of facts, unavailability of one or more essential witnesses, etc.) and, unless the detainee has requested the delay, approved by the facility administrator. If the detainee is being held in segregation, the delay shall not exceed 72 hours, barring an emergency."
 - On April 4, 2018, at 10:52 a.m. (b)(6); (b)(7)(C) completed the investigation for the April 3, 2018, disciplinary incident. The IDP hearing commenced at 12:42 p.m. on April 6, 2018, more than 48 hours after the conclusion of the investigation. The hearing officer did not document the reason for the delay.
11. ICE PBNDS 2011, *Searches of Detainees*, Section (V)(D)(2)(b) states, "Officers must obtain supervisory approval before conducting strip searches. Staff may conduct a strip

search where there is reasonable suspicion that contraband may be concealed on the person. ‘Reasonable suspicion’ means suspicion based on specific and articulable facts that would lead a reasonable officer to believe that a specific detainee is in possession of contraband. It is a more permissive (lower) standard than probable cause, but it is more than a mere hunch. It must be based on specific and articulable facts—along with reasonable inferences that may be drawn from those facts—that the officer shall document in Form G-1025 or equivalent.”

- The form documenting the strip search of DE LA ROSA on April 24, 2018 states, “Suicide Watch” and does not document the specific facts that led the officer to believe DE LA ROSA was in possession of contraband.

This practice also violates *SDC RHU Post Orders*, Section (III)(C)(1)(b), which states, “ICE detainees will not be strip searched unless there is a ‘reasonable suspicion’ that the detainee is concealing a weapon or contraband. A frisk search shall be performed in lieu of a strip search.”

12. ICE PBNDS 2011, *Special Management Units*, Section (V)(A)(3)(a-b) states, “All facilities shall implement written procedures for the regular review of all detainees held in administrative segregation, consistent with the procedures specified below. A supervisor shall conduct a review within 72 hours of the detainee’s placement in administrative segregation to determine whether segregation is still warranted... The review shall include an interview with the detainee... A supervisor shall conduct an identical review after the detainee has spent seven days in administrative segregation and every week thereafter for the first 30 days and every 10 days thereafter, at a minimum.”

- There is no documentation ICE or security staff interviewed DE LA ROSA during administrative segregation status reviews on April 26, 2018, and May 3, 2018.
- The May 3, 2018 status review was delinquent, as it was due on May 1, 2018, seven days after DE LA ROSA’s initial placement in segregation.

13. ICE PBNDS 2011, *Special Management Units*, Section (V)(B) states, “A detainee may be placed in disciplinary segregation only by order of the IDP, or its equivalent, after a hearing in which the detainee has been found to have committed a prohibited act and only when alternative dispositions may inadequately regulate the detainee’s behavior.”

- Security staff ordered DE LA ROSA’s placement in disciplinary segregation on April 3, 2018, and June 19, 2018, although the charges were not adjudicated until April 6, 2018, and June 21, 2018, respectively.

14. ICE PBNDS 2011, *Special Management Units*, Section (V)(B)(3) states, “All facilities shall implement written procedures for the regular review of all disciplinary segregation cases, consistent with the following procedures: A security supervisor shall interview the detainee and review his/her status in disciplinary segregation every seven days to determine whether the detainee: Abides by all rules and regulations; and, Is provided showers, meals, recreation and other basic living standards, as required by this detention

standard... The supervisor shall document his/her findings after every review, by completing a disciplinary segregation review (Form I-887). The supervisor may recommend the detainee's early release from the SMU upon finding time in disciplinary segregation is no longer necessary to regulate the detainee's behavior. An early-release recommendation must have the facility administrator's approval before the detainee may be returned to the general population. In conducting this review, the facility administrator will consider any request by the detainee to present written evidence or available witnesses. The review shall take into account the detainee's views."

- There is no documentation security staff reviewed DE LA ROSA's placement status in disciplinary segregation from April 6 to April 18, 2018.
- The July 3, 2018, status review was delinquent, as it was due on June 29, 2018, seven days after the June 22, 2018, status review. Although an EARM entry noted that on June 27, 2019, a Confinement Review Committee reviewed DE LA ROSA's segregation status and advised he remain in segregation, there was no additional documentation to support this review occurred. Furthermore, there is no documentation security staff interviewed DE LA ROSA during the disciplinary segregation status reviews on June 22, 2018, and July 3, 2018.
- On April 18, 2018, Security Chief (b)(6); [REDACTED] directed DE LA ROSA's release to the general population after he served only 15 days of the first 30-day disciplinary segregation sanction. Security Chief (b)(6); (b)(7)(C) [REDACTED] did not complete a status review documenting an interview of the detainee and a recommendation for early release based on a determination that disciplinary segregation was no longer necessary. Security Chief (b)(6); [REDACTED] documented the early release only on the Confinement Record, without rationale, and did not obtain approval from the facility administrator.²⁸⁸

15. ICE PBNDS 2011, *Special Management Units*, Section (V)(D)(1) states, "A permanent log shall be maintained in the SMU to record all activities concerning SMU detainees (e.g., meals served, recreational time, visitors, etc.)."

- There was no record of whether the lunch meal was served or refused on April 5, April 6, April 29, and June 22, 2018.

16. ICE PBNDS 2011, *Special Management Units*, Section (V)(M) states, "Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule."

- SDC was unable to produce CWLs for April 4, April 17, and July 3, 2018; therefore, ERAU could not verify completion of 30-minute security rounds.
- On July 10, 2018, Officer (b)(6); [REDACTED] logged security rounds at 9:13 p.m., 9:39 p.m., and 10:04 p.m. Video surveillance footage showed Officer (b)(6); (b)(7)(V) [REDACTED] signing documents on

²⁸⁸ The ICE detention standards do not address suspension of the balance of a disciplinary segregation sanction outside the status review process.

the clipboard next to the detainee's cell, but he did not look in the cell to personally observe DE LA ROSA.

These issues also violate *SDC RHU Post Orders*, Section (III)(B)(1)(i), which states, "Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule... Observation will include looking in each cell to ensure that no unusual or unauthorized activities are occurring."

ERAU noted the following additional violations of SDC-specific policy below:

1. *SDC RHU Post Orders*, Section (III)(L)(5) states, "Inmates/residents will be offered the opportunity to shower and shave at least three (3) times per week. In the event an inmate/resident refuses to shower for an entire one (1) week period, notify the Shift Supervisor/Unit Manager."
 - Confinement Activity Records document security staff offered DE LA ROSA showers only twice during the week of April 8, 2018 (April 9 and 11, 2018) and twice during the week of July 1, 2018 (July 4 and 6, 2018).
 - There is no documentation that security staff notified a supervisor when DE LA ROSA did not shower during the period from April 3 to 18, 2018.
2. *SDC Policy 9-13, Count Principles and Procedures* states, "At shift change, the oncoming *Correctional Officer* will conduct an informal count of all inmates in his/her area of responsibility;" and *SDC RHU Post Orders*, Section (II)(G), Start of Shift states, "Verify that all cell doors and food tray slots are secure."
 - On July 10, 2018, Officer (b)(6); (b)(7)(C) did not conduct a count or make a round to verify all cell doors and food tray slots were secure until he had been on the post for 28 minutes. Officer (b)(6); (b)(7)(C) informed ERAU that he timed his first security round based on Officer (b)(6); (b)(7)(C) last documented security round, which was not appropriately conducted according to video surveillance footage. Conducting security rounds in accordance with the standard and facility policy—specifically, verifying detainee welfare through direct observation at least every 30 minutes on an irregular schedule—serves a fundamental and critical safety and security purpose in restricted housing.
3. *SDC RHU Post Orders*, Section (IV) states, "Never leave your post for any reason unless properly relieved by an assigned officer or the Shift Supervisor."
 - On July 10, 2019, Officer (b)(6); (b)(7)(C) his post, 7A, on two occasions, at 10:13 p.m. and 10:34 p.m.

Areas of Concern

ERAU also noted the following concerns regarding DE LA ROSA's medical care:

- Nurses used template language programmed in eCW to document segregation rounds while DE LA ROSA was in the RHU for disciplinary reasons. All notes are virtually identical and did not include subjective information reflecting DE LA ROSA's answers in response to queries. In DE LA ROSA's case, nurses' findings that there was no evidence of hallucinatory and delusional thoughts would have been far better supported had they documented subjective information. Including this information helps to ensure that segregation rounds serve the intended purpose of verifying detainee health and welfare.
- On April 30, 2018, medical staff did not follow-up on or report DE LA ROSA's elevated blood pressure reading of 152/92 to a provider to determine possible monitoring and treatment needs. DE LA ROSA's blood pressure was within AHA parameters for elevated blood pressure six times, Stage One hypertension 21 times, and Stage Two hypertension eight times. Despite these readings, SDC medical staff only prescribed DE LA ROSA blood pressure medication after receiving the Medication Reconciliation for Discharge/Transfer List from CRCC. Furthermore, DE LA ROSA's medical record documents his last blood pressure reading was on June 19, 2018, 21 days before his death. Whether or not the detainee's refusal of medications impacted either his physical or mental health, N (b)(6); (b)(7)(C) s a prescribing provider, was obliged to act upon nurses' referrals, including educating the detainee on the risks.
- During interview, HSA (b)(6); (b)(7)(C) stated he informed nurses after DE LA ROSA's death that they are expected to follow the blood pressure guidelines within IHSC Directive 03-10, *Intake Screening and Intake Reviews*, which details what action should be taken when a detainee's blood pressure is elevated. HSA (b)(6); (b)(7)(C) was unable to provide ERAU with documentation to support that he informed medical staff to follow these guidelines outside of the intake screening and intake reviews process.
- On July 10, 2018, R (b)(6); (b)(7)(C), the first medical responder to arrive at DE LA ROSA's cell, brought emergency equipment with her; however, the AED was not present and the oxygen tank was disconnected from the regulator. HSA (b)(6); (b)(7)(C) explained that medical staff did not replenish emergency equipment, to include the AED, following a medical emergency earlier in the day. Ensuring necessary emergency equipment is available and operable is critical to an effective medical emergency response.

ERAU also noted the following concerns with security:

- On April 21, 2018, DE LA ROSA submitted an incident statement in which he asked security to move him to segregation because his cellmate threatened his life. Although the Cellmate History Housing record documented DE LA ROSA's cellmate was moved on April 23, 2018, there is no documentation of when security received the statement or what specific action security took pursuant to the claim. Within the detention file, a memorandum dated April 24, 2018, documented security placed DE LA ROSA on administration segregation status pending investigation for protective custody. Following a mental health assessment, medical staff placed DE LA ROSA on suicide watch, which continued until he was transferred to CRCC. Although placement on protective custody apparently overlapped with suicide watch, documentation related to protective custody was limited.
- After Officer (b)(6); (b)(7)(C) found DE LA ROSA hanging and called a medical emergency, he did not enter the cell until other officers arrived. Officer (b)(6); (b)(7)(C) stated SDC trained him not to open a cell door in the RHU unless another officer was present; however, SDC policy does not prohibit an officer from opening a cell door without another officer present. In fact, video surveillance footage of Pod 7B showed the officer on the previous shift opened cell doors without another officer present to allow detainees out for showers.
- The Classification Supervisor did not review and approve the detainee's initial classification, completed March 13, 2018, until March 29, 2018, 16 days after it was applied. The ICE PBNDS 2011 Standards do not set a specific timeframe for supervisory review but do state that the purpose of the review is to check "for accuracy and completeness and ensure that each detainee is assigned to the appropriate housing unit." Although in this case, DE LA ROSA's classification and housing assignment were appropriate, the purpose of supervisory review cannot be achieved if review of the classification decision is not timely.
- There were multiple illegible signatures with no accompanying printed names on documents in the detention file. Absent legible names, there is no way to account for actions and decisions.

APPENDIX 1

CONFINEMENT ACTIVITY RECORDS

The table below shows the activities refused by DE LA ROSA and undocumented meals by security staff while DE LA ROSA was in segregation.

Disciplinary Segregation from April 3, 2018, 8:52 p.m. to April 18, 2018, 6:10 p.m.		
Date	Activity Refused	Undocumented Meals
April 4, 2018	Shower	--
April 5, 2018	Recreation	Lunch
April 6, 2018	--	Lunch
April 8, 2018	Recreation	--
April 9, 2018	Shower	--
April 11, 2018	Shower & Recreation	--
April 12, 2018	Recreation	--
April 13, 2018	Recreation	--
April 14, 2018	Recreation	--
April 16, 2018	Recreation	--
Suicide Watch from April 24, 2018, 4:45 p.m. to May 4, 2018, 7:32 a.m.		
Date	Activity Refused	Undocumented Meals
April 29, 2018	--	Lunch
May 1, 2018	Recreation	--
May 2, 2018	Recreation	--
May 3, 2018	No activities logged	--
May 4, 2018	No activities logged	--
Disciplinary Segregation from June 19, 2018, 6:05 p.m. to July 10, 2018, 11:06 p.m.		
Date	Activity Refused	Undocumented Meals
June 22, 2018	--	Lunch

EXHIBITS

1. Georgia Bureau of Investigation, Division of Forensic Sciences Autopsy, Official Report, dated October 2, 2018.
2. Creative Corrections Detainee Death Review Healthcare and Security Analysis.

OFFICE OF THE MEDICAL EXAMINER

2100 JEFFERSON STREET
JACKSONVILLE, FLORIDA 32206

INSPECTION REPORT

NAME OF DECEASED: VOLKOV, Guerman
M.E. NUMBER: 18-2561
DATE OF DEATH: 11/30/2018
DATE/TIME OF INSPECTION: 12/1/2018 @ 09:00 AM
COUNTY OF DEATH: Duval

EXTERNAL EXAMINATION:

The unembalmed body (measured and weighed upon arrival) is that of a 70 inch, 224 pound, well nourished male, with predominantly European anthropologic features and light pigmentation, who appears consistent with his recorded age of 56 years. Rigor mortis is fully developed. Livor mortis is red-purple, posterior and blanches with pressure. The torso is cold to touch, following prior refrigeration.

The scalp hair is 6-8 inches maximum length, dark brown and straight. The irides are brown and the pupils are equal at 5 millimeters. The corneas are clear and free of arcus senilis. The sclerae and conjunctivae are pale and free of petechiae, tache noire and chemosis. The ear lobes are unremarkable. The oral and nasal mucosae are unremarkable. The lips and frenula are unremarkable. The teeth are natural and in moderate repair. The face has a beard and mustache of similar quality to his scalp hair. The anterior neck structures are midline.

The chest is symmetrical. The breasts are free of masses. The nipples have no lesions or discharge. The abdomen is slightly protuberant. The penis is circumcised, with both testes descended. The body hair distribution is normal. The extremities are symmetrical, without edema, discoloration or thickening. There is a 1 inch by ½ inch scar on the right knee. There is a ¼ inch skin tear on the anterior/medial right lower leg. As received, a pair of shackles are around both ankles; deep to these, there are curvilinear abrasions of the anterior and posterior surfaces of the distal lower legs. The back and anus are unremarkable. There is a ½ inch skin tag on the right upper back. The body is free of visible tattoos, piercings or other distinguishing features.

CLOTHING:

The body is received wearing brown underwear (previously cut), one orange sock (on left foot), a brown T shirt (previously cut), and an orange jump suit (previously cut). Received loose with the body are two brown shoes.

MEDICAL THERAPY:

An endotracheal tube and an orogastric tube enter the oral cavity. A nasal trumpet enters the right nostril. The body has a total of four disposable electrocardiographic electrode pads and two

defibrillator pads. Intravenous lines are found in the right antecubital fossa, lateral right wrist, dorsal left hand, and right femoral area. A pulse oximeter lead is on the tip of the left index finger. The left wrist has a hospital identification bracelet. A Foley catheter passes through the urethra.

WOUNDS:

There is a 1/4 inch abrasion on the distal/anterior right lower leg, and there is a 1/4 inch abrasion on the dorsal right foot.

TOXICOLOGICAL EXAMINATION:

Specimens collected and retained: antemortem fluids (three tubes).

Morgue technician: (b)(6); (b)(7)(C)
Photographer: (b)(6); (b)(7)(C)

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

1.24.2019

District 4 Associate Medical Examiner
PG:

OFFICE OF THE MEDICAL EXAMINER

2100 JEFFERSON STREET
JACKSONVILLE, FLORIDA 32206

MEDICAL EXAMINER REPORT

Opinion Section

NAME OF DECEASED: VOLKOV, Guerman
M.E. NUMBER: 18-2561

DIAGNOSES:

1. Abrasions of lower legs and dorsal right foot
2. Clinical history of small bowel obstruction and gastrointestinal hemorrhage

CAUSE OF DEATH: Small bowel obstruction, with
gastrointestinal hemorrhage

MANNER OF DEATH: Natural

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

. 24. 2019

District 4 Associate Medical Examiner
PG:

BUREAU of VITAL STATISTICS

CERTIFICATION OF DEATH

STATE FILE NUMBER: 2018193153

DATE ISSUED: JANUARY 14, 2019

DECEDENT INFORMATION

DATE FILED: DECEMBER 12, 2018

NAME: GUERMAN YURYEVICH VOLKOV

DATE OF DEATH: NOVEMBER 30, 2018

SEX: MALE

SSN: 999-99-9999

AGE: 056 YEARS

DATE OF BIRTH: FEBRUARY 16, 1962

BIRTHPLACE: TVER, RUSSIA

PLACE OF DEATH: EMERGENCY ROOM/OUTPATIENT

FACILITY NAME OR STREET ADDRESS: MEMORIAL HOSPITAL JACKSONVILLE

LOCATION OF DEATH: JACKSONVILLE, DUVAL COUNTY, 32216

RESIDENCE: 1 SHERIFFS OFFICE DR, MACCLENNY, FLORIDA 32063, UNITED STATES

COUNTY: BAKER

OCCUPATION, INDUSTRY: UNKNOWN, CONSTRUCTION

EDUCATION: UNKNOWN

EVER IN U.S. ARMED FORCES? NO

HISPANIC OR HAITIAN ORIGIN? NO, NOT OF HISPANIC/HAITIAN ORIGIN

RACE: WHITE

SURVIVING SPOUSE / PARENT NAME INFORMATION

(NAME PRIOR TO FIRST MARRIAGE, IF APPLICABLE)

MARITAL STATUS: DIVORCED

SURVIVING SPOUSE NAME: NONE

FATHER'S/PARENT'S NAME: (b)(6); (b)(7)(C)

MOTHER'S/PARENT'S NAME:

INFORMANT, FUNERAL FACILITY AND PLACE OF DISPOSITION INFORMATION

INFORMANT'S NAME: GUENRIH VOLKOV

RELATIONSHIP TO DECEDENT: SON

INFORMANT'S ADDRESS: RUSSIA

FUNERAL DIRECTOR/LICENSE NUMBER: (b)(6); (b)(7)(C) 45116

FUNERAL FACILITY: FORBES FUNERAL HOME F060873

409 W. MACCLENNY AVENUE, MACCLENNY, FLORIDA 32063

METHOD OF DISPOSITION: BURIAL

PLACE OF DISPOSITION: MACEDONIA CEMETERY
MACCLENNY, FLORIDA

CERTIFIER INFORMATION

TYPE OF CERTIFIER: DISTRICT MEDICAL EXAMINER

MEDICAL EXAMINER CASE NUMBER: 180402561

TIME OF DEATH (24 HOUR): 1250

DATE CERTIFIED: DECEMBER 12, 2018

CERTIFIER'S NAME: (b)(6); (b)(7)(C)

CERTIFIER'S LICENSE NUMBER: ME102924

NAME OF ATTENDING PHYSICIAN (IF OTHER THAN CERTIFIER): NOT APPLICABLE

CAUSE OF DEATH AND INJURY INFORMATION

MANNER OF DEATH: NATURAL

CAUSE OF DEATH - PART I - AND APPROXIMATE INTERVAL: ONSET TO DEATH

a. SMALL BOWEL OBSTRUCTION, WITH GASTROINTESTINAL HEMORRHAGE

b.

c.

d.

PART II - OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I:

AUTOPSY PERFORMED? NO

AUTOPSY FINDINGS AVAILABLE TO COMPLETE CAUSE OF DEATH?

DATE OF SURGERY:

DID TOBACCO USE CONTRIBUTE TO DEATH? NO

REASON FOR SURGERY:

PREGNANCY INFORMATION: NOT APPLICABLE

DATE OF INJURY: NOT APPLICABLE

TIME OF INJURY (24 HOUR):

INJURY AT WORK?

LOCATION OF INJURY:

DESCRIBE HOW INJURY OCCURRED:

PLACE OF INJURY:

IF TRANSPORTATION INJURY, STATUS OF DECEDENT:

TYPE OF VEHICLE:



, STATE REGISTRAR

REQ: 2020031528

THE ABOVE SIGNATURE CERTIFIES THAT THIS IS A TRUE AND CORRECT COPY OF THE OFFICIAL RECORD ON FILE IN THIS OFFICE.

WARNING:

THIS DOCUMENT IS PRINTED OR PHOTOCOPIED ON SECURITY PAPER WITH WATERMARKS OF THE GREAT SEAL OF THE STATE OF FLORIDA. DO NOT ACCEPT WITHOUT VERIFYING THE PRESENCE OF THE WATERMARKS. THE DOCUMENT FACE CONTAINS A MULTICOLORED BACKGROUND, GOLD EMBOSSED SEAL, AND THERMOCHROMIC FL. THE BACK CONTAINS SPECIAL LINES WITH TEXT. THIS DOCUMENT WILL NOT PRODUCE A COLOR COPY.

DH FORM 1947 (03-13)

DHS-20-0638-C-000258

CERTIFICATION OF VITAL RECORD

* 5 6 6 9 5 8 4 7 *

2020-ICLI-00057 404







Detainee Death Review Report

Guerman Volkov

Date of Death: November 30, 2018

Alien File Number: 209 879 518

Joint Integrity Case Management System (JICMS) #: 201901862

September 28, 2020

U.S. Immigration and Customs Enforcement
Office of Professional Responsibility

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DETAILS OF REVIEW

From February 5 to 7, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Baker County Detention Center (BCDC) in Macclenny, Florida (FL), to review the circumstances surrounding Guerman VOLKOV's detention and death. ERAU was assisted in its review by contract subject matter experts in correctional healthcare and security who are employed by Creative Corrections, a national management consulting firm.¹ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to VOLKOV, in addition to conducting in-person interviews of individuals employed by BCDC, Armor Correctional Health Services (ACHS) Inc., and the ICE Enforcement and Removal Operations (ERO) Miami Field Office (ERO Miami). VOLKOV was detained at BCDC from July 26, 2017 through November 30, 2018. The Medical Examiner's Office documented VOLKOV's cause of death as a small bowel obstruction² with gastrointestinal hemorrhage³ and the manner as natural.⁴

FACILITY PROFILE

BCDC is owned and operated by the Baker County Sheriff's Office (BCSO) under an Intergovernmental Service Agreement (IGSA) with ICE, which requires the facility to comply with the ICE National Detention Standards (NDS) 2000. Medical care is provided by ACHS, and ERO Miami provides oversight. ICE authorizes BCDC to house male and female detainees for periods longer than 72 hours and has an as-needed ICE detainee bed capacity.⁵ At the time of VOLKOV's death, the average daily population for ICE detainees was 267, and the facility housed approximately 226 male and 18 female ICE detainees.⁶

IMMIGRATION AND CRIMINAL HISTORY

On November 4, 1998, the Immigration and Naturalization Service (INS) admitted VOLKOV into the United States at Miami, FL, as a B-2 non-immigrant visitor for pleasure with authorization to remain in the United States for a temporary period not to exceed May 3, 1999.⁷ On May 13, 1999, the Hillsborough County Sheriff's Office arrested VOLKOV for disorderly conduct; he was convicted on September 8, 1999.⁸ The Hillsborough County Court sentenced VOLKOV with court costs.

On December 25, 1999, the Pasco County Sheriff's Office arrested VOLKOV for driving under the influence; he was convicted on February 2, 2000.⁹ The Pasco County Court sentenced VOLKOV to nine months' probation, a fine, court costs, community service, and driving while intoxicated school.

¹ See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis.

² A small bowel obstruction is a blockage in the small intestine, usually caused by scar tissue, hernia, or cancer.

³ Gastrointestinal hemorrhage refers to bleeding in the stomach and/or intestines.

⁴ See Exhibit 2: Medical Examiner Report of Guerman VOLKOV, 18-2561, dated January 24, 2019.

⁵ See ERO Facility List Report as of December 3, 2018.

⁶ See Information Request Memorandum, undated.

⁷ See INS I-94 Arrival Record, dated November 4, 1998.

⁸ See NNSV Query Result, dated August 11, 2017.

⁹ *Id.*

On February 10, 2016, the New Port Richey Police Department arrested VOLKOV for battery.¹⁰ The 6th Judicial Circuit Court of Florida convicted VOLKOV on March 18, 2016 and sentenced him to time served (38 days), 12 months' probation, court costs, and completion of a Batter's Intervention Program.¹¹

On May 21, 2017, the New Port Richey Police Department arrested VOLKOV for failure to appear.¹² On the same date, the New Port Richey Police Department released VOLKOV into the Pasco County Sheriff's Office's custody.¹³ On June 23, 2017, ERO Tampa lodged an Immigration Detainer against VOLKOV, who was being detained at the Pasco County Jail.¹⁴ On June 25, 2017, the Pasco County Sheriff's Office released VOLKOV into the custody of Pinellas County Sheriff's Office, who detained him at the Pinellas County Jail in Clearwater, FL.¹⁵

On June 26, 2017, pursuant to the detainer, Pinellas County Sheriff's Office released VOLKOV into ERO Tampa's custody.¹⁶ ERO Tampa issued VOLKOV a Notice to Appear (DHS Form I-862), charging him with removability as a non-immigrant overstay pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act and detained him at the Tampa Hold Room.¹⁷ On the same date, ERO Tampa transferred VOLKOV into ERO Miami's custody, and he was transferred to BCDC.

On July 27, 2017, VOLKOV filed an Application for Asylum and for Withholding of Removal (Form I-589).¹⁸ On December 13, 2017, an immigration judge (IJ) in Orlando, FL, ordered VOLKOV removed to Russia.¹⁹ On January 17, 2018, ERO Miami served VOLKOV with a Warning for Failure to Depart (ICE Form I-229(a)), which VOLKOV signed.²⁰ On January 29, 2018, ERO Miami submitted an electronic Travel Document Request (eTD) for VOLKOV with the Embassy of Russia.²¹

On March 13, 2018, ERO Miami completed a 90-day Post Order Custody Review (POCR)²² evaluation and issued a decision to continue VOLKOV's detention pending the issuance of a travel document.²³ On April 16, 2018, the Embassy of Russia denied issuance of a travel document for VOLKOV, stating that someone in Russia with the same name and date of birth had died in 2011, and they believed that VOLKOV might have been deceitful about his real name and date of birth.²⁴

¹⁰ *Id.*

¹¹ See Pasco County Judgement Sentence and/or Order of Probation, dated March 18, 2016.

¹² See NNSV Query Result, dated August 11, 2017. There was no disposition recorded.

¹³ See Pasco County Sheriff's Office Individual's Charge Report, dated June 26, 2017.

¹⁴ See DHS Form I-247A, dated June 23, 2017.

¹⁵ See Pinellas County Sheriff's Office Subject Charge Report, dated July 1, 2020; see also Pinellas County Sheriff's Office Transfer Information, dated June 26, 2017.

¹⁶ See Detainee Transfer Notification, dated June 26, 2017.

¹⁷ See DHS Form I-862, dated June 26, 2017; see also Enforce Alien Removal Module (EARM) Detention History.

¹⁸ See Form I-589, dated July 27, 2017.

¹⁹ See U.S. Department of Justice Executive Office for Immigration Review Orders of the Immigration Judge Orlando Immigration Court, Written Decision and Orders of the Immigration Judge, dated December 13, 2017.

²⁰ See ICE Form I-229(a), dated January 17, 2018.

²¹ See RE: VOLKOV, Guerman A209879518 letter, dated January 29, 2018.

²² See ICE Transfer Checklist, HQ POCR Checklist, dated March 20, 2018.

²³ See Decision to Continue Detention memorandum, dated March 20, 2018.

²⁴ See EARM Case Comments, late entry for April 16, 2018, dated May 3, 2018.

ERO Miami took a sworn statement from VOLKOV that he had provided his correct name and date of birth.

On June 19, 2018, ERO Miami completed a 180-day POCR evaluation and elevated it to ERO Headquarters for review.²⁵ On June 28, 2018, ERO Headquarters issued a decision to continue VOLKOV's detention.²⁶ On September 10, 2018, ERO Miami served VOLKOV with an ICE Form I-229(a), which VOLKOV refused to sign.²⁷ On September 11, 2018, ERO Miami completed a 270-day POCR evaluation and elevated it to ERO Headquarters for review.²⁸ ERO Headquarters notified ERO Miami that the Embassy of Russia had again denied issuance of a travel document for VOLKOV.²⁹ On October 4, 2018, VOLKOV signed a Record of Sworn Statement in Administrative Proceedings (ICE Form I-877), stating that he was, in fact, Guerman VOLKOV.³⁰

On November 23, 2018, ERO Miami notified VOLKOV that he would be transferred to Krome North Service Processing Center (KNSPC) in Miami, FL.³¹ VOLKOV refused to sign the transfer form. The same day, ERO Miami noted the transfer to KNSPC was cancelled because VOLKOV was in a combative state due to not wanting to leave BCDC.³²

CHRONOLOGY OF EVENTS³³

June 26, 2017

At 7:44 p.m., Sergeant (Sgt. (b)(6); (b)(7)(C)) and Officer (b)(6); (b)(7)(C)) booked VOLKOV into BCDC and issued him facility property.³⁴

At 10:57 p.m., Officer (b)(6); (b)(7)(C)) inventoried VOLKOV's property, documenting one each of the following: a red t-shirt; a pair of grey shorts; a pair of flip flops; and white underwear.³⁵ VOLKOV, Officer (b)(6); (b)(7)(C)) signed a Resident Transaction Receipt, which documented zero funds in VOLKOV's possession.³⁶ VOLKOV signed an English version of the Prison Rape Elimination Act (PREA) orientation acknowledgement form; the section of the form

²⁵ See ICE Transfer Checklist, HQ POCR Checklist, dated June 19, 2018.

²⁶ See Decision to Continue Detention memorandum, dated June 28, 2018.

²⁷ See ICE Form I-229(a), dated September 10, 2018.

²⁸ See ICE Transfer Checklist, HQ POCR Checklist, dated September 11, 2018; *see also* EARM Case Comments, entry dated September 11, 2018.

²⁹ *Id.*

³⁰ See ICE Form I-877, dated October 4, 2018.

³¹ See KRO/05-38.1 Detainee Transfer Notification, dated November 23, 2018.

³² See EARM Case Comments, entry dated November 23, 2018.

³³ Given the length of VOLKOV's detention in ICE custody (523 days), events and documentation addressed within the report are limited to key events.

³⁴ See BCSO Booking Information Report, dated June 26, 2017; *see also* BCSO Issued Property Report, dated June 26, 2017.

³⁵ See BCSO Booking Information – Property Inventory, dated June 26, 2017. ERAU notes that, based on an inspection of VOLKOV's property, there was no underwear present in the property bag. Furthermore, in addition to the inventoried items, there were one pair each of shoes, socks, and pants, as well as a belt, comb, keychain-like object, and miscellaneous papers, none of which were documented on the property inventory report.

³⁶ See BCSO Resident Transaction Receipt, dated June 26, 2017.

that documents the use of interpreters was left blank.³⁷ Officer (b)(6); (b)(7)(C) classified VOLKOV as a minimum custody detainee; there was no supervisory approval documented on the form.³⁸ Sgt. (b)(6); (b)(7)(C) assigned VOLKOV to general population Unit B3, cell 002.³⁹

June 27, 2017

At 1:00 a.m., (b)(6); (b)(7)(C), licensed practical nurse (LPN),⁴⁰ conducted VOLKOV's intake screening and documented⁴¹ the following:

- VOLKOV understood English.
- VOLKOV's vital signs were all within normal limits⁴² except for an elevated blood pressure of 136/90.⁴³
- VOLKOV was not previously incarcerated, although the BCDC medical record included transfer summaries from two other facilities.⁴⁴
- In the past two months, VOLKOV experienced epilepsy or seizures.⁴⁵
- VOLKOV's appearance, behavior, state of consciousness, ease of movement, breathing, and skin were within normal limits, with no evidence of disability or suicidal presentation.
- VOLKOV's mental health assessment was normal.⁴⁶
- VOLKOV denied having been in the hospital or emergency room within the last three months and reported his last health care visit as having been a few weeks prior.
- VOLKOV had broken and missing teeth.
- VOLKOV signed consent for medical treatment.

³⁷ See BCSO PREA Education Acknowledgement form, dated June 26, 2017. ERAU learned through staff interviews that VOLKOV was able to speak some English but it was fragmented and he was likely unable to express or understand some concepts, particularly related to medical issues. Although many BCDC staff members stated there was a language barrier with VOLKOV, there was only one instance in which BCDC staff documented use of interpretation services. BCDC medical staff further commented that VOLKOV expressed frustration with the inaccurate Russian dialect of the interpretation line, and at times, emphatically voiced preference to speak English.

³⁸ See BCSO Initial Custody Classification, dated June 26, 2017.

³⁹ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

⁴⁰ ERAU notes that although RN (b)(6); (b)(7)(C) attained registered nurse (RN) status in July of 2018, she will be referred to as LPN (b)(6); (b)(7)(C) throughout the remainder of this report.

⁴¹ ACHS Intake Health Screening, dated June 27, 2017.

⁴² Normal limits can vary depending on factors such as an individual's activity and age; however, generally speaking, a normal temperature is considered 98.6; the normal range for a pulse is 60 to 100 beats per minute; the normal range for respirations is 12 to 20 breaths per minute; and, a normal blood pressure is 120/80 or less.

⁴³ For the purpose of this report, an elevated blood pressure encompasses different stages of hypertension as defined by the American Heart Association (AHA). The first time a reading for each blood pressure category is introduced, it is defined. According to the AHA (2017), this blood pressure falls within AHA parameters for stage two hypertension, which is characterized by a systolic reading of at least 140 or a diastolic reading of at least 90.

⁴⁴ ERAU notes that transfer documents listed the medications VOLKOV had received as follows: lisinopril to treat hypertension; metoprolol to treat hypertension and heart failure; Keppra (levetiracetam) to treat seizure disorder; and Tegretol (carbamazepine) to treat seizures. The Pasco County Sheriff's Office document indicated a diagnosis of conversion disorder, with seizures or convulsion, as confirmed by an unnamed hospital, and that Pinellas County Sheriff's Office started VOLKOV on Tegretol due to a self-reported history of seizures. See Correct Care Solutions Transfer Form from Pasco County Sheriff's Office, dated June 25, 2017; see also Pinellas County Sheriff's Office Transfer Information, dated June 26, 2017.

⁴⁵ During her interview on February 6, 2019, RN (b)(6); (b)(7)(C) clarified she mistakenly noted in a field beside diabetes that VOLKOV had experienced symptoms two months ago when she intended to write it beside the epilepsy/seizures field.

⁴⁶ See ACHS Mental Health Screening, dated June 27, 2017.

LPN (b)(6); (b)(7)(C) placed VOLKOV on the chronic care clinic list due to his hypertension and seizure history and assigned him to a low bunk for seizure precautions.⁴⁷ LPN (b)(6); (b)(7)(C) cleared VOLKOV for housing in general population. (b)(6); (b)(7)(C)⁴⁸ signed as reviewer of the intake screening on the same day.

Per the direction of (b)(6); (b)(7)(C) ordered VOLKOV a cardiac diet and rewrites of the lisinopril (20 mg), metoprolol (25 mg), Keppra (500 mg), and carbamazepine (200 mg), twice daily, prescriptions listed on VOLKOV's transfer documents.⁴⁹

An unknown medical staff member created a Problem List⁵⁰ and documented VOLKOV's history of hypertension and seizures, and negative tuberculosis (TB) purified protein derivative (PPD) results.⁵¹ However, the TB PPD results included within the Problem List were from a test performed on June 10, 2017, as documented on the Pasco County Sheriff's Office Transfer Summary. BCDC medical staff did not perform a new TB test upon VOLKOV's arrival.

June 29, 2017

At 10:45 a.m., (b)(6); (b)(7)(C) conducted VOLKOV's initial chronic care⁵² assessment and documented⁵³ the following:

- VOLKOV had a history of hypertension and seizure disorder.
- VOLKOV's vital signs were all within normal limits except for an elevated blood pressure of 155/92.⁵⁴ Although qualifying for stage 2 hypertension, (b)(6); (b)(7)(C) wrote that VOLKOV was asymptomatic.
- VOLKOV appeared to be in good physical condition, and his physical examination was unremarkable.

⁴⁷ See ACHS Progress Note, entry dated June 27, 2017; see also ACHS Internal Clinic Referral Form, dated June 27, 2017; and, ACHS Special Needs Communication/Relocation Sheet, dated June 27, 2017.

⁴⁸ ERAU's review included examination of each health care staff member's license or certification for validity. Dr. (b)(6); (b)(7)(C) license indicated he was practicing under an Area of Critical Need Medical Doctor licensure, which requires that the physician have a valid license allowing for practice in any jurisdiction in the United States and that this individual only practice in certain designated, approved facilities located in communities of Florida where there is a critical need for physicians. As the ICE NDS 2000 Medical Care standard requires that the ICE Health Service Corps (IHSC) be consulted to determine the appropriate credential requirements for health care providers, ERAU confirmed with ERO IHSC that this license was sufficient.

⁴⁹ See ACHS Order Sheet, entry dated June 27, 2017; see also ACHS Restricted Diet Order Form, dated June 27, 2017; and, Medication Administration Record (MAR).

⁵⁰ A problem list supports healthcare staff's awareness of a patient's known medical conditions during encounters. The staff member's initials are illegible.

⁵¹ See ACHS Problem List, entry dated June 27, 2017.

⁵² During VOLKOV's detention, BCDC did not have an electronic medical record. (b)(6); (b)(7)(C) interview with ERAU on February 5, 2019, when asked if medical staff should use BCDC's standardized Chronic Care Form for documenting assessments like the one he conducted, he replied yes; however, the initial chronic care assessment was a hand-written entry in VOLKOV's Progress Note. Documentation and signatures were often illegible or missing, and nurses seldom used name stamps or printed their names and credentials. Mental health rounds were often not conducted on weekends when VOLKOV was on suicide watch or under mental health observation.

⁵³ See ACHS Progress Note and Order sheets, entries dated June 29, 2017.

⁵⁴ Although (b)(6); (b)(7)(C) recorded VOLKOV's blood pressure as 155/192 in his progress note, during his interview with ERAU (b)(6); (b)(7)(C) stated he believed he meant to write 155/92.

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

documented the assessment findings as seizure disorder and hypertension, and ordered the following:

- An electrocardiogram (EKG) stat.
- Laboratory studies, to include a complete blood count (CBC) with differential⁵⁵, comprehensive metabolic panel (CMP)⁵⁶, lipid profile⁵⁷, carbamazepine level, and a urinalysis, to be drawn on July 3, 2017.
- Aspirin⁵⁸ (81 mg) daily, clonidine (0.3 mg) for high blood pressure, and the discontinuation of VOLKOV's cardiac diet⁵⁹.
- Medical staff to re-check VOLKOV's blood pressure in 30 minutes, which LPN Roberts documented as normal at 105/75, and to also obtain VOLKOV's vital signs once daily.⁶⁰

The EKG⁶¹ subsequently evidenced a slow sinus rhythm, indicating a possible septal infarct⁶²; these results were determined to be borderline.⁶³

July 2, 2017 – July 3, 2017

At 2:00 a.m., (b)(6); (b)(7)(C) documented that medical staff drew VOLKOV's laboratory studies.⁶⁴ The results⁶⁵ received the following day depicted the following:

- The microscopic urinalysis, comprehensive metabolic profile, and carbamazepine levels were all within normal limits.
- The CBC laboratory results showed VOLKOV's red blood cell count was low at 4.07, hemoglobin was low at 13.0, hematocrit was low at 39.0, and mean corpuscular value (MCV) was slightly high at 95.9.⁶⁶

⁵⁵ A CBC with differential is a blood test that measures the number and/or types of red blood cells, white blood cells, and platelets in the blood and is used to help diagnose and monitor many different conditions.

⁵⁶ A metabolic panel is a comprehensive test that measures blood sugar levels, electrolyte and fluid balance, kidney function, and liver function.

⁵⁷ A lipid profile is a test that measures the amount of fat elements in the blood, to include triglycerides and cholesterol.

⁵⁸ Low dose aspirin (81 mg) is a common medication for patients with cardiac disease; it thins the blood and prevents strokes or heart attacks related to blood clotting.

⁵⁹ See ACHS Restricted Diet Order Form, dated June 29, 2017. During his interview with ERAU, (b)(6); (b)(7)(C) stated he had not been clear in his order to discontinue VOLKOV's cardiac diet, noting it was most likely based on a request from VOLKOV.

⁶⁰ Although (b)(6); (b)(7)(C) assessment indicates that he required medical staff to conduct daily blood pressure checks, there were no documented vital signs between June 29, 2017, and October 21, 2017.

⁶¹ See EKG, dated June 29, 2017.

⁶² A septal infarct is a patch of dead, dying, or decaying tissue on the wall of tissue that separates the right ventricle of the heart from the left ventricle. Septal infarct is usually caused by an inadequate blood supply during a heart attack. The EKG finding of septal infarct means the patient possibly had a heart attack at some point in the past.

⁶³ A borderline EKG means the findings are in a range that, while not precisely normal, are not significantly abnormal. BCDC medical staff never performed another EKG on VOLKOV prior to his death; nor was this finding added to VOLKOV's Problem List.

⁶⁴ See ACHS Progress Note, entry dated July 2, 2017.

⁶⁵ See Vista Clinical Lab Report, dated July 3, 2017.

⁶⁶ Normal reference ranges are as follows: red blood cell: 4.70-6.10; hemoglobin: 14.0-18.0; hematocrit: 42.0-52.0; and MCV: 80.0-95.0.

- VOLKOV's lipid panel showed normal cholesterol and triglyceride levels; however, his low-density lipoprotein (LDL) was high at 109.00, his very-low-density lipoprotein (VLDL) was high at 46.00, and his high-density lipoprotein (HDL) was low at 28.0.⁶⁷

(b)(6); (b)(7)(C) signed the lab report on July 10, 2017. During his interview, when asked if the recorded hemoglobin and hematocrit levels were of concern, (b)(6); (b)(7)(C) replied they were, as it could be a sign of internal bleeding or anemia.⁶⁸ When asked why the problem was not addressed in a treatment plan, he replied that perhaps he did not consider it a serious problem at the time.

July 7, 2017

At 2:00 p.m., VOLKOV signed a Refusal of Treatment form for his physical assessment.⁶⁹ An unidentified nurse recorded in the refusal section that VOLKOV was "okay." There is no progress note or other documentation that addresses VOLKOV's refusal. Medical staff attempted to conduct VOLKOV's physical assessment on August 9, 2017, but he again refused.⁷⁰

July 13, 2017

At 12:00 p.m., ICE Deportation Officer (DO) (b)(6); (b)(7)(C) approved VOLKOV's BCSO Inmate Request Form.⁷¹ The form stated that he had already had his court hearing, and a judge advised him to fill out an asylum application but that he would need the form to start his application. VOLKOV submitted his application on July 27, 2017.

July 20, 2017

At 9:00 p.m., (b)(6); (b)(7)(C) BCDC administrative staffer, signed receipt of VOLKOV's request form, which indicated he needed glasses because he could not see small letters.⁷² On the following day, (b)(6); (b)(7)(C) responded asking VOLKOV what focus he needed for reading glasses, but there is no evidence VOLKOV received (b)(6); (b)(7)(C) response. On the same date, in the temporary problems section of VOLKOV's Problem List,⁷³ an unidentified staff member noted that VOLKOV had vision problems; however, there was no other documentation in VOLKOV's medical record indicating medical staff assessed his vision nor that BCDC ever provided him with eyeglasses.⁷⁴

⁶⁷ Normal reference ranges are as follows: LDL: 0.00-99.0; VLDL: 8.00-39.00; and HDL: 40.0-60.0.

⁶⁸ ERAU interview with (b)(6); (b)(7)(C) dated February 5, 2019.

⁶⁹ See ACHS Refusal of Treatment form, dated July 7, 2017; see also ACHS Health Assessment form, dated July 7, 2017.

⁷⁰ See ACHS Refusal of Treatment form, dated August 9, 2017.

⁷¹ See BCSO Inmate Request Form, dated July 13, 2017. During his interview with ERAU on February 6, 2019, DO (b)(6); (b)(7)(C) stated he remembered VOLKOV well and that he could never really communicate with VOLKOV even though it seemed like VOLKOV was speaking English. ERAU reminded DO (b)(6); (b)(7)(C) of the importance of using language interpretation services with detainees who may be limited English proficient to make every effort to effectively communicate with the detainee.

⁷² See BCSO Inmate Request Form, dated July 20, 2017.

⁷³ See ACHS Problem List, entry dated July 20, 2017.

⁷⁴ ERAU notes there were no eyeglasses in VOLKOV's property either.

July 22, 2017 – July 23, 2017

At 7:00 a.m., VOLKOV submitted a sick call request stating he needed medication to sleep as he was only getting between one to two hours a night, if he was lucky.⁷⁵ At 9:15 p.m., an unidentified RN documented receipt of the request.

At 2:00 p.m. the following day, LPN (b)(6); (b)(7)(C) documented that VOLKOV refused to be seen for his sick call appointment as he did not want to wait and he signed the related refusal form.⁷⁶ At 11:00 p.m., the same unidentified RN from the previous day documented that she referred VOLKOV to a provider.

August 11, 2017

At 9:00 p.m., LPN (b)(6); (b)(7)(C) documented that during pill pass, she noticed VOLKOV's medications were expiring soon, so she notified the doctor, who provided a verbal order to renew all of VOLKOV's medications for 180 days.⁷⁷ Three days later, (b)(6); (b)(7)(C) signed the order. ERAU notes there is no documentation that BCDC assessed VOLKOV prior to renewal of the medications, and that his next chronic care clinic appointment was scheduled for September 12, 2017, a month later.

August 25, 2017 – August 30, 2017

On August 25, 2017, at 2:00 a.m., VOLKOV submitted a request form in English, addressed to (b)(6); (b)(7)(C), noting that he needed to call an attorney.⁷⁸ At 1:10 p.m., (b)(6); (b)(7)(C) administrative staffer, documented receipt of the request. On August 28, 2017, at an unknown time, (b)(6); (b)(7)(C) responded, asking VOLKOV to provide the name and phone number of his attorney so he could schedule the call. On August 29, 2017, at 2:15 p.m., VOLKOV submitted another request form in English, addressed to (b)(6); (b)(7)(C) with three telephone numbers.⁷⁹

On August 30, 2017, (b)(6); (b)(7)(C) responded to VOLKOV, noting that he needed names to schedule the call.

On an unknown date and time, (b)(6); (b)(7)(C) responded that he had scheduled a call for VOLKOV with attorney (b)(6); (b)(7)(C) at 12:30 p.m. on August 30, 2017.⁸⁰

September 10, 2017 – September 11, 2017

⁷⁵ See ACHS Sick Call Request form, dated July 22, 2017.

⁷⁶ See ACHS Refusal of Treatment form, dated July 23, 2017.

⁷⁷ See ACHS Progress Note, entry dated August 11, 2017.

⁷⁸ See BCSO Inmate Request Form, dated August 25, 2017.

⁷⁹ See BCSO Inmate Request Form, dated August 29, 2017.

⁸⁰ See BCSO Inmate Request Form, dated August 25, 2017.

On September 10, 2017, at an unknown time, VOLKOV submitted a sick call request, stating he would like to see the doctor due to thigh pain.⁸¹ At 9:00 p.m., an unidentified nurse documented receipt of VOLKOV's request.

On September 11, 2017, at 6:30 p.m., (b)(6); (b)(7)(C) documented that VOLKOV was having problems with other detainees in his housing unit and wanted to be placed in protective custody (PC) as he was scared for his life.⁸² VOLKOV signed a PC Placement Form concurring that he wished for BCDC to place him into PC, and Deputy (b)(6); (b)(7)(C) escorted VOLKOV to a cell within A Pod, Dorm 7 (A7).⁸³ Security staff initiated a Daily Record of Segregation Log.⁸⁴

[NOTE: As a practice, BCDC typically houses individuals placed in PC (or administrative segregation) in A7; when housing was unavailable there, BCDC leverages either the booking or medical areas as segregation overflow.⁸⁵]

September 12, 2017

At 10:00 a.m., (b)(6); (b)(7)(C) conducted a chronic care assessment and documented⁸⁶ the following:

- VOLKOV had a history of hypertension and seizure disorder for the past two years with no hospitalizations.
- VOLKOV had a painful inguinal hernia but was stable.⁸⁷
- VOLKOV's current medications were the same as documented on his MAR.
- VOLKOV's recorded vitals were within normal limits except for an elevated blood pressure of 131/89.
- VOLKOV appeared to be in good physical condition and had a good degree of control with his hypertensive and seizure disorder management.
- (b)(6); (b)(7)(C) annotated multiple lab results from VOLKOV's July 3, 2017 lab studies.

⁸¹ See ACHS Sick Call Request, dated September 10, 2017.

⁸² See BCSO Incident Report, dated September 11, 2017.

⁸³ See BCSO PC Placement Form, dated September 11, 2017; *see also* BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018. ERAU notes that A7 is a 31-bed segregation unit; each cell has a shower within it affording VOLKOV unlimited access to this activity.

⁸⁴ BCSO Policy CO 334, *Special Management Units*, requires that security maintain a Daily Record of Segregation. Furthermore, detainees placed in segregation retain their rights, and those in administrative confinement, or PC, are given the opportunity to shower daily. The Daily Record of Segregation log is used to document type of status, meals, physical appearance, and other detainee activities, to include visits by medical. As for showers, the Daily Record of Segregation log has no specific place to record when these were offered. *See* BCDC Daily Record of Segregation log, dated September 11, 2017.

⁸⁵ In such instances, showers are supposed to be logged in the Jail Log report, rather than the Daily Record of Segregation.

⁸⁶ See ACHS Chronic Care Clinic form PT-002, dated September 12, 2017. ERAU notes that (b)(6); (b)(7)(C) conducted this chronic care assessment using ACHS's standardized Chronic Care Clinic form in the SOAPE format. SOAPE refers to documentation that includes Subjective and Objective information, Assessment findings, Plan of care, and patient Education.

⁸⁷ An inguinal hernia is a condition in which soft tissue bulges through a weak point in the abdominal muscles. When left untreated or not surgically repaired, as needed, an inguinal hernia can lead to life-threatening complications, such as bowel obstruction.

VOLKOV's treatment plan remained unchanged. (b)(6); (b)(7)(C) noted that VOLKOV's next chronic care clinic appointment was to occur in three months and approved for VOLKOV to have a hernia belt; however, BCDC was unable to provide evidence that medical staff ever issued the hernia belt.⁸⁸

During his interview (b)(6); (b)(7)(C) stated he evaluates chronic care patients at least once every three months, unless a detainee's condition is stable such as with controlled asthma, which can be scheduled out longer.⁸⁹ ERAU notes that a review of related records for succeeding chronic care assessments (documented in the below table) indicated that although VOLKOV refused these appointments, medical did not consistently complete refusal forms or document efforts to encourage VOLKOV's acceptance and cooperation of these assessments prior to the renewal of his prescription medication.

Date	Chronic Care Clinic Appt.	Completed/Refused	Refusal Form Completed ⁹⁰
Dec. 7, 2017 ⁹¹	3-Month Follow-up	Refused	Yes: Dec. 10, 2017 ⁹²
Mar. 8, 2018 ⁹³	3-Month Follow-up	Refused	No; not documented in progress note
June 5, 2018 ⁹⁴	3-Month Follow-up	Refused	Yes: June 8, 2018 ⁹⁵
Sept. 6, 2018 ⁹⁶	3-Month Follow-up	Refused	Yes: September 6, 2018, but no witness to the refusal ⁹⁷

At an unknown time, RN (b)(6); (b)(7)(C) (first name unknown) documented on VOLKOV's September 10, 2017, sick call request form that his vitals were within normal limits except for an elevated blood pressure of 131/89.⁹⁹ and that the doctor saw VOLKOV the same day.

At approximately 12:00 p.m., an unknown staff member medically cleared VOLKOV for PC, pursuant to his request on September 11.¹⁰⁰ At 12:10 p.m., medical initiated a Confinement

⁸⁸ A hernia belt is a supportive undergarment for men, designed to keep protruding tissue in place and relieve discomfort. See ACHS Special Needs Communication/Relocation form, dated September 12, 2017; see also ACHS Order sheet, entry dated September 12, 2017.

⁸⁹ ERAU interview with Dr. Lafontant, dated February 5, 2019.

⁹⁰ During his interview with ERAU on February 5, 2019, Dr. Ahmed explained that the nurses coordinate the transport of detainees to the clinic and obtain refusal forms, as needed.

⁹¹ See ACHS Chronic Care Clinic, dated December 7, 2017.

⁹² See ACHS Refusal of Treatment form, dated December 10, 2017.

⁹³ See ACHS Chronic Care Clinic, dated March 8, 2018.

⁹⁴ See ACHS Chronic Care Clinic, dated June 5, 2018.

⁹⁵ See ACHS Refusal of Treatment form, dated June 8, 2018. ERAU notes there is no documentation that potential health consequences were explained to VOLKOV.

⁹⁶ See ACHS Chronic Care Clinic, dated September 6, 2018; see also ACHS Progress Note, entry dated September 6, 2018.

⁹⁷ See ACHS Refusal of Treatment form, dated September 6, 2018. ERAU notes that the nurse did not document that potential consequences of the refusal were explained to VOLKOV.

⁹⁸ RN Carter was no longer employed by BCDC at the time of ERAU's onsite review.

⁹⁹ According to the AHA (2017), this blood pressure reading indicates stage one hypertension, which is characterized by a systolic reading of 130 to 139 or a diastolic reading of 80 to 89.

¹⁰⁰ See Confinement/Restraint Clearance, dated September 12, 2017.

Log¹⁰¹, documenting VOLKOV's placement in PC after discovering him during nursing rounds.¹⁰²

At 4:15 p.m., VOLKOV told Officer (b)(6); (b)(7)(C) that he wanted to harm himself.¹⁰³ After removing VOLKOV from his cell, Sgt. (b)(6); (b)(7)(C) asked VOLKOV if he wanted to hurt himself and VOLKOV responded that he did. At 4:20 p.m., (b)(6); (b)(7)(C) notified LPN D. (b)(6); (b)(7)(C) (first name unknown) that VOLKOV stated if he could not go home, he wanted to kill himself.¹⁰⁵ (b)(6); (b)(7)(C) placed VOLKOV on suicide watch within the same cell, and LPN (b)(6); (b)(7)(C) notified Licensed Mental Health Counselor (LMHC) (b)(6); (b)(7)(C) LPN (b)(6); (b)(7)(C) initiated full suicide restrictions.¹⁰⁷ Officers removed all property from VOLKOV's cell and initiated suicide watch precautions.¹⁰⁸

September 13, 2017

At an unknown time, (b)(6); (b)(7)(C) completed an administrative segregation order that stated VOLKOV was under medical observation and had requested placement in PC.¹⁰⁹ At approximately 8:19 a.m., (b)(6); (b)(7)(C) re-classified VOLKOV, recommending an override of his classification level from minimum custody to medium; however, no supervisory approval was documented.¹¹⁰

At 3:57 p.m., (b)(6); (b)(7)(C) conducted VOLKOV's initial mental health evaluation¹¹¹ and documented¹¹² the following:

¹⁰¹ Medical staff use the Confinement Log to document the date/time they are notified by security of segregation placement, medical clearance, and rounds completed. During her interview with ERAU on February 5, 2019, Health Services Administrator (HSA) Summer White stated that when detainees are on suicide watch, nurses are expected to conduct rounds, to include vital signs readings, every 12-hour shift. Although mental health visits are required daily for those on mental health watch, nurses do not have to conduct rounds every 12-hour shift or obtain vital signs.

¹⁰² See ACHS Confinement Log, dated September 12 – 30, 2017.

¹⁰³ See BCSO Incident Report, dated September 12, 2017.

¹⁰⁴ LPN Mobley was no longer employed by BCDC at the time of ERAU's onsite review.

¹⁰⁵ See ACHS Progress Note, entry dated September 12, 2017; see also ACHS Special Needs Communication/Relocation form, dated September 12, 2017.

¹⁰⁶ LMHC Douglas was no longer employed by BCDC at the time of ERAU's onsite review. See ACHS Internal Clinic Referral Form, dated September 12, 2017.

¹⁰⁷ See ACHS Special Needs Communication/Relocation form, dated September 12, 2017; see also BCSO Mental Health Protocols Order Sheet, entry dated September 12, 2017. Per the protocol order sheet, continuous observation protocols include orders for active suicidal ideations, suicide tray with paper products only, suicide smock and suicide blanket only, no sharp objects, bedding, utensils, pencils, etc., and placement in medical housing. Furthermore, ICE detention standards and BCDC policy require that security staff complete rounds no less than every 15 minutes on individuals placed on suicide watch, with BCDC policy expanding this requirement to include those placed on medical or psychiatric watch.

¹⁰⁸ See BCDC Incident Report, dated September 12, 2017.

¹⁰⁹ See ICE Administrative Segregation Order (ICE Form I-886), dated September 13, 2017.

¹¹⁰ ERAU notes that Deputy Looby documented her reason for re-classifying VOLKOV to medium as meeting ICE's pre-classification level of medium-low. See BCSO Reclassification form, dated September 13, 2017; see also ICE Order to Detain (ICE Form I-203), dated June 26, 2017.

¹¹¹ LMHC Douglas made no reference to VOLKOV's language preference, language barrier, or if she used an interpreter during the examination.

¹¹² See ACHS Initial Mental Health Evaluation, dated September 13, 2017.

- VOLKOV consented to treatment for mental health services.¹¹³
- BCDC placed VOLKOV on suicide watch as a result of a language barrier. VOLKOV showed officers the sign of the cross (medical red cross sign) because he needed medical attention.
- VOLKOV denied suicidal and homicidal ideations and had no mental health history except for DUI classes in 1999.
- VOLKOV denied past, present, or pre-incarceration psychotropic treatment.
- VOLKOV had a history of hypertension and seizures, with his last seizure occurring in May 2017.
- VOLKOV reported prior hospitalization for two heart attacks, seizures, and a head injury related to a car accident.
- VOLKOV's mental status examination was within normal limits, and there was no diagnostic impression.¹¹⁴
- LMHC Douglas noted VOLKOV would be scheduled for a mental health follow-up in one to two weeks.

At approximately 4:30 p.m., LMH (b)(6); (b)(7)(C) released VOLKOV from suicide watch and cleared him for general population with no restrictions; she notified both LPN (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) (first name unknown).¹¹⁵ At approximately 4:40 p.m., BCDC placed VOLKOV back into general population dorm B-3.¹¹⁶

September 14, 2017

At 11:15 a.m., RN K (b)(6); (b)(7)(C) (first name unknown) documented that security brought VOLKOV to the clinic as he stated he was "losing [his] brain."¹¹⁷ VOLKOV explained that he was not getting along with another inmate in his housing unit and could not take it any longer. He denied any abuse occurred and denied having suicidal or homicidal ideation.

At approximately 1:00 p.m., Deputy (b)(6); (b)(7)(C) escorted VOLKOV to medical, where he told LMHC (b)(6); (b)(7)(C) and other nurses that other detainees were picking on him in dorm B-3.¹¹⁹ BCDC re-assigned VOLKOV to dorm B-1.¹²⁰

September 16, 2017

At approximately 6:00 p.m., VOLKOV requested to be placed in PC. A deputy escorted VOLKOV to booking, where he would be housed pending a classification review, and assigned him to booking cell 005.¹²¹ However, Deputy (b)(6); (b)(7)(C) did not complete VOLKOV's administrative

¹¹³ See ACHS Informed Consent to Mental Health Treatment form, dated September 13, 2017.

¹¹⁴ No diagnostic impression means that, following assessment, there was no evidence of a mental health diagnosis.

¹¹⁵ See ACHS Special Needs Communication/Relocation form, dated September 13, 2017; *see also* Mental Health Protocols Order Sheet, entry dated September 13, 2017.

¹¹⁶ See ACHS Suicide Observation Log, entry dated September 13, 2017; *see also* BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

¹¹⁷ RN Arias was no longer employed by BCDC at the time of ERAU's onsite review.

¹¹⁸ See ACHS Progress Note, entry dated September 14, 2017.

¹¹⁹ See BCSO Incident Report, dated September 14, 2017.

¹²⁰ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

¹²¹ *Id.*

segregation order until two days later.¹²² Although BCDC maintained a Daily Record of Segregation log during this timeframe, there was poor or no documentation that VOLKOV was offered all three meals or activities, such as recreation or showers.¹²³

September 20, 2017

At 3:07 p.m., LMHC (b)(6); (b)(7)(C) conducted a follow-up mental health assessment.¹²⁴ She documented VOLKOV was alert and cooperative, groomed, and fully oriented to time, person, place, and situation. VOLKOV denied suicidal thinking or intent and stated, “I love life.” VOLKOV demonstrated appropriate eye contact but presented with an anxious mood, rapid speech, and possible delusional thinking. He voiced that he felt unsafe because he believed there was a hit placed on him by the President and that he was afraid he would be raped in the night.

The deputy escorting VOLKOV assured him that he was safe, and LMH (b)(6); (b)(7)(C) explained how the facility maintains detainees’ safety. Although she noted need for a follow-up assessment on September 22, 2017, there are no records indicating one occurred.

September 29, 2017

At approximately 8:00 a.m., Officer (b)(6); (b)(7)(C) stated VOLKOV began loudly banging on his cell door.¹²⁵ Despite numerous orders from (b)(6); (b)(7)(C) for VOLKOV to cease his disruptive actions, VOLKOV did not comply. With the help of Deputy (b)(6); (b)(7)(C) and Corporal (Cpl.) (b)(6); (b)(7)(C), (b)(6); (b)(7)(C) placed VOLKOV into hand restraints, then a restraint chair, and applied a spit mask.¹²⁶

LPN (b)(6); (b)(7)(C) inspected the tightness of the restraint, checked VOLKOV’s vitals, all of which were within normal limits except for an elevated blood pressure of 115/87, and noted there were no injuries observed.¹²⁷ (b)(6); (b)(7)(C) medically cleared VOLKOV to remain in the restraint chair.¹²⁸

LPN (b)(6); (b)(7)(C) further documented that a follow-up nursing evaluation would occur in 24 hours, but none was documented in the medical record.¹²⁹

At approximately 9:45 a.m., security staff removed VOLKOV from the restraint chair, and he was again cleared by medical staff.¹³⁰

¹²² See BCSO Incident Report, dated September 16, 2017; see also ICE Administrative Segregation Order, dated September 18, 2017.

¹²³ See BCDC Daily Record of Segregation, entries from September 16 to October 2, 2017.

¹²⁴ See ACHS Mental Health Rounds/Contact form, dated September 20, 2017.

¹²⁵ See BCSO Incident Report, dated September 29, 2017.

¹²⁶ A spit mask covers an individual’s mouth and is designed to prevent an individual from spitting at staff.

¹²⁷ See BCSO Incident Report, dated September 29, 2017; see also ACHS Post Use-of-Force, dated September 29, 2017.

¹²⁸ See ACHS Confinement/Restraint Clearance form, dated September 29, 2017; see also ACHS Medical Restraint Log, dated September 29, 2017. Medical completed 15-minute restraint checks until VOLKOV was removed from restraints.

¹²⁹ See ACHS Post Use-of-Force form, dated September 29, 2017; see also ACHS Policy J-E-15 Post Use of Force/General.

¹³⁰ See BCSO Incident Report Supplement, dated September 29, 2017.

October 2, 2017

BCDC transferred VOLKOV from booking cell 005 to a cell within A7.¹³¹

October 10, 2017

At 1:30 p.m., BCDC placed VOLKOV on suicide watch after he told staff he just could not take it anymore.¹³²

At 3:00 p.m., RN (b)(6); (b)(7)(C) documented a nursing round, at which time VOLKOV appeared agitated and stated he was going to slit his wrist, acting out the action with his hands.¹³³ RN (b)(6); (b)(7)(C) did not obtain VOLKOV's vital signs but documented that his respirations were even and unlabored. LPN (b)(6); (b)(7)(C) noted notification of VOLKOV's placement on suicide watch to deputies (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) and detailed what the full suicide restrictions were.¹³⁴ LPN (b)(6); (b)(7)(C) then referred VOLKOV to behavioral health on an urgent basis based on his statement.¹³⁵

October 11, 2017

At 10:20 a.m., LMHC (b)(6); (b)(7)(C) documented a mental health round with VOLKOV, during which he denied both homicidal and suicidal ideations, clarifying that he was simply frustrated and felt misunderstood.¹³⁶ VOLKOV voiced being upset that both officers and inmates ridiculed him about being Russian, and he believed he had enemies. LMHC (b)(6); (b)(7)(C) released VOLKOV from suicide watch and noted follow-up was to occur in one to two weeks.

LPN (b)(6); (b)(7)(C) discontinued the suicide protocols ordered the previous day, and LMHC (b)(6); (b)(7)(C) signed the order sheet in concurrence.¹³⁷ LMH (b)(6); (b)(7)(C) notified Deputy (b)(6); (b)(7)(C) that VOLKOV was to be released to general population with no clothing or utensil restrictions.¹³⁸

October 13, 2017

¹³¹ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

¹³² See BCSO Incident Report, dated October 10, 2017. At 2:35 pm, LPN (b)(6); (b)(7)(C) documented that she received a call from Sgt. Sharman stating that security had placed VOLKOV on suicide watch; she then notified LMH (b)(6); (b)(7)(C). See also ACHS Progress Note, entry dated October 10, 2017.

¹³³ See ACHS Progress Note, entry dated October 10, 2017.

¹³⁴ See ACHS Special Needs Communication/Relocation form, dated October 10, 2017; see also Mental Health Protocols Order Sheet, entry dated October 10, 2017.

¹³⁵ See ACHS Internal Clinic Referral form, dated October 10, 2017.

¹³⁶ LMHC (b)(6); (b)(7)(C) documented that as VOLKOV refused to use the language line services, and although she spoke to him in English, it was hard for her to understand him. See ACHS Mental Health Rounds/Contact form, dated October 11, 2017.

¹³⁷ See Mental Health Protocols Order Sheet, entry dated October 11, 2017. Despite the fact that mental health staff had removed him from suicide watch on this date, not until a couple of days later did Deputy (b)(6); (b)(7)(C) document suspension of VOLKOV's PC status due to his placement on suicide watch since October 10, 2017. See also BCSO Incident Report, dated October 13, 2017.

¹³⁸ See ACHS Special Needs Communication/Relocation form, dated October 11, 2017.

At an unknown time, Deputy (b)(6); (b)(7)(C) completed VOLKOV's administrative segregation review but did not sign or indicate her recommendation regarding VOLKOV's PC status on the form.¹³⁹ Deputy (b)(6); (b)(7)(C) then completed VOLKOV's re-classification, again suggesting an override of his minimum classification level to medium; a supervisor did not approve the form.¹⁴⁰

Deputy (b)(6); (b)(7)(C) completed all of VOLKOV's routine administrative segregation reviews while he was housed at BCDC.¹⁴¹ When an ICE Form I-885 was present in the detention record, she did not consistently sign or indicate her recommendation of VOLKOV's PC status on the document, and often a Field Officer Director/Representative signature was missing. Furthermore, in some reviews, the classification documents lacked a custody score or custody level, and all lacked supervisory approval.

October 15, 2017 – October 19, 2017

At approximately 1:45 p.m., (b)(6); (b)(7)(C) again placed VOLKOV on suicide watch following his statement that he "just can't handle it anymore."¹⁴² (b)(6); (b)(7)(C) completed an urgent referral to behavioral health, and at 2:35 p.m., (b)(6); (b)(7)(C) documented VOLKOV's placement on continuous observation protocols, which were in place until November 9, 2017.¹⁴³

On October 16, 2017, at approximately 6:00 a.m., BCDC initiated the first 15-minute observation round since placing VOLKOV on continuous suicide watch observation. However, ERAU found that documentation related to these rounds was poor, disorganized, and lacking in some cases.¹⁴⁴ At an unknown time, LMHC (b)(6); (b)(7)(C) documented VOLKOV's refusal to be interviewed and that follow-up would occur the next day, yet she did not document a follow-up within the medical record.¹⁴⁵

On October 17, 2017, at 2:50 p.m., (b)(6); (b)(7)(C) prescribed Ativan (2 mg) by mouth every six hours as needed for anxiety/agitation.¹⁴⁶ If VOLKOV refused the oral dose (b)(6); (b)(7)(C) noted that the medication could be administered by intramuscular injection every six hours, as needed, for a maximum of four doses per 24 hours. Within the medical record, there was no corresponding assessment or progress note, nor does the MAR include a medication order on this date. Furthermore, if administered, medical staff did not document the actions prior to October 27, 2017.¹⁴⁷

¹³⁹ See ICE Administrative Segregation Review (ICE Form I-885), dated October 13, 2017. An illegible signature was included in the Field Officer Director/Representative section of the incomplete form. See also BCSO Reclassification form, dated October 13, 2017.

¹⁴⁰ See BCSO Reclassification form, dated October 13, 2017.

¹⁴¹ Given the length of VOLKOV's detention in ICE custody, these reviews are not discussed further within this report unless an issue other than the one addressed above is present.

¹⁴² See ACHS Internal Clinic Referral, dated October 15, 2017.

¹⁴³ See Mental Health Protocols Order Sheet, entry dated October 15, 2017.

¹⁴⁴ See ACHS Suicide Observation Log, initiation date October 15, 2017.

¹⁴⁵ See ACHS Mental Health Rounds/Contact form, dated October 15, 2017.

¹⁴⁶ See ACHS Order Sheet, entry dated October 17, 2017.

¹⁴⁷ See MAR.

On October 19, 2017, at 4:45 a.m., an unidentified nurse documented VOLKOV was asleep and resting quietly, with no acute distress noted.¹⁴⁸ At an unknown time, BCDC moved VOLKOV to medical housing.¹⁴⁹

October 20, 2017

At 1:00 a.m., an unidentified RN documented VOLKOV was resting quietly; he had taken his medications and denied wanting to hurt himself.¹⁵⁰

At 3:05 p.m., LMHC (b)(6); (b)(7)(C) documented alerting nurses regarding her concern of VOLKOV's increasing agitation.¹⁵¹ She noted that the order written on October 17, 2017, for intramuscular Ativan expired 24 hours after being written; therefore, nurses were asked to contact (b)(6); (b)(7)(C) for another such order.

At 4:15 p.m., VOLKOV was observed resting quietly with no signs or symptoms of agitation.¹⁵²

The first documented, daily vital check of VOLKOV from (b)(6); (b)(7)(C) June 29, 2017 order, took place on this date.¹⁵³ The Vital Signs Flow Sheet augmented the underlying order with directions to obtain vital signs every shift while housed in medical. However, between this date and November 13, 2017, they were only done every shift on October 23, 2017, and there were seven days on which vital signs were not recorded on the flow sheet at all. Additionally, two days' records did not include full sets of vital signs, with only blood pressure and/or pulse documented. Five entries were scratched out with attempted over-writes and could not be deciphered. On several occasions, if action was taken in response to blood pressure readings that were either abnormally high or low, it was not documented. Furthermore, no progress notes were entered for the weekend of October 21-22, 2017.

At an unknown time, DC (b)(6); (b)(7)(C) documented that while conducting pod visits the previous day, VOLKOV appeared to be disoriented and confused about where he was and what he was saying.¹⁵⁴ (b)(6); (b)(7)(C) relayed to ERAU that he recalled that VOLKOV was initially cooperative but at some point became less so.¹⁵⁵ When asked if he reported his observations to anyone at the facility, he stated that had it appeared to him that the detainee wanted to harm himself he would have reported that information.

October 23, 2017 – October 25, 2017

At 2:43 p.m. (b)(6); (b)(7)(C) noted a late entry for checks completed earlier in the day, documenting¹⁵⁶ the following:

¹⁴⁸ See ACHS Progress Note, entry dated October 19, 2017.

¹⁴⁹ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

¹⁵⁰ See ACHS Progress Note, entry dated October 20, 2017.

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ See ACHS Vital Signs Flow Sheet, dated October 21, 2017, through November 13, 2017.

¹⁵⁴ See EARM Case Comments entry dated October 20, 2017.

¹⁵⁵ ERAU interview with (b)(6); (b)(7)(C) dated February 6, 2019.

¹⁵⁶ See ACHS Progress Note, entry dated October 23, 2017.

- Right arm vitals findings: blood pressure significantly low at 79/56¹⁵⁷; respirations normal at 16; pulse normal at 71; and temperature illegibly written but possibly 94.7, which would have been a sign of hypothermia.
- Left arm vitals findings: blood pressure low at 82/62 and pulse normal at 74.
- She gave VOLKOV Gatorade, which he consumed in her presence. A blood pressure re-check at 11:05 a.m. was slightly improved at 90/56.
- VOLKOV had a steady gait.

On October 24, 2017, at 3:30 a.m., an unidentified nurse documented VOLKOV was quiet all night, took all medications, and was in no distress.¹⁵⁸

On October 25, 2017, at 1:00 a.m., an unidentified RN documented VOLKOV was resting quietly in his cell, and at 4:15 p.m., (b)(6); (b)(7)(C) gave VOLKOV a Gatorade.¹⁵⁹

October 27, 2017

At 1:50 p.m., (b)(6); (b)(7)(C) documented VOLKOV was heard yelling in his cell.¹⁶⁰ Deputy (b)(6); (b)(7)(C) (first name unknown) informed (b)(6); (b)(7)(C) that VOLKOV was banging his head on the door. Upon instruction to cease banging his head, he stopped but continued to yell. (b)(6); (b)(7)(C) advised RN (b)(6); (b)(7)(C) that VOLKOV had been requesting an Ativan injection, but (b)(6); (b)(7)(C) explained, as the order (from October 17th) was written, it could only be given if he was a threat to himself, and at that time he “never posed a threat to himself.”¹⁶¹ (b)(6); (b)(7)(C) noted she would continue to monitor VOLKOV.

At 2:10 p.m., an unidentified nurse documented placing a call to the Mental Health Department.¹⁶²

At 2:20 p.m., (b)(6); (b)(7)(C) renewed the prescription of Ativan (2 mg) every six hours for anxiety/agitation, as needed, and if oral medication was refused, it could be given intramuscularly at the same dose and frequency, up to a maximum of four doses per 24 hours.¹⁶³

¹⁵⁷ According to the Mayo Clinic, most doctors consider blood pressure too low only if it causes symptoms, while other experts define low blood pressure as readings lower than 90/60. If either number is below that, the pressure is abnormal. A sudden fall in blood pressure can be dangerous as it can cause falls related to dizziness, lightheadedness, fainting, blurred vision, and fatigue. Extreme hypotension can result in shock, identified by confusion, rapid shallow breathing, weak rapid pulse, and cold clammy skin.

¹⁵⁸ See ACHS Progress Note, entry dated October 24, 2017.

¹⁵⁹ See ACHS Progress Note, entries dated October 25, 2017.

¹⁶⁰ See ACHS Progress Note, entry dated October 27, 2017.

¹⁶¹ Per Creative Corrections, (b)(6); (b)(7)(C) who prevented the intramuscular injection of Ativan on October 27, 2017, based on how the order was written, was acting prudently and in accordance with the National Commission on Correctional Healthcare, Standard J-I-02, which states, “Though the right to refuse treatment is inherent in the notion of informed consent, exceptions may arise in psychiatric emergencies. State laws vary on this matter but, as a rule, forced psychotropic medication is employed only when the inmate is imminently dangerous to self or others due to mental disease or defect. Facilities that do not force psychotropic medication in an emergency generally transfer the patient immediately to a hospital emergency room for assessment and treatment.”

¹⁶² See ACHS Progress Note, entry dated October 27, 2017.

¹⁶³ See ACHS Order Sheet, entry dated October 27, 2017.

At an undocumented time, (b)(6); (b)(7)(C) RN, administered an injection of Ativan intramuscularly.¹⁶⁴

At 3:25 p.m., an unidentified nurse documented that (b)(6); (b)(7)(C) ACHS Corporate Clinical Coordinator for Behavioral Health, called in response to a message left with the Mental Health Department.¹⁶⁵ (b)(6); (b)(7)(C) indicated that “emergency psychotropic medication” could only be used if a patient is a threat to himself or someone else. During his interview with ERAU, Dr. (b)(6); (b)(7)(C) indicated that Ativan would not have required an informed consent since it was an as-needed medication and denied that his orders were in error. He also stated that the practice of involuntary psychotropic administration is very common and that “There is no harm in giving the medication before the patient gets agitated to the point of hurting himself.” Consistent with these representations, (b)(6); (b)(7)(C) changed the Ativan prescription on October 31, 2017 to twice daily, which medical staff regularly administered starting that day to November 14, 2017. There is no documentation to support that VOLKOV signed a consent for psychotropic medication treatment within the medical record.

October 29, 2017

At 8:30 p.m., (b)(6); (b)(7)(C) documented that VOLKOV took his nighttime medications, along with Ativan 2 mg orally for anxiety; however, there is no documentation to explain the administration of as-needed Ativan.¹⁶⁶

October 30, 2017

At 2:00 p.m., an unidentified nurse documented that VOLKOV was becoming agitated in his cell, repeatedly yelling “One case, one judge” and requested Ativan to help “his head.”¹⁶⁷ (b)(6); (b)(7)(C) renewed Ativan (2 mg) by mouth for three days, as needed, but did not include a directive to administer the drug intramuscularly if the oral dose was refused.¹⁶⁸ An unidentified RN administered one dose of the medication at an unspecified time.¹⁶⁹

At some time in the afternoon, (b)(6); (b)(7)(C) assessed VOLKOV for his complaint of left inguinal hernia pain and request for surgical correction.¹⁷⁰ The assessment found the hernia to be “bulging” but reducible, thus not meeting the criteria for surgical correction.¹⁷¹ The note also referred to vital signs recorded by (b)(6); (b)(7)(C) at 12:10 p.m., which were within normal limits except for a low blood pressure of 92/54.¹⁷² (b)(6); (b)(7)(C) educated VOLKOV about inguinal hernias, and VOLKOV agreed with the decision not to proceed with surgical correction. There was no

¹⁶⁴ See MAR. There was no related progress note within the medical record addressing the need for administration of Ativan. Due to the undocumented time, it is also unknown if (b)(6); (b)(7)(C) administered the medication prior to Dr. (b)(6); (b)(7)(C) order renewal. R (b)(6); (b)(7)(C) as no longer employed at BCDC at the time of ERAU’s onsite review.

¹⁶⁵ See ACHS Order Sheet, entry dated October 27, 2017.

¹⁶⁶ See ACHS Progress Note, entry dated October 29, 2017; see also MAR.

¹⁶⁷ See ACHS Progress Note, entry dated October 30, 2017.

¹⁶⁸ See ACHS Order Sheet, entry dated October 30, 2017.

¹⁶⁹ See MAR.

¹⁷⁰ See ACHS Progress Note, entry dated October 30, 2017.

¹⁷¹ As previously noted, the left inguinal hernia was not included on VOLKOV’s Problem List to serve as communication to other nurses and providers, as well as to ensure provider follow-up during future clinical encounters. During his interview (b)(6); (b)(7)(C) stated the hernia could have caused the small bowel obstruction.

¹⁷² See ACHS Vital Signs Flow Sheet, dated October 21, 2017, through November 13, 2017.

reference to the option of getting VOLKOV a hernia belt, as initially authorized on September 12, 2017, and no follow-up was ordered.

October 31, 2017

At 11:28 a.m., LMHC (b)(6); (b)(7)(C) documented a mental health follow-up.¹⁷³ She described VOLKOV as disheveled and un-showered, cooperative but irritable. VOLKOV was fully oriented and offered good eye contact. When asked if he wanted to hurt himself or anyone else, he replied he was not sure, then “rambled on” about his pending court date. She ordered VOLKOV to remain on suicide watch and planned a follow-up.

At an undocumented time, (b)(6); (b)(7)(C) completed a psychiatric appointment with VOLKOV.¹⁷⁴ (b)(6); (b)(7)(C) noted VOLKOV had no prior mental health history but was now agitated, banging his head, and screaming while on suicide watch. VOLKOV continued to express thoughts of self-harm, stating, “I just want to die. You don’t deport me to Russia.” He added, “Two months ago, I was a different man. I am sitting like an idiot here.” VOLKOV’s speech was coherent and his thought content unremarkable. He denied active hallucinations but stated “I have seizure.”¹⁷⁵ Dr. (b)(6); (b)(7)(C) described VOLKOV as disheveled, agitated, overly dramatic, depressed, and anxious, and diagnosed him with acute stress disorder. (b)(6); (b)(7)(C) noted VOLKOV’s response to treatment was “Partial.”

At 7:20 p.m., (b)(6); (b)(7)(C) discontinued the previous orders for Ativan, started Ativan (2 mg) by mouth twice daily for 30 days and Thorazine¹⁷⁶ (50 mg) by mouth twice daily, and scheduled a follow-up for two weeks later.¹⁷⁷ Medical staff administered the first dose of Ativan the morning of November 1, 2017, and it was regularly administered and accepted twice daily until the evening dose on November 7, 2018, at which time the order was changed; VOLKOV was also largely compliant with the Thorazine treatment.¹⁷⁸ (b)(6); (b)(7)(C) completed an Abnormal Involuntary Movement Scale (AIMS)¹⁷⁹ assessment on this date, documenting normal findings and a score of zero.¹⁸⁰ During interview, regarding the absence of a psychotropic informed consent form for the use of Thorazine, (b)(6); (b)(7)(C) replied it may have been filed in someone else’s record, as he was certain he had completed it. He also confirmed AIMS should be done every six months when a detainee is receiving high risk psychotropic medication, such as Thorazine.¹⁸¹

November 1, 2017

¹⁷³ See ACHS Mental Health Rounds/Contact form, dated October 31, 2017. LMHC (b)(6); (b)(7)(C) noted this encounter was a follow-up to the October 27, 2017 assessment; however, there was no October 27, 2017 assessment present in the medical record.

¹⁷⁴ See ACHS Psychiatric Progress Note, entry dated October 31, 2017.

¹⁷⁵ It is unknown if VOLKOV did in fact have an undocumented seizure while at BCDC or if he meant he has a history of seizures.

¹⁷⁶ Thorazine, generic name chlorpromazine, is a psychotropic medication used to treat behavior disorders.

¹⁷⁷ See ACHS Order Sheet, entry dated October 31, 2017.

¹⁷⁸ See MAR.

¹⁷⁹ AIMS is a test to determine the presence of potentially serious side effects from psychotropic medications.

¹⁸⁰ See ACHS AIMS, entry dated October 31, 2017.

¹⁸¹ ERAU interview with (b)(6); (b)(7)(C) dated February 5, 2019.

At 11:00 a.m., (b)(6); (b)(7)(C) documented she provided Gatorade to VOLKOV.

At 2:25 p.m., LMHC (b)(6); (b)(7)(C) documented a mental health follow-up, noting that VOLKOV stated he wanted to kill himself.¹⁸² He was alert and cooperative, with a dysphoric.¹⁸³ mood. VOLKOV continued to discuss his court case but was redirected to talk about his girlfriend, which seemingly depressed him as he believed she abandoned him. VOLKOV continued to state he trusted no one and would not until he knew the outcome of his pending November 8, 2017, court case. LMHC (b)(6); (b)(7)(C) noted that (b)(6); (b)(7)(C) had seen VOLKOV the previous day and placed him on mental health medications for stress. LMHC (b)(6); (b)(7)(C) ordered he remain on suicide watch because he verbalized wanting to die and scheduled a follow-up for the following day.

November 2, 2017

At 11:28 a.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up.¹⁸⁴ She observed VOLKOV sitting on the side of his bed and repeatedly ranting, “One court, one prison.” He stated he would like to be in a regular unit, but he continued to refuse to articulate how he intended to keep himself safe; therefore, LMHC (b)(6); (b)(7)(C) continued the suicide watch order.

At 4:30 p.m., RN (b)(6); (b)(7)(C) documented that VOLKOV remained in medical on suicide watch.¹⁸⁵ Although he did not respond to questions in English and switched between languages, he responded positively to orders. She gave VOLKOV Gatorade and noted he had a steady gait.

At an unknown time, (b)(6); (b)(7)(C) documented that he advised (b)(6); (b)(7)(C) request to have the seizure medication, Tegretol, increased via verbal order, (b)(6); (b)(7)(C) prescribed a dosage increase to 400 mg twice daily for 30 days, doubling the previous dosage.¹⁸⁶ There is no further documentation within the medical record regarding why (b)(6); (b)(7)(C) requested to have the Tegretol increased or that an evaluation was conducted prior to ordering the increase.

¹⁸² See ACHS Mental Health Rounds/Contact form, dated November 1, 2017.

¹⁸³ Dysphoric is a profound state of unease or dissatisfaction.

¹⁸⁴ See ACHS Mental Health Rounds/Contact form, dated November 2, 2017.

¹⁸⁵ See ACHS Progress Note, entry dated November 2, 2017.

¹⁸⁶ See ACHS Order Sheet, entry dated November 2, 2017; see also MAR.

November 3, 2017

At 1:00 a.m., (b)(6); (b)(7)(C) documented that VOLKOV was not in distress and stated he wanted to return to Russia.¹⁸⁷

At 11:25 a.m., (b)(6); (b)(7)(C) conducted a mental health follow-up, noting that VOLKOV was again refusing to shower.¹⁸⁸ He was disheveled, dysphoric, and avoided eye contact. He denied homicidal ideation but stated he had “no reason for this life.” VOLKOV was irritable and continued the same conversation about President Trump and “one court, one prison.” As he refused to discuss a safety plan, LMHC (b)(6); (b)(7)(C) continued his suicide watch and scheduled a follow-up.

November 6, 2017

At 11:20 a.m., (b)(6); (b)(7)(C) conducted a mental health follow-up, noting that VOLKOV spoke too softly to understand him.¹⁸⁹ He had not showered and was described as disheveled, withdrawn, depressed, and disoriented. LMHC (b)(6); (b)(7)(C) stated that VOLKOV would stand in his cell and once the cell door was opened, he would turn away from the door and walk to his bed in a wobbly and unsteady manner. When asked questions, VOLKOV only mumbled. LMHC (b)(6); (b)(7)(C) asked LPN (b)(6); (b)(7)(C) to take VOLKOV’s blood pressure and temperature; (b)(6); (b)(7)(C) documented.¹⁹⁰ a low blood pressure of 75/58 and normal pulse and respirations of 65 and 16, respectively. LPN (b)(6); (b)(7)(C) gave VOLKOV Gatorade and notified (b)(6); (b)(7)(C) who responded that VOLKOV was not moving around enough and “There’s nothing we can do for him.” LMHC (b)(6); (b)(7)(C) convinced VOLKOV to take a shower, which perked him up, and noted he ate his lunch. LMHC (b)(6); (b)(7)(C) encouraged VOLKOV to be more mobile, continued his suicide watch, and noted a follow-up for the next day.

During his interview with ERAU, (b)(6); (b)(7)(C) stated the declining blood pressure could have been caused by an internal bleed.¹⁹¹ He also recalled he may have stated there was nothing they could do for VOLKOV but did not elaborate further.

November 7, 2017

At 1:00 a.m., RN (b)(6); (b)(7)(C) documented that while administering VOLKOV’s medication, he noticed a strong urine smell coming from the cell.¹⁹² VOLKOV complied with the directive to shower, and BCDC changed the blanket and bedding.

At 10:50 a.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up, documenting that VOLKOV appeared alert but continued to complain of weakness.¹⁹³ He appeared depressed but was sleeping and eating well. VOLKOV discussed his court appearance slated for the next day and continued

¹⁸⁷ See ACHS Progress Note, entry dated November 3, 2017.

¹⁸⁸ See ACHS Mental Health Rounds/Contact form, dated November 3, 2017.

¹⁸⁹ See ACHS Mental Health Rounds/Contact form, dated November 6, 2017.

¹⁹⁰ See ACHS Progress Note, entry dated November 6, 2017. ERAU notes (b)(6); (b)(7)(C) did not record a temperature.

¹⁹¹ ERAU interview with (b)(6); (b)(7)(C) dated February 5, 2019.

¹⁹² See ACHS Progress Note, entry dated November 7, 2017.

¹⁹³ See ACHS Mental Health Rounds/Contact form, dated November 7, 2017.

to verbalize hopelessness. LMHC (b)(6); (b)(7)(C) documented scheduling VOLKOV to see (b)(6); (b)(7)(C) to assess his safety and depression and evaluate his medications. She documented follow-up for the next day.

At 3:10 p.m., RN (b)(6); (b)(7)(C) documented VOLKOV's report of depression.¹⁹⁴ R (b)(6); (b)(7)(C) noted VOLKOV's vital signs were all within normal limits and that he had a steady gait. She documented giving him Gatorade and that medical had scheduled him to see (b)(6); (b)(7)(C) same day for his complaint.

At 7:00 p.m. (b)(6); (b)(7)(C) attempted to conduct an encounter with VOLKOV but noted he found him too sedated to engage in a meaningful conversation.¹⁹⁵ He reduced the Ativan to one mg twice daily and scheduled him for re-evaluation in one week.

November 8, 2017

At 4:00 a.m. (b)(6); (b)(7)(C) documented that VOLKOV took all his medications and spoke with him at the door.¹⁹⁶

At 3:49 p.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up, noting that VOLKOV was more animated and his blood pressure, as reported by nurses, was normal.¹⁹⁷ He denied wanting to kill himself while at BCDC but that he would kill himself at another facility. (b)(6); (b)(7)(C) continued his suicide watch and noted a follow-up for the next day.

November 9, 2017

At 1:50 p.m., LMHC (b)(6); (b)(7)(C) documented that VOLKOV was smiling and walking around his cell.¹⁹⁸ VOLKOV was animated and discussed his return to general population. He stated he could feel positivity coming back to him and denied suicidal ideations. LMHC (b)(6); (b)(7)(C) downgraded VOLKOV from suicide watch to psych watch (mental health observation).¹⁹⁹

At 3:30 p.m., (b)(6); (b)(7)(C) conducted a follow-up assessment and noted that VOLKOV was much calmer and more cooperative.²⁰⁰ He complained of being too sleepy, and (b)(6); (b)(7)(C) noted that his blood pressure was running low. (b)(6); (b)(7)(C) increased the Ativan to 0.5 mg by mouth, two times daily, and the Thorazine to 25 mg by mouth, twice daily for 30 days, and noted a follow-up

¹⁹⁴ See ACHS Progress Note, entry dated November 7, 2017.

¹⁹⁵ See ACHS Psychiatric Progress Note, entry dated November 7, 2017.

¹⁹⁶ See ACHS Progress Note, entry dated November 8, 2017.

¹⁹⁷ See ACHS Mental Health Rounds/Contact form, dated November 8, 2017.

¹⁹⁸ See ACHS Mental Health Rounds/Contact form, dated November 9, 2017.

¹⁹⁹ See ACHS Special Needs Communication/Relocation form, dated November 9, 2017; see also Mental Health Protocols Order Sheet, entry dated November 9, 2017. The mental health observation orders required housing in medical with random checks, no utensil restrictions, one set of clothes, and regular bedding, but no laundry bag or razor.

²⁰⁰ See ACHS Psychiatric Progress Note, entry dated November 9, 2017.

appointment in four weeks.²⁰¹ (b)(6); (b)(7)(C) conducted another AIMS assessment, documenting a score of 0.²⁰²

At 6:10 p.m., an unidentified nurse noted an order clarification directing the continuation of one mg of Ativan by mouth twice daily until the one-half mg pills arrived at the pharmacy.²⁰³

November 10, 2017

At 8:35 a.m. (b)(6); (b)(7)(C) documented that she had reviewed VOLKOV's blood pressure read-out with (b)(6); (b)(7)(C) the day before, and he requested to have (b)(6); (b)(7)(C) decrease his lisinopril.²⁰⁴ Pursuant to the request, (b)(6); (b)(7)(C) decreased the lisinopril to 10 mg daily.²⁰⁵

November 13, 2017

At 1:40 p.m., LMHC (b)(6); (b)(7)(C) completed a mental health follow-up, documenting that VOLKOV refused to discuss if he wanted to go to either protective custody or general population, merely stating he wanted to sleep more.²⁰⁶ LMHC (b)(6); (b)(7)(C) documented VOLKOV's mood as dysphoric, that he denied suicidal and homicidal ideations, and that he had displayed no ideations of self-harm in weeks. She maintained his medical observation status and documented follow-up for the next day.

At 3:43 p.m., (b)(6); (b)(7)(C) noted that VOLKOV remained on mental health watch and was "only speaking in British."²⁰⁷ She described him as agitated and noted he drank Gatorade.

November 14, 2017

An unidentified nurse reviewed VOLKOV's medications with (b)(6); (b)(7)(C) and documented that the Ativan was discontinued.²⁰⁸

At 9:05 a.m., LMHC (b)(6); (b)(7)(C) noted VOLKOV's removal from mental health observation and relocation to general population and that he notified both Office (b)(6); (b)(7)(C) and LPN (b)(6); (b)(7)(C) accordingly.²⁰⁹

At 9:05 a.m., VOLKOV was transferred to general population dorm B-8.²¹⁰

²⁰¹ See ACHS Order Sheet, entry dated November 9, 2017; *see also* MAR.

²⁰² See ACHS AIMS, entry dated November 9, 2017.

²⁰³ See ACHS Order Sheet, entry dated November 9, 2017; *see also* MAR (b)(6); (b)(7)(C) administered the first dosage of Ativan (0.5 mg) on the evening of November 11, 2017.

²⁰⁴ See ACHS Progress Note, entry dated November 10, 2017.

²⁰⁵ See ACHS Order Sheet, entry dated November 10, 2017; *see also* MAR.

²⁰⁶ See Mental Health Rounds/Contract form, dated November 13, 2017.

²⁰⁷ See ACHS Progress Note, entry dated November 13, 2017.

²⁰⁸ See ACHS Progress Note and Order sheet, both dated November 14, 2017; *see also* MAR.

²⁰⁹ See ACHS Special Needs Communication/Relocation form, dated November 14, 2017.

²¹⁰ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018; *see also* Daily Record of Segregation, dated November 14, 2017. ERAU notes that the Daily Record of Segregation log covering the period from September 16, 2017, to November 14, 2017, documented that VOLKOV accepted most meals and never missed more than two meals in a row; however, it did not note whether showers and recreation were offered to or refused by VOLKOV. The only mention of showers taken were by medical staff.

November 15, 2017

At 3:15 p.m., LMHC (b)(6); (b)(7)(C) completed a mental health encounter, noting VOLKOV was doing excellent, came to the session smiling and had met some good people in the dorm. He denied suicidal or homicidal ideations.

November 16, 2017

At 3:25 p.m., Deputy (b)(6); (b)(7)(C) documented that several detainees were complaining of VOLKOV's bizarre behavior.²¹¹ (b)(6); (b)(7)(C) escorted VOLKOV to medical for evaluation.

At 5:00 p.m., (b)(6); (b)(7)(C) conducted a psychiatric assessment.²¹² He ordered the start of Vistaril²¹³ (25 mg) by mouth twice daily, increased the Thorazine dosage to 50 mg, twice daily for 60 days, and for VOLKOV to return to the clinic in four weeks.²¹⁴ However, medical did not start the increased Thorazine dosage until November 20, 2017 or the Vistaril until November 24, 2017, following repeat orders by (b)(6); (b)(7)(C) on November 20, 2017.²¹⁵

At 5:15 p.m., (b)(6); (b)(7)(C) initiated close observation protocols²¹⁶ for VOLKOV as a form of administrative segregation and documented notification to medical and security.²¹⁷ BCDC assigned VOLKOV to medical housing, where he remained until November 25, 2017.²¹⁸ BCDC security staff initiated a Daily Record of Segregation log and medical staff initiated the Confinement Log.

ERAU notes that VOLKOV was housed in administrative segregation starting this date through the date of his death. Generally, his administrative segregation placement was due to his request for PC, except for the periods during which he was placed on suicide or psych watch. The Daily Record of Segregation logs during this time confirm that he accepted most meals, never missing more than two meals in a row.²¹⁹ The only documented instance of VOLKOV being offered

²¹¹ See BCSO Incident Report, dated November 16, 2017.

²¹² See ACHS Psychiatric Progress Note, entry dated November 16, 2017.

²¹³ Vistaril, generic name hydroxyzine, is a medication used to treat anxiety, nausea, vomiting, allergies, skin rash, hives, and itching. Because it causes drowsiness, it can also be used to promote sleep.

²¹⁴ See ACHS Order Sheet, entry dated November 16, 2017.

²¹⁵ See MAR.

²¹⁶ See ACHS Special Needs Communication/Relocation, dated November 16, 2017; *see also* Mental Health Protocols Order Sheet, entry dated November 16, 2017. Per the protocol order sheet, close observation requires staff to check and observe the patient every 15 minutes or more, suicide tray or paper products only, and specified orders for clothing restrictions and housing. (b)(6); (b)(7)(C) allowed VOLKOV only one set of clothing, no razor or laundry bag, and required that he be transferred to booking or medical for housing.

²¹⁷ *Id.*

²¹⁸ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

²¹⁹ There are no Daily Record of Segregation logs for April 12 through April 18, 2018, July 28, 2018, or October 6, 2018. There are two records for October 5, 2018.

recreation in this log, however, was on the first day of his placement, November 16, 2017.²²⁰ Additionally, there were only six documented instances of showers offered.²²¹

November 17, 2017

(b)(6); (b)(7)(C) completed an administrative segregation order due to VOLKOV's placement on medical observation the previous day.²²² Although the order requires one, there is no medical staff comment or signature present on the document. (b)(6); (b)(7)(C) documented that VOLKOV did not request a hearing concerning his placement in segregation; an Administrative Sgt. (name illegible) signed the form on the same date. (b)(6); (b)(7)(C) initiated a re-classification, which was devoid of a custody score, custody level, or supervisory approval.²²³

At 2:20 p.m., (b)(6); (b)(7)(C) relayed a verbal order to (b)(6); (b)(7)(C) to obtain VOLKOV's vital signs weekly while housed in medical.²²⁴ Vital signs obtained at that time were all within normal limits and his weight was 194 pounds.²²⁵ (b)(6); (b)(7)(C) further documented that VOLKOV was only speaking Russian.²²⁶

November 20, 2017

At 11:00 a.m., (b)(6); (b)(7)(C) repeated orders for Vistaril and Thorazine, and a follow-up on December 19, 2017.²²⁷ At 12:30 p.m., (b)(6); (b)(7)(C) conducted an encounter with VOLKOV, documenting that he appeared calm.²²⁸ (b)(6); (b)(7)(C) noted that VOLKOV continued to respond to internal stimuli and ordered continuation of his medications.

November 25, 2017

At 7:05 a.m., Deputy (b)(6); (b)(7)(C) documented that he and Lieutenant (Lt.) (b)(6); (b)(7)(C) attempted to move VOLKOV from medical to booking, but he refused to exit the cell.²²⁹ (b)(6); (b)(7)(C) authorized for VOLKOV to be forcibly restrained, at which time Deputy (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) restrained and removed VOLKOV. They then escorted him to booking cell 302 without incident, where he remained until February 13, 2018.²³⁰

²²⁰ See BCDC Daily Record of Segregation log, entry dated November 16, 2017. Security staff use Jail Log Reports to document security checks, and ERO notes there were other documented instances of VOLKOV being offered recreation in these reports; however, BCSO Policy CO 334 does not state that recreation offered and acceptance/refusal can be documented in the Jail Log Report.

²²¹ Documentation reflects VOLKOV refused a shower on December 11 and 14, 2017, and February 11, 2018, and accepted a shower on March 18, 29, and 31, 2018. See BCDC Daily Record of Segregation, entries dated December 11 and 14, 2017; February 11, 2018; and March 18, 29, and 31, 2018.

²²² See ICE Form I-886, dated November 17, 2017.

²²³ See BCSO Reclassification, dated November 17, 2017.

²²⁴ See ACHS Order Sheet, entry dated November 17, 2017.

²²⁵ See ACHS Vital Signs Flow Sheet, entry dated November 17, 2017.

²²⁶ See ACHS Progress Note, entry dated November 17, 2017.

²²⁷ See ACHS Order Sheet, entry dated November 20, 2017. There was no associated progress note explaining the basis for repeating the orders.

²²⁸ See ACHS Psychiatric Progress Note, dated November 20, 2017.

²²⁹ See BCSO Incident Report, dated November 25, 2017.

²³⁰ See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

At 3:02 p.m., (b)(6); (b)(7)(C) completed a Post Use-of-Force assessment, documenting VOLKOV reported being “good.”²³¹ VOLKOV’s recorded vital signs were all within normal limits except for a low blood pressure of 100/50. She described VOLKOV as alert, oriented, and cooperative. While the document did not identify the circumstances of the use of force incident, R (b)(6); (b)(7)(C) noted that VOLKOV had no injuries or complaints. A nursing follow-up was scheduled for the next day.

November 26, 2017

At 4:00 p.m., (b)(6); (b)(7)(C) RN documented a follow-up, Post Use-of-Force assessment.²³² VOLKOV denied any pain or discomfort, and no injuries were observed. The assessment did not include a neurological examination and was not in SOAPE format, as directed by AHCS policy.

November 27, 2017

At 3:45 p.m. and 4:15 p.m., LMHC (b)(6); (b)(7)(C) documented two different mental health follow-ups while VOLKOV was in segregation; according to her encounter notes, LMHC (b)(6); (b)(7)(C) did so because she was on leave and had just returned on this date.²³³ During the first encounter, LMHC (b)(6); (b)(7)(C) noted that VOLKOV was irritable and angry, almost disgusted that she had disturbed him, but denied suicidal ideations. When she returned 30 minutes later, he had just finished his dinner and said he was good. LMHC (b)(6); (b)(7)(C) continued VOLKOV’s mental health observation status and noted a follow-up for the next day.

November 28, 2017 – December 1, 2017

At 12:30 p.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up, documenting that VOLKOV barely spoke other than to say he was good and not suicidal.²³⁴ VOLKOV’s status remained the same and LMHC (b)(6); (b)(7)(C) documented follow-up for the next day. During this time period, LMHC (b)(6); (b)(7)(C) attempted to conduct three additional mental health follow-ups (one each day) but VOLKOV refused to be interviewed. Each day, she documented that VOLKOV would remain on mental health observation, and she would attempt a follow-up the next day.

December 4, 2017

At 12:25 p.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up documenting that VOLKOV tried to avoid conversation, but with persistence, he cooperated.²³⁵ He was alert, groomed, and fully oriented. He offered good eye contact, and his behavior was unremarkable. When questioned about his risk for suicide, he replied, “I have no desire to hurt myself. I see no reason to hurt myself.” LMHC (b)(6); (b)(7)(C) documented that VOLKOV was released from mental health observation, a follow-up would occur within one to two weeks, and that she notified²³⁶ both medical and security. (b)(6); (b)(7)(C) discontinued all suicide precautionary measures.²³⁷

²³¹ See ACHS Post-Use-Of-Force, dated November 25, 2017.

²³² See ACHS Progress Note, entry dated November 26, 2017.

²³³ See ACHS Mental Health Rounds/Contact form, both dated November 27, 2017.

²³⁴ See ACHS Mental Health Rounds/Contact form, dated November 28, 2017.

²³⁵ See ACHS Mental Health Rounds/Contact form, dated December 4, 2017.

²³⁶ See ACHS Special Needs Communication/Relocation, dated December 4, 2017.

²³⁷ See ACHS Mental Health Protocols Order Sheet, entry dated December 4, 2017.

December 6, 2017

At 5:10 p.m., (b)(6); (b)(7)(C) conducted an encounter with VOLKOV, during which he reported still having racing thoughts.²³⁸ He stated the seizures stopped, that he was getting three to four hours of sleep per night, and his appetite was good. (b)(6); (b)(7)(C) described him as well groomed, fully oriented, and coherent but anxious. He denied suicidal or homicidal ideations, as well as abnormal perceptions. (b)(6); (b)(7)(C) again noted VOLKOV's diagnosis as acute stress disorder. To help him sleep better, (b)(6); (b)(7)(C) increased the Vistaril dosage to 25 mg in the morning and 50 mg at night and scheduled a follow-up in 8 weeks.²³⁹

December 11, 2017

At 4:45 p.m., LMHC (b)(6); (b)(7)(C) attempted to conduct a follow-up mental health round but VOLKOV refused.²⁴⁰ She noted he looked up, stated he was fine, then went back to resting, refusing to converse any longer. LMHC (b)(6); (b)(7)(C) plan was to conduct weekly rounds and to follow up with mental health in 8 to 10 weeks.

December 15, 2017

Medical staff documented VOLKOV's refusal of the December 14, 2017, nighttime medications and all medications on December 15, 2017.²⁴¹ VOLKOV refused to sign both refusal forms.

December 16, 2017

At 3:20 p.m., RN (b)(6); (b)(7)(C) (first name unknown) documented notification from security that VOLKOV was "not acting right."²⁴² Upon entering the cell, he was lying on his back with his right leg bent in the air, complaining of muscle spasms. Via verbal order, (b)(6); (b)(7)(C) prescribed Flexeril²⁴³ (10 mg) to be taken once.²⁴⁴

At 4:40 p.m., RN (b)(6); (b)(7)(C) documented that VOLKOV was sitting up at his bedside.²⁴⁵ She took VOLKOV's vital signs, which were all within normal limits. VOLKOV was not in distress and verbalized feeling better.

²³⁸ See ACHS Psychiatric Progress Note, entry dated December 6, 2017.

²³⁹ *Id.* See also ACHS Order Sheet, entry dated December 6, 2017.

²⁴⁰ See ACHS Mental Health Rounds/Contact form, dated December 11, 2017.

²⁴¹ ERAU notes that some of the medical staff signatures are illegible on the refusal forms. See ACHS Refusal of Treatment forms, both dated December 15, 2017; see also MAR.

²⁴² See ACHS Progress Note, entry dated December 16, 2017.

²⁴³ Flexeril is a muscle relaxing medication.

²⁴⁴ See ACHS Order Sheet, entry dated December 16, 2017.

²⁴⁵ See ACHS Progress Note, entry dated December 16, 2017.

December 26, 2017

At 7:30 p.m., I (b)(6); (b)(7)(C) renewed the order for Tegretol (400 mg) twice daily for 180 days.²⁴⁶ There is no documented evidence that (b)(6); (b)(7)(C) assessed VOLKOV prior to renewing the medication orders.

January 12, 2018

Deputy (b)(6); (b)(7)(C) documented completion of a 30-day AS review, indicating VOLKOV requested to remain in PC.²⁴⁷ Deputy (b)(6); (b)(7)(C) documented that VOLKOV had been in AS for 60 days and the initial placement remained valid, as VOLKOV was still a threat to himself and unwilling or unable to live in general population. Nevertheless, when she completed the ICE Form I-885, Deputy (b)(6); (b)(7)(C) recommended VOLKOV's removal from PC.²⁴⁸ An unidentified supervisor (signature was illegible) concurred with the recommendation on the form.²⁴⁹ Deputy (b)(6); (b)(7)(C) completed VOLKOV's re-classification, recommending an override from minimum to medium custody; no supervisory approval was documented on the form.²⁵⁰ Further still, despite the recommendation on the form, VOLKOV remained in PC.

January 25, 2018

At an unknown time, LMH (b)(6); (b)(7)(C) documented that she believed VOLKOV would benefit from a higher level of care at a chronic therapeutic mental health facility or at the Krome Transitional Unit.²⁵¹ She expanded that VOLKOV spent his days sleeping, eating, and regularly talking loudly to himself in his cell, and she thought he would benefit from a new environment.

February 1, 2018 – February 3, 2018

At 7:15 p.m., (b)(6); (b)(7)(C) conducted an encounter with VOLKOV, documenting that during their last encounter on December 6, 2017, he increased his medications due to his acute stress disorder.²⁵² (b)(6); (b)(7)(C) noted that VOLKOV denied hearing voices, his response to the treatment was fair, and follow-up would occur in 8 weeks.²⁵³ (b)(6); (b)(7)(C) renewed orders for Vistaril and Thorazine.²⁵⁴

On February 3, 2018, (b)(6); (b)(7)(C) verbally renewed orders for VOLKOV's metoprolol, aspirin, and Keppra.²⁵⁴ There is no documentation that he assessed VOLKOV prior to renewing the orders.

²⁴⁶ See ACHS Order Sheet, entry dated December 26, 2017.

²⁴⁷ See BCSO Incident Report, dated January 12, 2018.

²⁴⁸ See ICE Form I-885, dated January 12, 2018.

²⁴⁹ ERAU notes that approval was date marked January 10, 2018; the discrepancy in dates cannot be explained.

²⁵⁰ See BCSO Reclassification, dated January 12, 2018.

²⁵¹ See IHSC Clinical Segregation Checklist, dated January 25, 2018.

²⁵² See ACHS Psychiatric Progress Note, entry dated February 1, 2018.

²⁵³ See ACHS Order Sheet, entry dated February 1, 2018; *see also* MAR.

²⁵⁴ See ACHS Order Sheet, entry dated February 3, 2018; *see also* MAR.

February 5, 2018

At an unknown time, HSA (b)(6); (b)(7)(C) documented that she believed VOLKOV would benefit from a higher level of care at the Krome Transitional Unit, as he required stimulation and socialization.²⁵⁶ During her interview with ERAU, HS (b)(6); (b)(7)(C) stated HS (b)(6); (b)(7)(C) filled out the IHSC Clinical Segregation Checklist pursuant to a request came from the IHSC Field Medical Coordinator.²⁵⁷

February 13, 2018

At 4:13 p.m., Cpl (b)(6); (b)(7)(C) documented that while picking up trays in booking, he observed VOLKOV bleeding from the left side of his head.²⁵⁸ VOLKOV was then escorted to medical via wheelchair. During his interview (b)(6); (b)(7)(C) stated that VOLKOV told him he had had a seizure and that he believed he wheeled VOLKOV to medical and left him with the medical officer.²⁵⁹ He added that a nurse examined VOLKOV and cleaned up the wound.

(b)(6); (b)(7)(C) recalled that VOLKOV was housed in booking for a long time and that he spoke a “little bit” of English. When asked how recreation and showers are offered to detainees housed in booking, (b)(6); (b)(7)(C) replied that recreation cannot be given until after the final count of the day around 11:00 p.m. He did not recall VOLKOV ever going to recreation but said he only showered about half the times it was offered.

At 4:30 p.m., (b)(6); (b)(7)(C) documented that VOLKOV was brought to medical following an unwitnessed fall.²⁶⁰ She noted a quarter size abrasion on the left side of his forehead and that VOLKOV’s pupils were equal and reactive, and he denied pain or nausea. VOLKOV’s documented vital signs were all within normal limits except for a low blood pressure of 85/65. HSA (b)(6); (b)(7)(C) gave VOLKOV Gatorade and an icepack for his forehead. Via verbal order, Dr. (b)(6); (b)(7)(C) required VOLKOV’s housing in medical until evaluated by the doctor and to push fluids.²⁶¹ Medical staff obtained VOLKOV’s blood pressure and pulse every hour from 4:30 p.m. until 8:30 p.m.; all recorded vitals were within normal limits except for the initial low blood pressure reading of 85/65 at 4:30 p.m.²⁶²

At 6:30 p.m., (b)(6); (b)(7)(C) LPN, documented that VOLKOV continued to be housed in medical, appearing to be in no acute distress.²⁶³ He denied suicidal or homicidal ideations and took his nighttime medications, Gatorade, and a pitcher of water.

²⁵⁵ HSA (b)(6); (b)(7)(C) was no longer employed by BCDC at the time of ERAU’s on site review.

²⁵⁶ See IHSC Clinical Segregation Checklist, dated February 5, 2018.

²⁵⁷ ERAU interview with HSA (b)(6); (b)(7)(C) dated February 5, 2019.

²⁵⁸ See BCSO Incident Report, dated February 15, 2018.

²⁵⁹ ERAU interview with (b)(6); (b)(7)(C) dated February 6, 2019.

²⁶⁰ See ACHS Progress Note, entry dated February 13, 2018. As this event was unwitnessed, it is unknown if the possible cause of the fall was a seizure or low blood pressure, the latter of which can cause dizziness and fainting.

²⁶¹ *Id.*; see also ACHS Order Sheet and ACHS Special Needs Communication/Relocation sheet, both dated February 13, 2018.

²⁶² See ACHS Vital Signs Flow Sheet, entries dated February 13, 2018.

²⁶³ See ACHS Progress Note, entry dated February 13, 2018.

February 14, 2018

At 5:10 a.m., LPN (b)(6); (b)(7)(C) documented VOLKOV's refusal of all morning medications and Gatorade, and that his blood pressure was low at 70/52.²⁶⁴

At 5:20 a.m., LPN (b)(6); (b)(7)(C) again offered VOLKOV his medications and Gatorade, both of which he accepted; however, the blood pressure medications were withheld due to the low blood pressure reading.²⁶⁵ LPN (b)(6); (b)(7)(C) notified (b)(6); (b)(7)(C) accordingly.

At 8:30 a.m., LPN (b)(6); (b)(7)(C) took VOLKOV's vital signs, all of which were within normal limits, and notified (b)(6); (b)(7)(C) of the results. VOLKOV denied any pain or discomfort, and LPN (b)(6); (b)(7)(C) gave him a pitcher of water and Gatorade. Via verbal order, (b)(6); (b)(7)(C) requested that nurses continue to push fluids and order laboratory tests, to include a CBC, CMP, and blood levels for Tegretol and Keppra.²⁶⁶ The CMP and drug level results were normal except for a slightly low sodium²⁶⁷ level of 133 and a low chloride²⁶⁸ level of 92.²⁶⁹ However, the CBC panel was not included in the laboratory results and there was no progress note documenting receipt of those results or re-order of the CBC.

At 4:30 p.m., LPN (b)(6); (b)(7)(C) documented a blood pressure and pulse rate check, both of which were within normal limits.²⁷⁰

At 8:00 p.m., RN (b)(6); (b)(7)(C) documented that VOLKOV reported no pain or discomfort.²⁷¹

February 15, 2018

Throughout the day, medical staff documented VOLKOV's vital signs as remaining stable at 95/70, 108/78, and 121/80, and his pulse and respirations remained within normal limits, essentially unchanged from previous reads.²⁷²

At 3:00 p.m., RN (b)(6); (b)(7)(C) documented that VOLKOV reported no pain or discomfort.²⁷³

At 3:50 p.m., (b)(6); (b)(7)(C) documented that VOLKOV claimed to be "ok" with no symptoms.²⁷⁴ (b)(6); (b)(7)(C) ordered the continuation of VOLKOV's housing in medical, but if he was asymptomatic, medical could transfer him to booking.

²⁶⁴ See ACHS Progress Note, entry dated February 14, 2018.

²⁶⁵ *Id.*

²⁶⁶ *Id.*; see also ACHS Order Sheet, entry dated February 14, 2018.

²⁶⁷ The normal adult value for sodium in the blood is 134 to 144, with low levels commonly caused by dehydration.

²⁶⁸ The normal adult value for chloride in the blood is 96 to 106, with low levels commonly caused by dehydration.

²⁶⁹ See LabCorp Patient Report, dated February 14, 2018.

²⁷⁰ See ACHS Vital Signs Flow Sheet, entry dated February 14, 2018.

²⁷¹ *Id.*

²⁷² See ACHS Vital Signs Flow Sheet, entries dated February 15, 2018.

²⁷³ See ACHS Progress Note, entry dated February 15, 2018.

²⁷⁴ *Id.*

At 9:30 p.m., LPN (b)(6); (b)(7)(C) documented that VOLKOV reported no pain or discomfort.²⁷⁵

February 16, 2018

On this date, medical staff twice took VOLKOV's vital signs, which were within normal limits on both occasions.²⁷⁶ At 9:00 a.m., RN (b)(6); (b)(7)(C) documented (b)(6); (b)(7)(C) verbally ordered VOLKOV's transfer back to booking.²⁷⁷

February 18, 2018 – February 22, 2018

At 5:30 a.m., an unidentified nurse advised (b)(6); (b)(7)(C) of VOLKOV's low blood pressure of 63/50 and rapid heart rate of 111 after rising from sleep.²⁷⁸ (b)(6); (b)(7)(C) ordered morning blood pressure medications withheld, the offering of Gatorade every shift, and monitoring of blood pressure for every shift for five days.²⁷⁹

At 11:30 a.m., a follow-up blood pressure reading remained low at 74/80, and the re-check at 9:20 p.m. read borderline normal at 90/65.²⁸⁰

At 12:30 p.m., (b)(6); (b)(7)(C) (first name unknown) documented that (b)(6); (b)(7)(C) verbally ordered the immediate discontinuation of metoprolol.²⁸¹ (b)(6); (b)(7)(C) orders also required medical staff to encourage fluid intake and exercise, as tolerated.

On February 19, 2018, at 8:30 a.m., VOLKOV's blood pressure was normal at 92/70.²⁸² This is the only documented blood pressure reading on this date.

On February 20, 2018, at 9:30 a.m., (b)(6); (b)(7)(C) documented VOLKOV's transport to medical via wheelchair.²⁸³ VOLKOV's recorded vital signs were all within normal limits except for a low blood pressure of 88/61. (b)(6); (b)(7)(C) noted his respirations were even and unlabored, with no acute distress. She administered two servings of Gatorade and a pitcher of water while he sat in the lobby. (b)(6); (b)(7)(C) notified the doctor and received verbal orders to encourage fluids and exercise.

At 10:00 a.m., (b)(6); (b)(7)(C) re-checked VOLKOV's vital signs, which were all within normal limits.²⁸⁴ VOLKOV returned to his cell.

²⁷⁵ *Id.*

²⁷⁶ See ACHS Vital Signs Flow Sheet, entries dated February 16, 2018.

²⁷⁷ See ACHS Progress Note and Order Sheet, entries dated February 16, 2018.

²⁷⁸ See ACHS Progress Note, entry dated February 18, 2018.

²⁷⁹ *Id.*; see also ACHS Order Sheet, entry dated February 18, 2018.

²⁸⁰ See ACHS Vital Signs Flow Sheet, entries dated February 18, 2018.

²⁸¹ See ACHS Order Sheet, entry dated February 18, 2018.

²⁸² See ACHS Vital Signs Flow Sheet, entry dated February 19, 2018.

²⁸³ See ACHS Progress Note, entry dated February 20, 2018.

²⁸⁴ *Id.*

On February 21, 2018 and February 22, 2018, medical documented two sets of vitals for VOLKOV, all of which were within normal limits; a record of body temperatures was not noted.²⁸⁵

March 9, 2018 – March 30, 2018

LMHC (b)(6); (b)(7)(C) first name unknown), conducted multiple mental health encounters with VOLKOV, which are summarized in Appendix A.²⁸⁶ During one encounter, LMHC (b)(6); (b)(7)(C) diagnosed VOLKOV with schizophrenia, although there is no documentation supporting a prior history of schizophrenia. During another, LMHC (b)(6); (b)(7)(C) documented VOLKOV was on suicide watch, although records do not indicate he was on suicide watch at the time; rather, per the Daily Record of Segregation and Confinement Log, it appears VOLKOV was only on mental health watch.²⁸⁷ During her interview, HSA (b)(6); (b)(7)(C) stated that LMHC (b)(6); (b)(7)(C) was with BCDC only a short time, adding that he mixed up patient information and “just couldn’t keep everything straight.”²⁸⁸ LMHC (b)(6); (b)(7)(C) documentation lacked necessary accuracy, and ERAU was unable to determine which of the accounts of VOLKOV’s status were valid.

April 3, 2018

At 9:00 p.m., LPN (b)(6); (b)(7)(C) documented that during medication pass, medical noticed VOLKOV’s medications had expired; (b)(6); (b)(7)(C) renewed Vistaril and Thorazine via verbal order.²⁸⁹

April 9, 2018

At 6:00 p.m., (b)(6); (b)(7)(C) conducted an encounter with VOLKOV, documenting that he reported the voices were down, his sleep was improved, and he wanted to continue the same treatment.²⁹⁰ (b)(6); (b)(7)(C) documented a diagnosis of unspecified psychosis and a follow-up to occur in eight weeks, and renewed orders for Vistaril and Thorazine.²⁹¹

May 4, 2018

At an unknown time, BCDC security staff moved VOLKOV to a cell within A7.²⁹²

²⁸⁵ See ACHS Vital Signs Flow Sheet, entries dated February 21 and 22, 2018.

²⁸⁶ ERAU notes that mental health rounds are not documented during the weekends and holidays due to the absence of onsite mental health staff during those times. According to HSA White, nurses are now expected to conduct mental health rounds on days when mental health staff are not available. ERAU interview with HSA (b)(6); (b)(7)(C) February 5, 2019.

²⁸⁷ See Confinement Log, dated March 2018; see also Daily Record of Segregation, entries dated March 9 – 30, 2018.

²⁸⁸ ERAU interview with HSA (b)(6); (b)(7)(C) dated February 5, 2019.

²⁸⁹ See ACHS Order Sheet, entry dated April 3, 2018; see also ACHS Progress Note, entry dated April 3, 2018; and, MAR.

²⁹⁰ See ACHS Psychiatric Progress Note, dated April 9, 2018.

²⁹¹ *Id.*; see also ACHS Order Sheet, entry dated April 9, 2018; and, MAR.

²⁹² See BCSO Inmate Cell History Report, dated June 26, 2017, through November 30, 2018.

May 5, 2018

At 1:25 p.m., an unidentified nurse documented that (b)(6); (b)(7)(C) verbally ordered a decrease in lisinopril to 10 mg once daily for 45 days.²⁹³

May 23, 2018

At 3:15 p.m., LMHC (b)(6); (b)(7)(C) completed a mental health round, noting a language barrier with VOLKOV.²⁹⁴ VOLKOV reported he was able to sleep since being on medication. LMHC (b)(6); (b)(7)(C) described VOLKOV's hygiene as poor and his speech as incoherent at times. VOLKOV denied a need for any mental health services or treatment, stating he was happy with his current medication treatment. He denied suicidal or homicidal ideation and audio/visual hallucinations. All other mental health findings were within normal limits. VOLKOV presented a euthymic²⁹⁵ mood with no paranoia. LMHC Scott's documented plan was to follow up with mental health monthly, as needed, and (b)(6); (b)(7)(C) for medication management.

May 30, 2018

(b)(6); (b)(7)(C) signed an incomplete AIMS on this date; there is no documentation to support that VOLKOV refused to participate in the evaluation.²⁹⁶

June 4, 2018 – June 10, 2018

On June 4, 2018, at 7:00 p.m., (b)(6); (b)(7)(C) signed a Psychiatric Progress Note, crossing out the entirety of the form with a circled "R" (refused).²⁹⁷ He further noted "Refused" in VOLKOV's order sheet, with no additional context.²⁹⁸

On June 5, 2018, at 4:00 p.m., (b)(6); (b)(7)(C) documented that (b)(6); (b)(7)(C) provided a verbal order to renew aspirin, lisinopril, Keppra, and Tegretol.²⁹⁹ There was no documentation that an assessment of VOLKOV was conducted prior to renewal of the medications.

On June 10, 2018, at 10:00 a.m., (b)(6); (b)(7)(C) completed VOLKOV's annual TB screening and assessment³⁰⁰ and administered a PPD skin test; two days later, the results returned as negative.

On June 11, 2018, at 1:30 p.m., (b)(6); (b)(7)(C) documented VOLKOV's refusal to accept behavioral health services because he stated he was fine, though he refused to sign the refusal form.³⁰¹

²⁹³ See ACHS Order Sheet, entry dated May 5, 2018; *see also* MAR.

²⁹⁴ See ACHS Mental Health Rounds/Contact form, dated May 23, 2018.

²⁹⁵ Euthymia refers to a normal, tranquil mental state or mood.

²⁹⁶ See ACHS AIMS, entry dated May 30, 2018.

²⁹⁷ See ACHS Psychiatric Progress Note, dated June 4, 2018.

²⁹⁸ See ACHS Order Sheet, entry dated June 4, 2018.

²⁹⁹ See ACHS Order Sheet, entry dated June 5, 2018.

³⁰⁰ See ACHS Tuberculosis Screening, Assessment and Order form, dated June 10, 2018.

³⁰¹ See ACHS Refusal of Treatment form, dated June 11, 2018.

July 2, 2018

At 8:30 p.m., (b)(6); (b)(7)(C) conducted an encounter with VOLKOV, documenting that the mental status exam was within normal limits, and VOLKOV's response to treatment was good.³⁰² Dr. (b)(6); (b)(7)(C) documented diagnosis remained the same, with target symptoms being anxiety, insomnia, and hallucinations.

At 8:55 p.m., (b)(6); (b)(7)(C) renewed the Vistaril and Thorazine orders and noted the next appointment was to occur on September 3, 2018.³⁰³

July 13, 2018

At 1:31 p.m., LMHC (b)(6); (b)(7)(C) completed a mental health round and documented that all findings were within normal limits.³⁰⁴ LMHC (b)(6); (b)(7)(C) documented VOLKOV was provided access to care and monitoring for continuum of service and offered follow-up psychoeducation care as needed and that the plan was to continue with current treatment and housing.

July 17, 2018

At an unknown time, (b)(6); (b)(7)(C) completed an Internal Clinic Referral Form to behavioral health stating the nature of the problem as "decompensating, minimal verbal response when communication attempted, patient unkempt."

July 18, 2018

At 10:37 a.m., LMHC (b)(6); (b)(7)(C) documented that VOLKOV refused mental health treatment but would not offer a reason as to why; she obtained a witness signature from Deputy (b)(6); (b)(7)(C) due to VOLKOV's refusal.³⁰⁵ There was no additional context in LMHC (b)(6); (b)(7)(C) progress note.³⁰⁶

July 25, 2018

At 2:35 p.m., LMHC (b)(6); (b)(7)(C) documented a mental health round, noting all findings were within normal limits.³⁰⁷ LMHC (b)(6); (b)(7)(C) further noted that VOLKOV did not exhibit signs of suicidal or homicidal ideation or self-injurious behavior; the treatment plan section was left incomplete.

August 2, 2018

At 9:00 a.m., Deputy (b)(6); (b)(7)(C) documented completion of a 30-day administrative segregation review, indicating VOLKOV verbally requested to remain in PC but refused to complete a new

³⁰² See ACHS Psychiatric Progress Note, entry dated July 2, 2018.

³⁰³ See ACHS Order Sheet, entry dated July 2, 2018.

³⁰⁴ See ACHS Mental Health Rounds/Contact form, dated July 13, 2018.

³⁰⁵ See ACHS Refusal of Treatment form, dated July 18, 2018.

³⁰⁶ See ACHS Progress Note, entry dated July 18, 2018.

³⁰⁷ See ACHS Mental Health Rounds/Contact form, dated July 25, 2018.

PC request form.³⁰⁸ Unlike the previous reviews conducted by Deputy (b)(6); (b)(7)(C) there was no ICE Form I-885 or reclassification present in the detention record for this or any review after this date.

August 3, 2018

Starting on this date through November 9, 2018, LMHC (b)(6); (b)(7)(C) documented conducting 18 separate mental health progress rounds, each time noting only that VOLKOV was seen and the mental health examination was within normal limits.³⁰⁹

August 9, 2018

At approximately 2:22 p.m., LPN (b)(6); (b)(7)(C) documented VOLKOV's refusal of his annual history and physical, stating there was "no need for physical."³¹⁰ VOLKOV refused to signed the form; therefore, LPN (b)(6); (b)(7)(C) obtained a witness signature from Dep (b)(6); (b)(7)(C) (first name unknown).³¹¹ There is no documentation within the medical record suggesting the annual assessment was offered again at a later time.

September 13 – 14, 2018

At an unknown time, an unknown individual documented that VOLKOV refused a psychiatric round.³¹² At 3:00 p.m. the following day, LPN (b)(6); (b)(7)(C) documented that VOLKOV refused to participate in a behavioral health assessment with (b)(6); (b)(7)(C) the previous day. As VOLKOV declined to sign the refusal form, she obtained a witness signature; however, LPN (b)(6); (b)(7)(C) did not document that potential consequences of the refusal were explained to VOLKOV.³¹³

September 25, 2018 – September 30, 2018

At an unknown time, LPN (b)(6); (b)(7)(C)³¹⁴ (first name unknown) submitted a referral to behavioral health, noting routine priority to address mental health medications due to expire on September 30, 2018.³¹⁵

On September 26, 2018, at 1:28 p.m., LMHC (b)(6); (b)(7)(C) completed a mental health round with VOLKOV.³¹⁶ LMHC (b)(6); (b)(7)(C) described VOLKOV as alert, groomed, fully oriented, using good eye contact, and normal in affect, speech, thought content, perceptions, and thought processes.

³⁰⁸ See BCSO Incident Report, dated August 2, 2018.

³⁰⁹ LMHC (b)(6); (b)(7)(C) conducted almost all of these rounds exactly seven days apart. There were double entries for three days, with time stamp differences varying between 1 and 29 minutes. See ACHS Mental Health Rounds Progress Notes, entries dated August 3 through November 9, 2018.

³¹⁰ See ACHS Progress Note, entry dated August 9, 2018; see also ACHS Health Assessment, dated August 9, 2018; and, ACHS Dental Visual Screening, dated August 9, 2018. ERAU notes the health assessment lacked a signature from any health professional.

³¹¹ See ACHS Refusal of Treatment Form, dated August 9, 2018. Deputy (b)(6); (b)(7)(C) first name is illegible.

³¹² See ACHS Psychiatric Progress Note, entry dated September 13, 2018.

³¹³ See ACHS Refusal of Treatment form, dated September 14, 2018. The witness signature is illegible.

³¹⁴ At the time of ERAU's site visit, LPN (b)(6); (b)(7)(C) was no longer employed by BCDC.

³¹⁵ See ACHS Internal Clinic Referral Form, dated September 25, 2018.

³¹⁶ See ACHS Mental Health Rounds/Contact form, dated September 26, 2018.

VOLKOV demonstrated a guarded attitude, and his mood was described as labile.³¹⁷ and irritable. VOLKOV presented no signs or symptoms of suicidal intent or behavior and/or psychotic outburst. During the encounter, VOLKOV refused mental health treatment.³¹⁸ LMHC (b)(6); (b)(7)(C) completed a refusal form, noting VOLKOV declined to sign it, and obtained Deputy (b)(6); (b)(7)(C) signature as witness.

On September 27, 2018, at 9:30 p.m., (b)(6); (b)(7)(C) completed a psychiatric round with VOLKOV.³¹⁹ Other than noting that that VOLKOV appeared disheveled, all other objective information and VOLKOV's response to treatment were noted as fair. D (b)(6); (b)(7)(C) diagnosis remained unspecified psychosis, and he made no changes to VOLKOV's medication regimen.

On September 29, 2018, at an unknown time, (b)(6); (b)(7)(C) submitted another referral to behavioral health, now noting an urgent need to address VOLKOV's mental health medications due to expire the following day.³²⁰

On September 30, 2018, at 3:00 a.m., via verbal order, (b)(6); (b)(7)(C) renewed the Thorazine and Vistaril medication orders for another seven days.³²¹

October 1, 2018

At 6:30 p.m., (b)(6); (b)(7)(C) documented VOLKOV refused his mental health follow-up appointment.³²² As VOLKOV refused to sign the form, (b)(6); (b)(7)(C) obtained Deputy (b)(6); (b)(7)(C) signature as witness.

October 2, 2018

At 11:18 a.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up, documenting that VOLKOV refused psychiatric treatment the day prior but did not provide a reason for his refusal.³²³ The assessment note stated that prior to this entry, VOLKOV refused psychiatric treatment with his medications needing to be refilled. To assist and encourage him, since he had also refused mental health services on September 26, 2018, a "collaborative effort took place between medical and mental health to cajole and admonish him to take his medication," as well as to attend all psychiatric appointments. VOLKOV had no signs or symptoms of suicidal or homicidal ideations or self-injurious behavior. The medication update was re-scheduled for October 4, 2018.³²⁴

³¹⁷ A labile mood is one that readily changes (mood swings), and which can be out of proportion to the situation at hand.

³¹⁸ See ACHS Refusal of Treatment Form, dated September 26, 2018; see also ACHS Progress Note, entry dated September 26, 2018.

³¹⁹ See ACHS Psychiatric Progress Note, entry dated September 27, 2018.

³²⁰ See ACHS Internal Clinic Referral Form, dated September 29, 2018.

³²¹ See ACHS Order Sheet, entry dated September 30, 2018.

³²² See ACHS Refusal of Treatment form, dated October 1, 2018.

³²³ See ACHS Mental Health Rounds/Contact form, dated October 2, 2018.

³²⁴ See *supra*, note 326.

October 4, 2018 – October 6, 2018

At an unknown time, (b)(6); (b)(7)(C) completed a psychiatric appointment with VOLKOV as a follow-up to his October 1, 2018, assessment refusal.³²⁵ During the encounter, VOLKOV stated, “I am alright. I take my pills. I don’t have any problems.” (b)(6); (b)(7)(C) documented VOLKOV’s appearance as disheveled, and his mental status as normal. His response to treatment was determined to be fair, and the diagnostic impression and medication regimen remained the same. VOLKOV’s next appointment was scheduled for November 29, 2018.

On October 6, 2018, at 8:50 p.m. (b)(6); (b)(7)(C) renewed the Vistaril and Thorazine orders for 90 days.³²⁶

November 16, 2018

At 3:01 p.m., LMHC (b)(6); (b)(7)(C) conducted a mental health follow-up, documenting that VOLKOV stated he was good and gave a thumbs up along with his response.³²⁷ He denied suicidal or homicidal ideations, and his mental status examination was within normal limits.

November 23, 2018

At an unknown time, RN (b)(6); (b)(7)(C) completed VOLKOV’s transfer summary, indicating VOLKOV was being transferred to KNSPC the same day.³²⁸ His current medical problems were listed as hypertension, seizures, suicide watch three times, and unspecified psychosis. There was no reference to his abdominal hernia or his heart condition. His medication included aspirin (81 mg) at night, lisinopril (10 mg) at night, hydroxyzine (25 mg) in the morning and (50 mg) at night, and carbamazepine (200 mg), chlorpromazine (50 mg), and levetiracetam (500 mg), all twice daily.

At 7:45 a.m., Deputy I (b)(6); (b)(7)(C) documented that VOLKOV became verbally combative when preparing him for his transfer to Krome.³²⁹ Deputy (b)(6); (b)(7)(C) noted that (b)(6); (b)(7)(C) attempted to explain to VOLKOV that he was being transferred, and (b)(6); (b)(7)(C) utilized the translation line to again explain the situation, which VOLKOV then stated he understood. Deputy (b)(6); (b)(7)(C) further documented that VOLKOV had a strong odor about him, and when escorted to the shower area, he refused to shower, change clothes, or sign release paperwork. At that time, (b)(6); (b)(7)(C) advised security staff to remove the detainee from the transfer list.³³⁰ During his interview (b)(6); (b)(7)(C) stated VOLKOV thought he was being sent back to Russia, and due to VOLKOV’s agitation, he removed him from the trip; (b)(6); (b)(7)(C) added that VOLKOV ultimately

³²⁵ See ACHS Psychiatric Progress Note, entry dated October 4, 2018.

³²⁶ See ACHS Order Sheet, entry dated October 6, 2018; *see also* MAR.

³²⁷ See ACHS Mental Health Rounds/Contact form, dated November 16, 2018.

³²⁸ See Medical Summary of Federal Prisoner/Alien in Transit, dated November 23, 2018.

³²⁹ See BCSO Incident Report, dated November 23, 2018.

³³⁰ ERAU notes that although a completed BCDC Booking Information Form documents VOLKOV was released at 10:00 a.m. on this date, a comment within EARM further supports VOLKOV’s transfer to Krome was canceled due to his combative state. *See* BCSO Booking Information, dated November 23, 2018.

understood, and replied “I stay here.”³³¹ During his interview, (b)(6); (b)(7)(C) stated he agreed with (b)(6); (b)(7)(C) call, noting that that behavior could jeopardize everyone’s safety.³³²

November 26, 2018

At 6:40 a.m., Deputy (b)(6); (b)(7)(C) documented that VOLKOV refused both his breakfast and his morning medication.³³³ While making a round at this time, Deputy (b)(6); (b)(7)(C) approached VOLKOV’s cell and found him kneeling on the floor with his upper torso on the bed as if he were praying. Deputy (b)(6); (b)(7)(C) tapped on the cell window and asked VOLKOV if he was okay, to which VOLKOV nodded and gave a thumbs up. After completing the remainder of his security check, (b)(6); (b)(7)(C) checked on VOLKOV again, at which point he was sitting on the floor. Deputy (b)(6); (b)(7)(C) had the pod control officer open the cell door so that he could better communicate and evaluate VOLKOV’s appearance. He noticed that VOLKOV’s face was pale and asked him what was wrong, to which he replied “Pressure.” At this time, (b)(6); (b)(7)(C) radioed for a medical emergency and asked for a wheelchair. Medical staff arrived two minutes later and placed VOLKOV in the wheelchair; during transport to medical, he was transitioned to a stretcher due to discomfort. During his interview, (b)(6); (b)(7)(C) stated that VOLKOV was unable to hold himself upright in the wheelchair.³³⁴ Regarding his earlier conversation with VOLKOV, (b)(6); (b)(7)(C) was asked if he ever used interpretation services when speaking with detainees and he stated no, then added he was aware of its availability but had never used it, nor had he seen anyone else use it.

At 7:05 a.m., (b)(6); (b)(7)(C) documented VOLKOV was transferred to the examination area via stretcher.³³⁵ after determining he was unresponsive.³³⁶ VOLKOV’s recorded vital signs were all within normal limits except for a rapid pulse of 114 and respirations of 22. VOLKOV was pale, diaphoretic,³³⁷ confused, having difficulty being aroused, and demonstrating periods of apnea.³³⁸ LPN (b)(6); (b)(7)(C) noted VOLKOV had abrasions on the right side of his scalp, on his left upper arm, and on his lower right calf, and that his prognosis was poor. Medical staff elevated his feet and head and encouraged him to respond and to remain awake while waiting for emergency medical services (EMS) to arrive. (b)(6); (b)(7)(C) documented that (b)(6); (b)(7)(C) was notified and supplemental oxygen was ordered immediately.

At 7:15 a.m., (b)(6); (b)(7)(C) transferred VOLKOV to an outside hospital per the telephone order (b)(6); (b)(7)(C)³³⁹

³³¹ ERAU interview with (b)(6); (b)(7)(C) dated February 6, 2019.

³³² ERAU interview with Deputy (b)(6); (b)(7)(C), dated February 5, 2019.

³³³ See BCSO Incident Report, dated November 26, 2018.

³³⁴ ERAU interview with Deputy (b)(6); (b)(7)(C) dated February 6, 2019.

³³⁵ Video surveillance footage further supports BCDC medical staff wheeled a stretcher through the medical corridor to VOLKOV. See Medical Surveillance Footage, dated November 26, 2018.

³³⁶ See ACHS Urgent Care Assessment, dated November 26, 2018.

³³⁷ Diaphoretic means profusely sweating.

³³⁸ Apnea refers to periods when respirations stop.

³³⁹ See ACHS Urgent Care Assessment, dated November 26, 2018.

At 7:36 a.m., EMS arrived in BCDC's sally port; two EMS responders pushed a stretcher from the medical corridor to the medical lobby.³⁴⁰ At 7:38 a.m., EMS wheeled VOLKOV out of the medical lobby.³⁴¹ Six minutes later, EMS loaded VOLKOV into the ambulance.³⁴² Deputy Shackelford rode in the ambulance, recalling that VOLKOV was fine but looked sickly.³⁴³ At 7:45 a.m., Deputy (b)(6); (b)(7)(C) departed BCDC and arrived five minutes later to the Ed Fraser Memorial Hospital (EFMH) in Macclenny, FL.³⁴⁴ At 7:50 a.m., EMS departed BCDC for EFMH, where they arrived one minute later.³⁴⁵

At 9:45 a.m., EFMH staff reported to BCDC medical staff that VOLKOV had an abnormally low hemoglobin level of 3.2 but that his condition was stable.³⁴⁶ EFMH provided VOLKOV with intravenous treatment pending his transfer to Memorial Hospital Jacksonville (MHJ) in Jacksonville, FL.

At 2:00 p.m., Deputy (b)(6); (b)(7)(C) departed EFMH and arrived at MHJ at 2:45 p.m.³⁴⁷ At 3:41 p.m., MHJ assumed care of VOLKOV.³⁴⁸

November 27, 2018

VOLKOV remained hospitalized at MHJ. At 6:00 p.m. (b)(6); (b)(7)(C) assigned to hospital vigil duty, documented that VOLKOV was uncooperative with MHJ medical staff, stating "No more medicine."³⁴⁹ (b)(6); (b)(7)(C) further noted that every attempt to provide medical treatment was refused by VOLKOV even though the hospital staff informed him, via a translation service, that his continued refusal could result in his death. There are no notes in the medical record on this date.

November 28, 2018

At 6:00 p.m., Deputy (b)(6); (b)(7)(C) documented that VOLKOV continued to refuse treatment.³⁵⁰ At 8:00 p.m., hospital medical staff informed VOLKOV that, without his cooperation, there was nothing else they could do for him, and VOLKOV willingly signed a refusal of care form.

At 8:15 p.m., RN (b)(6); (b)(7)(C) documented her contact with MHJ to obtain a report on VOLKOV after being advised that he was refusing all treatment.³⁵¹ The hospital nurse reported that he continued refusing all treatment, his condition had not changed since being admitted, and a small bowel obstruction was suspected. VOLKOV removed his own naso-gastric tube, stating he would

³⁴⁰ See Sally Port/Booking Video Surveillance Footage, dated November 26, 2018.

³⁴¹ See Medical Surveillance Footage, dated November 26, 2018.

³⁴² See Sally Port/Booking Video Surveillance Footage, dated November 26, 2018.

³⁴³ ERAU interview with Deputy (b)(6); (b)(7)(C), dated February 5, 2019.

³⁴⁴ See BCDC Transport Checklist, dated November 26, 2018.

³⁴⁵ See Emergency Pro Incident #184058, dated November 26, 2018.

³⁴⁶ See ACHS Progress Note, entry dated November 26, 2018.

³⁴⁷ See BCDC Transport Checklist, dated November 26, 2018. ERAU notes that BCDC maintained custodial supervision of VOLKOV while he received off-site treatment at MHJ.

³⁴⁸ See Memorial Hospital of Jacksonville HPI-General Illness, dated November 26, 2018.

³⁴⁹ See BCSO Incident Report, dated November 27, 2018.

³⁵⁰ *Id.*

³⁵¹ See ACHS Progress Note, entry dated November 28, 2018.

rather die than get better. He was cursing and yelling at anyone who tried to treat him or convince him to stay for treatment and that he wished to die in the United States. The hospital nurse reported VOLKOV was found to be anemic with a hemoglobin of 8.4, and abdominal distention was still present. The initial hospital plan was to re-insert the naso-gastric tube with the hope that the bowel would decompress, with no planned surgery at the time. However, R(b)(6); (b)(7)(C) documented, VOLKOV's refusal of treatment impeded this plan and he was returned to BCDC.³⁵²

During his interview, Deputy (b)(6); (b)(7)(C) recalled a few events and observations from his hospital vigil duty.³⁵³ He stated that hospital staff used a translation service and told VOLKOV that it was a matter of when he would die, not if. He also stated that when the hospital released VOLKOV, he was cooperative with getting dressed, and they used a wheelchair to take him to the transport vehicle.

At 8:30 p.m., BCDC Director of Nursing (DON) (b)(6); (b)(7)(C) documented that VOLKOV was in the process of returning from the hospital.³⁵⁴ He contacted (b)(6); (b)(7)(C) who ordered observation in medical housing and placement on suicide watch due to VOLKOV's comments while in the hospital.³⁵⁵

At 9:06 p.m., the transport vehicle arrived to BCDC.³⁵⁶ VOLKOV stood on his own and exited the vehicle. At 9:07 p.m., he temporarily leaned on the vehicle and then walked into the booking area. A deputy (name unknown) escorted VOLKOV toward the booking area and held his arm but shortly after, VOLKOV walked unassisted into booking.

BCDC security staff placed VOLKOV into medical room #2, which has a camera; however, he sat on the bottom bunk, out of camera view.³⁵⁷ (b)(6); (b)(7)(C) entered VOLKOV's cell with a blood pressure machine, spoke to him from the doorway, and pointed at her arm.³⁵⁸ Shortly afterward, Deputy (b)(6); (b)(7)(C) appeared in the doorway and also pointed at her arm. (b)(6); (b)(7)(C) left the doorway, and DO (b)(6); (b)(7)(C) appeared in her place. (b)(6); (b)(7)(C) again pointed to her arm. At 9:11 p.m. (b)(6); (b)(7)(C) walked over to VOLKOV, spoke to him, then left the cell. (b)(6); (b)(7)(C) documented that VOLKOV refused an assessment by medical, to include vital signs.³⁵⁹ VOLKOV declined to sign the refusal form; therefore, Deputy (b)(6); (b)(7)(C) signed as witness. (b)(6); (b)(7)(C) completed an ASAP referral³⁶⁰ to medical due to VOLKOV's refusal and documented VOLKOV's placement on suicide watch and housing in medical per (b)(6); (b)(7)(C) order.³⁶¹

³⁵² See *supra* note 354.

³⁵³ ERAU interview with (b)(6); (b)(7)(C) dated February 5, 2019.

³⁵⁴ See ACHS Progress Note, entry dated November 28, 2018.

³⁵⁵ *Id.*; see also ACHS Order Sheet, entry dated November 28, 2018.

³⁵⁶ See BCDC Sally Port and Booking Video Surveillance Footage, dated November 28, 2018.

³⁵⁷ See BCDC Med Hall and Med Iso Video Surveillance Footage, dated November 28, 2018.

³⁵⁸ See BCDC Med Iso Video Surveillance Footage, dated November 28, 2018.

³⁵⁹ See ACHS Refusal of Treatment form, dated November 28, 2018. ERAU notes there are two times documented on this form: one at 9:10 p.m. and another at 10:10 p.m.

³⁶⁰ See ACHS Internal Clinic Referral Form, dated November 28, 2018.

³⁶¹ See ACHS Progress Note, entry dated November 28, 2018; see also ACHS Special Needs Communication/Relocation Form, dated November 28, 2018.

At 9:13 p.m., (b)(6); (b)(7)(C) left the cell.³⁶² At 9:16 p.m., multiple deputies arrived at the doorway and spoke to VOLKOV. At 9:19 p.m., VOLKOV walked to door and spoke to staff. At 9:20 p.m., VOLKOV leaned against wall while deputies removed his leg irons. At 9:23 p.m., (b)(6); (b)(7)(C) and a deputy removed VOLKOV's shirt. At 9:25 p.m., VOLKOV dropped his pants but appeared to have difficulty removing them; a minute later, he walked back to his bunk and sat down. Shortly afterward, (b)(6); (b)(7)(C) and three deputies entered the cell. At 9:29 p.m., staff assisted VOLKOV in putting on a suicide smock and then departed the cell. At 9:30 p.m., Deputy I (b)(6); (b)(7)(C) closed the cell door.

At 9:41 p.m., (b)(6); (b)(7)(C) logged conducting a round, although video surveillance footage supports otherwise.³⁶³ At 9:54 p.m., VOLKOV walked to his cell door, knocked on it for approximately two minutes, then returned back to his bunk.³⁶⁴ (b)(6); (b)(7)(C) logged conducting another round at this time, which once again was not supported by video surveillance footage.³⁶⁵

At 9:56 p.m., (b)(6); (b)(7)(C)³⁶⁶

At 10:00 p.m., (b)(6); (b)(7)(C) documented ordering a restricted diet in accordance with the suicide watch protocol/policy and vital signs monitoring once per shift.³⁶⁷

At 10:11 p.m. (b)(6); (b)(7)(C) conducted his first round.³⁶⁸ This was the first time VOLKOV was observed since his placement on suicide watch and the departure (b)(6); (b)(7)(C) from his cell at 9:30 p.m. During the remainder of his shift (b)(6); (b)(7)(C) checked on VOLKOV within the 15-minute requirement 13 times and exceeded the time requirement on 14 occasions, with 33 minutes being the longest time between rounds.³⁶⁹

November 29, 2018

At 5:00 a.m., R (b)(6); (b)(7)(C) documented VOLKOV was compliant with his medication.³⁷⁰

At approximately 6:00 a.m., Deputy (b)(6); (b)(7)(C) relieved (b)(6); (b)(7)(C). During his shift, (b)(6); (b)(7)(C) exceeded the 15-minute check requirement on half of his rounds, with 29 minutes being the longest time between rounds.

³⁶² See Med Iso Video Surveillance Footage, dated November 28, 2018.

³⁶³ See BCSO Jail Log Report, dated November 28, 2018; see also Med Hall Video Surveillance Footage, dated November 28, 2018.

³⁶⁴ See Med Iso Video Surveillance Footage, dated November 28, 2018.

³⁶⁵ See Med Hall Video Surveillance Footage, dated November 28, 2018.

³⁶⁶ *Id.* ERAU notified the ICE Joint Intake Center (JIC) of this matter on February 6, 2019 (JICMS case number: 201903791). As of this report's publication date, the case is still open and pending.

³⁶⁷ See ACHS Progress Note, entry dated November 28, 2018.

³⁶⁸ See Med Hall Video Surveillance Footage, dated November 28, 2018. ERAU notes that Deputy Curry documented a time of 10:13 p.m. within the Jail Log Report. This is the last comparison ERAU made of documented security checks against video footage until Deputy (b)(6); (b)(7)(C) shift on November 30, 2018, the day of VOLKOV's transfer to the hospital and ultimate death.

³⁶⁹ See BCSO Jail Log Report, dated November 28, 2018 – November 29, 2018.

³⁷⁰ See ACHS Progress Note, entry dated November 29, 2018.

³⁷¹ See BCSO Jail Log Report, dated November 29, 2018.

At 7:00 a.m., (b)(6); (b)(7)(C) documented VOLKOV's vital signs were within normal limits, his respirations were even and unlabored, and he was scheduled to see the psychiatrist the same day.³⁷²

At 7:55 a.m., (b)(6); (b)(7)(C) conducted a suicide risk assessment, at which time VOLKOV stated, "I don't want to kill myself, not today, not tomorrow, not next month."³⁷³ LMHC (b)(6); (b)(7)(C) placed VOLKOV on close observation with 30-minute checks and no clothing restriction; she continued his dietary status along with no utensils in his cell.³⁷⁴

At 9:00 a.m., (b)(6); (b)(7)(C) evaluated VOLKOV, documenting normal vital signs except for a rapid pulse at 119 and a somewhat low oxygen level of 92.³⁷⁵ (b)(6); (b)(7)(C) documented that Dr. (b)(6); (b)(7)(C) ordered VOLKOV oxygen via nasal canula at two liters, as needed, if oxygen level fell below 92 percent, as well as laboratory studies.³⁷⁶ New medication orders included Colace³⁷⁷ (100 mg) twice daily, as needed, and ferrous sulfate³⁷⁸ (325 mg), twice daily for 45 days.

At 12:15 p.m., (b)(6); (b)(7)(C) discontinued all suicide precautionary measures, to include clothing and utensil restrictions, and authorized VOLKOV's housing in medical.³⁷⁹ At 1:35 p.m., LMHC (b)(6); (b)(7)(C) issued guidance to discontinue mental health observation but continue housing in medical as VOLKOV was receiving medical care.³⁸⁰

At 2:15 p.m., (b)(6); (b)(7)(C) documented completion of VOLKOV's laboratory results.³⁸¹ At 4:30 p.m., (b)(6); (b)(7)(C) is noted VOLKOV was resting peacefully in his cell.

At 5:40 p.m., (b)(6); (b)(7)(C) conducted an evaluation of VOLKOV.³⁸² He documented receipt of VOLKOV's labs and that he reported feeling much better. The laboratory results, unsigned by Dr. (b)(6); (b)(7)(C) documented multiple abnormal levels.³⁸³ However, (b)(6); (b)(7)(C) noted that although VOLKOV's laboratory results were low, his vital signs were all within normal limits except for an elevated blood pressure of 125/89, his appearance was improved, and VOLKOV removed the oxygen himself.

³⁷² See ACHS Progress Note, entry dated November 29, 2018.

³⁷³ *Id.*; see also ACHS Mental Health Rounds/Contact form, dated November 29, 2018.

³⁷⁴ *Id.*; see also ACHS Mental Health Protocols Order Sheet, entry dated November 29, 2018; and, ACHS Special Needs Communication/Relocation, dated November 29, 2018. ERAU notes although LMHC (b)(6); (b)(7)(C) placed VOLKOV to close observation now requiring 30-minute checks, the BCDC Jail Log Report indicated VOLKOV remained on 15-minute checks, consistent with BCSO Policy CO 334, which states, "inmates/detainees housed on a medical, psychiatric, or suicide watch shall be considered on Close Supervision watch physically observed and checks documented by detention deputies at intervals not to exceed 15 minutes." As such, ERAU analyzed security check compliance with the 15-minute requirement.

³⁷⁵ See ACHS Progress Note, entry dated November 29, 2018.

³⁷⁶ *Id.*; see also ACHS Order Sheet, entry dated November 29, 2018.

³⁷⁷ Colace is a stool softener.

³⁷⁸ Ferrous sulfate is an iron supplement used to treat anemia.

³⁷⁹ See ACHS Mental Health Protocols Order Sheet, entry dated November 29, 2018; see also ACHS Special Needs Communication/Relocation, dated November 29, 2018.

³⁸⁰ See ACHS Mental Health Rounds/Contact form, dated November 29, 2018.

³⁸¹ See ACHS Progress Note, entry dated November 29, 2018.

³⁸² *Id.*

³⁸³ See LabCorp Patient Report, dated November 29, 2018.

At approximately 6:00 p.m., Deputy (b)(6); (b)(7)(C) relieved (b)(6); (b)(7)(C)³⁸⁴. During his shift, (b)(6); (b)(7)(C) conducted rounds within 15 minutes on all but two rounds, with the time between those rounds being 18 and 19 minutes, respectively.

At 7:00 p.m., (b)(6); (b)(7)(C) completed a psychiatric round with VOLKOV.³⁸⁵ (b)(6); (b)(7)(C) ordered a two-week hold on the Vistaril and Thorazine and follow-up in 30 days. (b)(6); (b)(7)(C) explained during his interview that he discontinued these drugs as they could cause dehydration and further risk to VOLKOV's condition.³⁸⁶

At 8:00 p.m., (b)(6); (b)(7)(C) recorded VOLKOV's vital signs, noting an elevated blood pressure elevated reading of 139/88 and abnormally rapid pulse of 103.³⁸⁷

At approximately 10:50 p.m., (b)(6); (b)(7)(C) relieved (b)(6); (b)(7)(C)³⁸⁸. During her shift, (b)(6); (b)(7)(C) conducted only 6 of the 24 rounds within the 15-minute requirement, with the longest time between rounds at 42 minutes.

November 30, 2018 – Day of Death

At 2:45 a.m., (b)(6); (b)(7)(C) documented VOLKOV was sitting on the side of the bed talking, with no acute distress noted and the following vital signs: an elevated blood pressure reading of 143/94; abnormally rapid pulse of 112; and rapid respirations at 23, but even and unlabored.³⁸⁹

At 6:30 a.m., (b)(6); (b)(7)(C) noted that VOLKOV stated, "I'm good," and offered no complaints of pain or discomfort.³⁹⁰ VOLKOV's respirations were even and unlabored. At 8:45 a.m., RN (b)(6); (b)(7)(C) noted that VOLKOV was resting quietly, again denying pain or discomfort. He lifted his right arm and gave a thumbs up sign.

At 6:00 a.m., (b)(6); (b)(7)(C)³⁹¹ He recalled that (b)(6); (b)(7)(C) told him VOLKOV had a "rough night."³⁹² From 6:00 a.m. to 12:00 p.m., Deputy (b)(6); (b)(7)(C)³⁹³ documented completing 18 rounds within the 15-minute requirement and exceeding it 6 times.³⁹⁴ During his interview, (b)(6); (b)(7)(C) confirmed the 15-minute check requirement but added he does not get the checks done every 15 minutes because he is so busy on the unit.³⁹⁵ Despite logging 24 rounds in the Jail Log Report during this six-hour period, video surveillance footage³⁹⁵ shows that Deputy (b)(6); (b)(7)(C) only conducted seven rounds at the following times:

³⁸⁴ See BCSO Jail Log Report, dated November 29, 2018.

³⁸⁵ See ACHS Psychiatric Progress Note, entry dated November 29, 2018.

³⁸⁶ ERAU interview with (b)(6); (b)(7)(C), dated February 5, 2019.

³⁸⁷ See ACHS Psychiatric Progress Note, entry dated November 29, 2018.

³⁸⁸ See BCSO Jail Log Report, dated November 29, 2018 – November 30, 2018.

³⁸⁹ See ACHS Vital Signs Flow Sheet, entry dated November 30, 2018.

³⁹⁰ See ACHS Progress Note, entry dated November 30, 2018.

³⁹¹ See Med Hall Video Surveillance Footage, dated November 30, 2018.

³⁹² ERAU interview with Deputy (b)(6); (b)(7)(C), dated February 5, 2019.

³⁹³ See BCSO Jail Log Report, dated November 30, 2018.

³⁹⁴ ERAU interview with Deputy (b)(6); (b)(7)(C), dated February 5, 2019.

³⁹⁵ See Med Hall Video Surveillance Footage, dated November 30, 2018. ERAU also notified the ICE JIC of this matter on February 27, 2019, (JICMS case number: 201903791) upon discovery.

Time	Note
6:05 a.m.	Initial shift round
6:37 a.m.	Opened cell for medical
7:58 a.m.	81-minute lapse
9:07 a.m.	69-minute lapse
9:36 a.m.	29-minute lapse
11:26 a.m.	110-minute lapse
11:33 a.m.	7-minute lapse

At 11:33 a.m., Office (b)(6); (b)(7)(C) opened VOLKOV's cell door. A minute later, VOLKOV walked unassisted to the medical treatment room. LPN (b)(6); (b)(7)(C) documented that VOLKOV's condition had decompensated, and his vital signs were unstable.³⁹⁶ (b)(6); (b)(7)(C) evaluated VOLKOV, documenting he complained of abdominal distention and pain.³⁹⁷ He noted that VOLKOV appeared to be in distress, had difficulty breathing, was pale, and had a distended abdomen, and that severe pain was present on palpation. VOLKOV's vital signs included a normal blood pressure of 94/61, rapid pulse at 120, and very low oxygen level of 76. (b)(6); (b)(7)(C) findings included generalized weakness, difficulty breathing, distended abdomen, and hypertension. As a result, (b)(6); (b)(7)(C) ordered VOLKOV's transfer to the outside hospital.³⁹⁸ HSA (b)(6); (b)(7)(C) stated in her interview that she told VOLKOV this was life or death, and he needed to go to the hospital, to which he replied, "I think that's a good idea."³⁹⁹ At 11:49 a.m., BCDC contacted EMS.⁴⁰⁰

At 11:59 a.m., the ambulance arrived at BCDC.⁴⁰¹ At 12:04 p.m., EMS wheeled VOLKOV out of the medical treatment room on a stretcher.⁴⁰² At 12:08 p.m., EMS loaded VOLKOV into the ambulance and, at 12:15 p.m., departed BCDC with the chase vehicle following.⁴⁰³ Deputy (b)(6); (b)(7)(C) Sullivan drove the chase vehicle and Deputy (b)(6); (b)(7)(C) rode in the ambulance.⁴⁰⁴

Deputy (b)(6); (b)(7)(C) stated that on the way to the hospital, EMS staff started an IV and monitored VOLKOV's blood pressure. Deputy (b)(6); (b)(7)(C) recalled that VOLKOV seemed fine in the ambulance, as he was raised up on the stretcher and talking. The EMS report documented VOLKOV appeared weak and lethargic and slow to respond to questions.⁴⁰⁵

At 12:49 p.m., EMS arrived at MHJ.⁴⁰⁶ Upon arrival, Deputy (b)(6); (b)(7)(C) stated EMS wheeled VOLKOV into the waiting area.⁴⁰⁷ Deputy (b)(6); (b)(7)(C) stated that after parking the chase vehicle, he ran to catch up and noted VOLKOV was taking shallow breaths and holding an oxygen mask

³⁹⁶ See ACHS Progress Note, entries dated November 30, 2018.

³⁹⁷ *Id.* ERAU notes that (b)(6); (b)(7)(C) documented VOLKOV was transported from his cell into the medical treatment room via wheelchair, which video footage does not support.

³⁹⁸ See ACHS Order Sheet, entry dated November 30, 2018.

³⁹⁹ ERAU interview with HSA (b)(6); (b)(7)(C) dated February 5, 2019.

⁴⁰⁰ See Emergency Pro Inc#184278 Report, dated November 30, 2018.

⁴⁰¹ See Sally Port Video Surveillance Footage, dated November 30, 2018.

⁴⁰² See Med Hall Video Surveillance Footage, dated November 30, 2018.

⁴⁰³ See Sally Port Video Surveillance Footage, dated November 30, 2018.

⁴⁰⁴ ERAU interview with Deputy (b)(6); (b)(7)(C) dated February 5, 2019.

⁴⁰⁵ See Emergency Pro Inc#184278 Report, dated November 30, 2018.

⁴⁰⁶ *Id.*

⁴⁰⁷ ERAU interview with Deputy (b)(6); (b)(7)(C) dated February 5, 2019.

to his mouth.⁴⁰⁸ They were in the waiting area for a few minutes when a doctor came over, felt VOLKOV's belly, which was distended, and stated that they needed to move VOLKOV to a treatment room. Deputy McNarnay grabbed the foot of the stretcher and started to assist the EMS staff in moving him, when VOLKOV turned to the side and began vomiting blood and feces.⁴⁰⁹

Hospital records describe VOLKOV as hypoxic,⁴¹⁰ ill-appearing, and having difficulty breathing.⁴¹¹ When moved into the hospital room, he vomited profusely, then stopped breathing. At 1:11 p.m., he was intubated, and MHJ staff started cardiopulmonary resuscitation (CPR). VOLKOV's initially distended abdomen decompressed after significantly large amounts of vomit was expelled. MHJ staff suspected VOLKOV had a bowel obstruction leading to respiratory arrest. MHJ staff ceased CPR efforts at 1:59 p.m. and pronounced VOLKOV deceased.⁴¹² At approximately 2:00 p.m., Deputy (b)(6); (b)(7)(C) contacted (b)(6); (b)(7)(C) and informed him that VOLKOV had passed away.⁴¹³

(b)(6); (b)(7)(C) documented that the Jacksonville Sheriff's Office had jurisdiction over the death and they coordinated notifying the coroner.⁴¹⁴ At 4:00 p.m., Deputies (b)(6); (b)(7)(C)⁴¹⁵ and (b)(6); (b)(7)(C) escorted VOLKOV's body to the hospital morgue until the Medical Examiner's Office took custody of VOLKOV's body at 5:46 p.m.

Post-Death Actions

On December 1, 2018, ERO Supervisory Detention and Deportation Officer N (b)(6); (b)(7)(C) documented there was no next of kin to notify.⁴¹⁶

On January 14, 2019, the State of Florida issued VOLKOV's Certification of Death.⁴¹⁷

On January 24, 2019, the Medical Examiner noted the diagnoses of: 1) Abrasions of the lower legs and dorsal right foot; and 2) Clinical history of small bowel obstruction and gastrointestinal hemorrhage.⁴¹⁸ The cause of death was natural, as a result of a small bowel obstruction, with gastrointestinal hemorrhage.

⁴⁰⁸ ERAU interview with Deputy (b)(6); (b)(7)(C) dated February 6, 2019.

⁴⁰⁹ ERAU interview with Deputy (b)(6); (b)(7)(C) dated February 5, 2019.

⁴¹⁰ Hypoxia is the absence of enough oxygen in the tissues to sustain body functions.

⁴¹¹ See Memorial Hospital of Jacksonville Patient Summary, dated November 30, 2018.

⁴¹² *Id.*; see also Memorial Hospital Death Report, dated November 30, 2018.

⁴¹³ See BCDC Incident Report, dated November 30, 2018.

⁴¹⁴ *Id.*

⁴¹⁵ During his interview with ERAU on February 5, 2019, Deputy (b)(6); (b)(7)(C) stated he was never apprised of any services available for staff that encountered a death.

⁴¹⁶ See EARM Case Comments, entry dated December 1, 2018.

⁴¹⁷ See Exhibit 3: State of Florida, Certification of Death, dated January 14, 2019.

⁴¹⁸ See Exhibit 2: Medical Examiner Report of Guerman VOLKOV, 18-2561, dated January 24, 2019.

FINDINGS

ERAU reviewed the medical care BCDC provided VOLKOV, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found 12 deficiencies in BCDC's compliance with the ICE NDS 2000. In this report, ERAU has also included other areas of concern that are not covered by ICE NDS 2000. These deficiencies and areas of concern are noted for informational purposes only and should not be construed as contributory to the detainee's death.

1. *Medical Care*, Section (III)(D), which states, "All new arrivals shall receive TB screening by PPD (mantoux method) or chest x-ray. The PPD shall be the primary screening method unless this diagnostic test is contraindicated; then a chest x-ray is obtained."

- Upon intake, medical staff did not administer a PPD skin test to screen VOLKOV for TB.

This also violates ACHS Policy J-B-01.1, *Management of Tuberculosis*.

2. *Medical Care*, Section (III)(I), which states, "Distribution of medication will be according to the specific instructions and procedures established by the health care provider."

- Medical staff inconsistently documented the administration of medications on VOLKOV's MAR.

3. *Medical Care*, Section (III)(L), which states, "As a rule, medical treatment will not be administered against the detainee's will. The facility health care provider will obtain signed and dated consent forms from all detainees before any medical examination or treatment, except in emergency circumstances. If a detainee refuses treatment, the INS will be consulted in determining whether forced treatment will be administered, unless the situation is an emergency. In emergency situations, the INS shall be notified as soon as possible."

- Medical staff did not obtain a signed consent form for the administration of psychotropic medications Thorazine and Ativan.

This also violates ACHS Policy J-D-02.5, *Psychotropic Medications*.

- Medical staff inconsistently documented VOLKOV's refusal of treatment. Even when refusal forms were present in VOLKOV's medical record, they were often missing relevant information such as the reason for refusal, date, and staff signatures. In addition, nurses often failed to document refusals in the progress notes.

This also violates ACHS Policy J-I-05, *Informed Consent and Right to Refuse*.

4. *Funds and Personal Property*, Section (I), which states, "All facilities will provide for the control and safeguarding of detainees' personal property. This will include the secure storage of funds, valuables, baggage and other personnel property; a procedure for documentation and

receipting of surrendered property; and the initial and regularly scheduled inventories of all funds, valuables and other property.”

- The property inventory conducted upon VOLKOV’s arrival to BCDC was inaccurate and incomplete. Upon reviewing VOLKOV’s property, ERAU found seven items, consisting of typical personal items (e.g., clothing, shoes, and miscellaneous papers) that were not listed on VOLKOV’s initial property inventory form. Additionally, the pair of underwear listed on VOLKOV’s property form was not in his property at the time of ERAU’s review.

This also violates BCDC policy CO 312, *Admission Procedures*.

5. *Detainee Classification System*, Section (III)(C), which states, “In all detention facilities, a supervisor will review the intake/processing officer’s classification files for accuracy and completeness.”

- The initial custody classification that Officer (b)(6); (b)(7)(C) conducted on June 26, 2017, was not reviewed and approved by a supervisor.

6. *Detainee Classification System*, Section (III)(A)(3), which states, “The first-line supervisor will review and approve each detainee’s classification.”

- There were no supervisory reviews completed on any of the re-classification actions related to VOLKOV.

7. *Suicide Prevention and Intervention*, Section (III)(C), which states, “Observation of imminently suicidal detainees by medical or detention staff shall occur no less than every 15 minutes. The Clinical Director may recommend constant direct supervision.”

- BCDC corrections staff did not consistently conduct suicide watch rounds within the required 15-minute timeframe, based on review of surveillance footage and facility logs. For example, while VOLKOV was on suicide watch, in one instance, there was a 41-minute gap between rounds and in another, Deputy (b)(6); (b)(7)(C) solely logged two rounds she did not conduct.

This also violates BCDC Policy CO 363, *Suicide Prevention and Intervention*, and BCDC Policy CO 334, *Special Management Units*.

8. *Special Management Unit*, Section (III)(E)(1), which states, “A permanent log will be maintained in the SMU. The log will record all activities concerning the SMU detainees, e.g., meals served, recreation, visitors, etc.”

- BCDC logs that tracked VOLKOV’s activities, such as showers, recreation, meals, and other activities, were inconsistent and generally did not provide information related to officers offering those activities or whether VOLKOV accepted or refused them.

9. *Special Management Unit*, Section (III)(D)(6), which states, “Each segregated detainee shall have the opportunity to shower and shave at least three times a week, unless these procedures would present an undue security hazard. This security hazard will be documented and signed by the OIC, indicating his/her review and approval.”

- There is no documentation that VOLKOV was offered a shower three times a week when he was housed in medical or booking.

This also violates BCDC Policy CO 334, *Special Management Units*.

10. *Special Management Unit*, Section (III)(B), which states, “A written order shall be completed and approved by a supervisory officer before a detainee is placed in administrative segregation, except when exigent circumstances make this impracticable. In such cases, an order shall be prepared as soon as possible. A copy of the order shall be given to the detainee within 24 hours, unless delivery would jeopardize the safety, security, or orderly operation of the facility.”

- Although VOLKOV was placed on medical observation on November 16, 2017, an administrative segregation order was not completed until November 17, 2017, with no exigent circumstances noted.

11. *Special Management Unit*, Section (III)(C), which states, “The I-885 will be used for the review... A supervisory officer shall conduct the same type of review after the detainee has spent seven days in administrative segregation, and every week thereafter for the first month and at least every 30 days thereafter. The review shall include an interview with the detainee. A written record shall be made of the decision and the justification.”

- Although Deputy Looby documented in an incident report that she conducted administrative segregation reviews on August 2, 2018, September 4, 2018, October 1, 2018, and November 1, 2018, she failed to use the ICE Form I-885 during the review.

12. *Recreation*, Section (III)(B)(1), which states, “If outdoor recreation is available at the facility, each detainee shall have access for at least one hour daily, at a reasonable time of day, five days a week, weather permitting.”

- There is no documentation that VOLKOV had access to recreation for one hour daily, five days a week. In addition, one staff member reported to ERAU that recreation for those housed in booking is only be available after 11:00 p.m.

This also violates BCDC Policy CO 334, *Special Management Units*.

AREAS OF CONCERN

Although not reflective of any violation of the detention standards, ERAU noted the following areas of concern:

1. BCSO Policy CO 334, *Segregation Management Units*, Section B states, “Inmates/detainees housed on a medical, psychiatric, or suicide watch shall be considered on a Close Supervision watch physically observed and checks documented by detention deputies at intervals not to exceed 15 minutes.”
 - Multiple deputies repeatedly exceeded the 15-minute check requirement, and most significantly, on November 30, 2018, Deputy Bishop falsified conducting 17 of 24 rounds that video surveillance footage confirmed did not occur.
2. ACHS Policy J-D-02.5, *Psychotropic Medication*, Section 14 states, “Patients prescribed psychotropic medications for an extended period of time will be evaluated initially for baseline and at least biannually for potential development of tardive dyskinesia or side effects by means of an AIMS completed by the healthcare provider, which will be recorded in the medical record.”
 - Mental health staff did not conduct an AIMS assessment every six months or at other regular intervals following the initiation of Ativan and Thorazine. VOLKOV’s last documented AIMS assessment occurred in November 2017.
3. ACHS Policy J-E-15, *Post Use of Force/General*, Section B(8) states, “Patient will be re-evaluated by nursing with 24 hours of incident; evaluation will be documented in the medical record in SOAPE format. This will include visual assessment, vital signs, and neurological check.”
 - Medical staff did not use the SOAPE format and/or did not conduct a neurological check on a 24-hour follow-up evaluation following two separate use-of-force incidents that occurred on September 29, 2017 and November 25, 2017.
4. ACHS Policy J-G-01, *Chronic Disease Services*, Section Policy states, “(3) Chronic illnesses are listed on the master problem list.”
 - Medical staff did not document VOLKOV’s abdominal hernia, anemia, and other applicable mental health diagnoses on his Problem List.
5. ACHS Policy J-H-01, *Health Record Format and Contents*, Section 5 states, “Medical record entries shall be documented using components of a problem-oriented medical records such as the “Problem List”, and the SOAPE format are legibly written with a signature, date, and time.”
 - Generally, medical staff documentation was not written in the SOAPE format and was not legibly written with a signature, date, and time. VOLKOV’s psychiatric progress notes were especially difficult to read, making it hard to determine the outcome of various encounters.
6. (b)(6); (b)(7)(C) February 14, 2018, laboratory order request included CBC levels; however, the laboratory results were devoid of CBC levels and they were never completed. Furthermore, (b)(6); (b)(7)(C) did not address abnormal laboratory values from baseline studies, specifically

those related to low red blood cells. Consequently, VOLKOV's reduced red blood cell count was not identified until the day of his death.

7. VOLKOV was not assessed for language preference, level of English proficiency, and/or the need for interpretation services were not documented at the time of intake. Despite being trained on the resource, only once did a deputy utilize a language line or translation services when communicating with VOLKOV. Furthermore, there were multiple occasions that staff documented VOLKOV's dialect made it hard to converse with him. Although ERAU recognizes multiple staff members reported VOLKOV's disinterest in the use of interpretation services during encounters, documentation of these issues, along with its inclusion on the problem list, would have assisted all staff to recognize the need to attempt to use interpretation assistance.
8. On June 29, 2017, an abnormal EKG reading showing a possible septal infarct was never repeated, nor did the physician obtain subjective information for an accurate history of cardiac disease.
9. On October 29, 2017, a nurse administered Ativan intramuscularly, absent a documented justification. Furthermore, the psychiatrist's order for intramuscular administration of Ativan was confusing to nurses, as evidenced by a medical staff member contacting a Corporate Clinical Director for clarification.
10. On November 2, 2017, (b)(6); (b)(7)(C) ordered an increase in Tegretol in the absence of an evaluation of VOLKOV or an order for completion of a Tegretol level. Evaluations are imperative to ensure proper therapeutic dosing and avoidance of adverse reactions.
11. Medical staff did not promptly fill the psychiatrist's November 16, 2017 orders for Vistaril and increase in Thorazine. Medical staff did not start the Vistaril and increased dose of Thorazine until November 24, 2017, and November 20, 2017, respectively. Based on available information, ERAU cannot determine if the delays were attributable to process failures on the part of the psychiatrist, nurses, or both.
12. VOLKOV's only documented chronic care appointment was on September 12, 2017, and although medical staff noted that the other chronic care appointments were offered and refused, they either did not document refusals or dated them several days later. Furthermore, the physician renewed orders for three-month periods via verbal orders, in the absence of current assessment findings and did not document in the progress note or on chronic care assessment form that he conducted a review of the medical record.
13. A hernia belt approved by the physician on September 12, 2017 was never issued to VOLKOV.
14. Mental health rounds often were not conducted on weekends. Furthermore, a nursing round was not documented on the Confinement Log as having been completed on Thursday, March 22, 2018.

15. Medical staff did not perform a vision test following a July 20, 2017, request for eyeglasses, nor was any evidence found that eyeglasses were provided.
16. Pain assessments with location, intensity factors, and levels were never documented for complaints related to pain.
17. Nurses failed to document times of administration of as-needed medications on the MAR.
18. Vital signs were not regularly obtained in accordance with physician orders; for example, one blood pressure was taken when the orders called for two daily and limited vital sign readings were documented.
19. Policy standards between BCSO and ACHS are contradictory, particularly as they relate to suicide precautions. ACHS policy J-G-05, *Suicide Prevention Program* states, "Once a patient has been identified as 'at risk' for suicide, he/she shall not be housed alone unless continuous observation is maintained," while BCDC Policy CO 363, *Suicide Prevention and Intervention* states, "Observation of imminently suicidal inmates/detainees by correctional deputies shall occur no less than every 15 minutes."
20. Deputy (b)(6);
(b)(7)(C) administrative segregation reviews were incomplete, either lacking necessary signatures or recommendations, or documents utilized in prior reviews were not consistent. Although it is not a requirement of the ICE NDS 2000, as BCDC is an IGSA facility, or BCSO policy to complete a re-classification during an administrative segregation review, procedural consistency is imperative.
21. BCDC does not utilize a logbook for hospital vigils. Consideration should be given to assigning a logbook so that status updates and unusual incidents can be documented onsite.
22. BCDC management did not conduct a staff debriefing or follow-up after VOLKOV's death. ERAU further notes that BCSO Policy EMG 011, *Death and Serious Injury*, does not require a staff debriefing and follow-up as part of the after-incident response.
23. Employee assistance was not offered to one of the security staff members who witnessed VOLKOV's death. While onsite, ERAU was told that the Sheriff's Department chaplain may be used if needed.

APPENDIX A

Summaries of LMHC Scott's Mental Health Rounds	
Date & Time	Assessment Findings and Follow-up
March 9, 2018 8:15 a.m. ⁴¹⁹	VOLKOV refused to speak to LMHC Scott, who described VOLKOV as disheveled, restless, guarded, anxious, incoherent, paranoid ⁴²⁰ , and delusional. VOLKOV avoided eye contact and had a flat, restricted affect; his thought process was disorganized, and he appeared to be actively

⁴¹⁹ See ACHS Mental Health Rounds/Contact form, dated March 9, 2018.

⁴²⁰ Paranoia is an unrealistic distrust of others or a feeling of being persecuted.

	hallucinating. VOLKOV denied suicidal or homicidal ideation. LMHC (b)(6); (b)(7)(C) noted VOLKOV had a history of schizophrenia ⁴²¹ , paranoid type, and was placed in confinement due to escalating symptoms of agitation and delusions of paranoia. ⁴²²
March 12, 2018 12:00 p.m. ⁴²³	LMHC (b)(6); (b)(7)(C) conducted an encounter with VOLKOV, documenting the reason as “Suicide Watch.” However, there was no Mental Health Protocols Order Form filed or other documented orders for suicide watch. VOLKOV refused the interview, presenting in a disheveled and incoherent manner. LMHC (b)(6); (b)(7)(C) noted the detainee, “Speaks Russian and little English.” VOLKOV avoided eye contact and was described as angry, evasive, paranoid, withdrawn, and restricted in affect ⁴²⁴ . His speech was pressured ⁴²⁵ and tangential ⁴²⁶ . LMHC (b)(6); (b)(7)(C) documented plan was to continue “suicide watch.”
March 13, 2018 8:10 a.m. ⁴²⁷	VOLKOV “mumbled something.” He avoided eye contact and was described as withdrawn, agitated, evasive, anxious, angry, hostile, irritable, and delusional ⁴²⁸ . He had a flat affect and appeared to behave in a paranoid manner. He was speaking in Russian and was “impossible to completely understand”. The plan was to continue suicide watch, which, as noted above, was misstated.
March 14, 2018 3:00 p.m. ⁴²⁹	VOLKOV responded to LMHC (b)(6); (b)(7)(C) after prompting. He appeared disheveled and avoided eye contact. He was withdrawn, guarded, dysphoric ⁴³⁰ , paranoid, delusional, and restricted in affect. VOLKOV was incoherent and uncooperative with the assessment. The officers reported no problems with his behavior.
March 16, 2018 9:00 a.m. ⁴³¹	VOLKOV stated he wanted to get out. He was groomed, fully oriented, and offered appropriate eye contact. His behavior was described as agitated, angry, hostile, demanding and arrogant. He denied suicidal or homicidal ideation, yet he “threatened suicide when he did not get his way.” The assessment noted, “Detoxing off meth”, and the plan was to continue “suicide watch.” During his interview, (b)(6); (b)(7)(C) stated the detainee was not detoxing, as he had been detained too long for that to occur.
March 19, 2018 10:05 a.m. ⁴³²	VOLKOV stated he was okay and asked what time it was. He remained withdrawn, guarded, dysphoric, paranoid, and flat in affect. His speech was

⁴²¹ Schizophrenia is a mental health disorder which affects a person’s ability to think, feel, and behave clearly.

⁴²² As there is no prior reference to a history of schizophrenia, it is unknown where LMHC (b)(6); (b)(7)(C) obtained that diagnosis.

⁴²³ See ACHS Mental Health Rounds/Contact form, dated March 12, 2018.

⁴²⁴ Restricted, or flat, affect means a lowered range in emotion or display of feelings.

⁴²⁵ Pressured speech is a tendency to speak rapidly and frenziedly, as if motivated by an urgency unknown to the listener.

⁴²⁶ Tangential speech is a communication disorder in which the train of thought wanders and shows a lack of focus.

⁴²⁷ See ACHS Mental Health Rounds/Contact form, dated March 13, 2018.

⁴²⁸ Delusions are beliefs or altered reality which is persistently held despite evidence or agreement to the contrary, generally in reference to a mental disorder.

⁴²⁹ See ACHS Mental Health Rounds/Contact form, dated March 14, 2018.

⁴³⁰ Dysphoria is a state of feeling uneasy, unhappy, or unwell.

⁴³¹ See ACHS Mental Health Rounds/Contact form, dated March 16, 2018.

⁴³² See ACHS Mental Health Rounds/Contact form, dated March 19, 2018.

	pressured, tangential and difficult to understand. The plan was to continue with “suicide watch”.
March 20, 2018 10:00 a.m. ⁴³³	VOLKOV refused the interview, stating only that he was okay. He was withdrawn, guarded, flat in affect, and incoherent in speech due to his strong accent and mumbling. “Suicide watch” was to be continued.
March 21, 2018 12:20 p.m. ⁴³⁴	VOLKOV refused the interview. He was incoherent but appeared to be stable. He avoided eye contact and was withdrawn, dysphoric, guarded, and appeared paranoid. The assessment was otherwise refused. “Suicide watch” was to be continued.
March 22, 2018 9:20 a.m. ⁴³⁵	VOLKOV refused the interview. He was incoherent and withdrawn, refusing to be examined. The plan was to continue “confinement.”
March 23, 2018 9:15 a.m. ⁴³⁶	VOLKOV stated he was fine but otherwise refused the interview. His current status notes it was not possible to discuss his mental status due to his mumbling and heavy accent, and, also, his paranoia and guardedness in responding during the interview. The plan was to continue confinement.
March 26, 2018 12:00 p.m. ⁴³⁷	VOLKOV stated he was “doing good”. He was evasive, with a flat affect, dysphoric mood, and paranoid in thought content. His thought process appeared to have loose associations, and he presented a “strong possibility” of actively hallucinating. The assessment noted he was difficult to communicate with due to his heavy Russian accent and what appears to be paranoid delusions. The plan was to continue confinement in booking.
March 27, 2018 10:00 a.m. ⁴³⁸	VOLKOV’s thinking seemed to be clearer, having questioned what the time was. He remained difficult to understand. The plan was to continue confinement.
March 28, 2018 12:30 p.m. ⁴³⁹	VOLKOV stated he was okay, but he otherwise refused the interview. He was disheveled and disoriented to person place and situation. He avoided eye contact, was guarded, dysphoric, and had a flat affect. He had been sleeping and when awakened refused the interview. “Suicide watch” was continued.
March 29, 2018 10:15 a.m. ⁴⁴⁰	VOLKOV stated he was okay but he otherwise refused the interview. He avoided eye contact and demonstrated withdrawn behavior, flat affect, dysphoric mood, incoherent speech, and guarded attitude. The current behavior was described as, “rarely changes. Lays in bed sleeping or resting. Heavy accent, withdrawn, guarded.” The plan was to continue confinement.
March 30, 2018 8:50 a.m. ⁴⁴¹	VOLKOV’s “heavy accent – marbles”, made it “very difficult to evaluate comprehensively.” He stated he was okay, and the mental health status was otherwise within normal limits. The plan was to continue with “mental health watch.”

⁴³³ See ACHS Mental Health Rounds/Contact form, dated March 20, 2018.

⁴³⁴ See ACHS Mental Health Rounds/Contact form, dated March 21, 2018.

⁴³⁵ See ACHS Mental Health Rounds/Contact form, dated March 22, 2018.

⁴³⁶ See ACHS Mental Health Rounds/Contact form, dated March 23, 2018.

⁴³⁷ See ACHS Mental Health Rounds/Contact form, dated March 26, 2018.

⁴³⁸ See ACHS Mental Health Rounds/Contact form, dated March 27, 2018.

⁴³⁹ See ACHS Mental Health Rounds/Contact form, dated March 28, 2018.

⁴⁴⁰ See ACHS Mental Health Rounds/Contact form, dated March 29, 2018.

⁴⁴¹ See ACHS Mental Health Rounds/Contact form, dated March 30, 2018.

EXHIBITS

1. Creative Corrections Healthcare and Security Compliance Analysis
2. Medical Examiner Report of Guerman VOLKOV, 18-2561, dated January 24, 2019
3. State of Florida Bureau of Vital Statistics, Certification of Death, dated January 14, 2019



U.S. Immigration
and Customs
Enforcement

MEMORANDUM FOR: Enrique M. Lucero
Executive Associate Director
Office of Enforcement and Removal Operations

THROUGH: (b)(6); (b)(7)(C)
(b)(6); (b)(7)(C)
Associate Director

FROM: (b)(6); (b)(7)(C)
Acting Assistant Director
Inspections and Detention Oversight Division

SUBJECT: Detainee Death Review Findings – Guerman VOLKOV
JICMS (b)(7)(E)

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) External Reviews and Analysis Unit (ERAU) has completed its review of the death of Guerman VOLKOV, a 56-year-old citizen of Russia, who died on November 30, 2018, while in ICE custody at the Memorial Hospital of Jacksonville (MHJ) in Jacksonville, Florida (FL). Prior to his transfer to the hospital, VOLKOV was detained at the Baker County Detention Center (BCDC) in Macclenny, FL. The Medical Examiner's Office documented VOLKOV's cause of death as a small bowel obstruction¹ with gastrointestinal hemorrhage² and the manner as natural.³

Abbreviated Chronology⁴

On November 4, 1998, the Immigration and Naturalization Service admitted VOLKOV into the United States at Miami, FL, as a B-2 non-immigrant visitor for pleasure with authorization to remain in the United States for a temporary period not to exceed May 3, 1999. VOLKOV overstayed his visa, and between 1999 and 2016, he was arrested on three occasions for disorderly conduct, driving under the influence, and battery. He was convicted in each case. On May 21, 2017, the New Port Richey Police Department arrested VOLKOV for failure to appear. On June 23, 2017, while detained at the Pasco County Jail in Land O'Lakes, FL, the Office of Enforcement and Removal Operations' (ERO) Tampa field office lodged an Immigration Detainer (DHS Form

¹ A small bowel obstruction is a blockage in the small intestine, usually caused by scar tissue, hernia, or cancer.

² Gastrointestinal hemorrhage refers to bleeding in the stomach and/or intestines.

³ See Medical Examiner Report of Guerman VOLKOV, 18-2561, dated January 24, 2019.

⁴ Due to the length of his stay in ICE custody (523 days), the information in this summary has been substantially consolidated and highlights key events that took place over the course of his time in custody. For a more complete chronology, see the attached Detainee Death Report.

I-247A) on VOLKOV. On June 26, 2017, pursuant to the detainer, VOLKOV was released into ERO Tampa's custody. ERO Tampa issued VOLKOV a Notice to Appear (DHS Form I-862), charging him as a non-immigrant overstay pursuant to Section 237(a)(1)(B) of the Immigration and Nationality Act and detained him at the Tampa Hold Room. Later that day, ERO Miami transferred him to BCDC, where he was housed for over 17 months.

In January 2018, ERO Miami submitted an electronic Travel Document Request to the Embassy of Russia for VOLKOV. In April 2018, the Embassy of Russia declined to issue a travel document, stating that they believed that VOLKOV might have been deceitful about his real name and date of birth. ERO Miami took a sworn statement from VOLKOV that he had provided his correct name and date of birth. In September 2018, ERO Headquarters notified ERO Miami that the Embassy of Russia had again denied issuance of a travel document for VOLKOV.

At BCDC, although VOLKOV was initially housed in general population, he requested placement in administrative segregation for protective purposes on numerous occasions for several reasons. In fact, he remained on some form of administrative segregation status, whether protective custody, suicide watch, or medical observation, for most of his time in detention. For the duration of his time in administrative segregation, the security personnel responsible for documenting VOLKOV's stay repeatedly failed to complete reviews, conduct reviews on a timely basis, or provide sufficient documentation in accordance with the requirements of either the National Detention Standard or BCDC's policies and procedures. Furthermore, security staff provided either inconsistent or incomplete logs for purposes of tracking VOLKOV's activities while in segregation, (e.g. showers, recreation, and meals) or identifying important details (e.g. officer identities or whether VOLKOV accepted or refused activities). In fact, for the time VOLKOV was housed in either medical or booking⁵ units, there was no documentation evidencing that recreation or showers were offered as required.

Additionally, throughout his detention at BCDC, VOLKOV had an extraordinary number of encounters with medical personnel, given both his placement in administrative segregation and his health conditions. Because of his history of hypertension and seizures, during VOLKOV's medical intake screening, he was placed on the chronic care list and scheduled to receive chronic care assessments every three months. However, the provider only completed the initial and 90-day follow-up chronic care assessments because VOLKOV refused to participate in subsequent assessments. Medical staff's efforts to gain VOLKOV's cooperation for these assessments were unsuccessful, and many of VOLKOV's medical assessment refusals were either not documented on a refusal form, completed days later, or lacked necessary signatures.

Medical staff did not document some medical and/or mental health conditions on his Problem List that they subsequently became aware of after processing VOLKOV, including an abdominal hernia, anemia, and other applicable mental health diagnoses. Providers also failed to follow through with their own orders or conduct necessary and routine assessments related to VOLKOV's chronic issues and prescribed medications. Among the issues identified in the attached report, on June 29, 2017, an abnormal EKG reading showing a possible septal infarct was never repeated; nor did the physician obtain subjective information for an accurate history of cardiac disease. On February 14, 2018, a provider ordered multiple laboratory studies; however, the results were

⁵ Booking cells are routinely used by BCDC as overflow for administrative segregation needs.

devoid of findings for a specific test. A provider never re-ordered that test or addressed the abnormal laboratory values from the tests that were performed. On September 12, 2017, a provider approved VOLKOV for a hernia belt; however, it was never issued to him. On multiple occasions, a provider ordered medication renewals without conducting an evaluation of VOLKOV to ensure proper therapeutic dosing. Likewise, providers did not routinely conduct Abnormal Involuntary Movement Scale assessments, and both are necessary to assess for adverse reactions to medications.

While detained at BCDC, VOLKOV had multiple visits with mental health staff. In October 2017, he was diagnosed with acute stress disorder by a psychiatrist and was prescribed two psychotropic medications, for which medical staff never obtained his informed consent. VOLKOV was evaluated by three different Licensed Mental Health Counselors (LMHC) during his stay, and although their encounters were generally conducted consistently, mental health rounds were often not completed on the weekends when he was on either suicide watch or mental health observation. Furthermore, one of the LMHCs provided VOLKOV care for only a two-month period and documented numerous encounters that were inconsistent with VOLKOV's other related records. Specifically, during one encounter, the LMHC diagnosed VOLKOV with schizophrenia, although there is no documentation supporting a prior history of this disease.

Regarding medication administration, VOLKOV was prescribed numerous medications during his detention and was largely compliant with his regimen. However, nurses failed to document administration times of as-needed medications and did not always follow the provider's orders to completion. In one instance, a nurse administered Ativan, an anti-anxiety medication, via intramuscular injection in the absence of emergency need or court order. In another, the provider ordered vital signs checks every shift; however, nursing staff inconsistently completed these checks over numerous days, the documentation available is largely indecipherable, and where blood pressure readings were available, they were either abnormally high or low, but the actions taken were scarcely documented.

There were two incidents in which BCDC security staff used force to make VOLKOV comply. In the first, he was placed in a restraint chair due to continually banging loudly on his cell door and refusing to stop. In the second, he had to be physically removed from his cell due to his refusal to relocate. Although medical staff conducted an evaluation of VOLKOV immediately following each incident, they neglected to complete a neurological examination or a follow-up evaluation within 24 hours.

VOLKOV was sent to the hospital on two occasions, the first on November 26, 2018, and the second on November 30, 2018, both times due to a (suspected and then confirmed) small bowel obstruction. During the first hospital visit, VOLKOV was uncooperative with hospital staff and, despite staff informing him via translation service that his continued refusal could result in his death, he discharged himself from the hospital against medical advice and returned to BCDC on November 28, 2018. Upon his return, given his comments while in the hospital, VOLKOV was placed on suicide watch until November 29, 2018. On the afternoon of November 29, 2018, he was removed from suicide watch but remained in medical housing for treatment until he was transferred to the hospital the following day. Despite his housing status, the rounds conducted by security personnel during this time did not fully comply with the 15-minute check requirement.

On the morning of November 30, 2018, a provider evaluated VOLKOV, documented a decompensated state, advised VOLKOV he needed to go to the hospital and upon his agreement, ordered his transfer to MHJ. EMS departed the facility at 12:15 p.m. and arrived with VOLKOV at MHJ at 12:49 p.m. While at MHJ, VOLKOV vomited blood and feces, and eventually stopped breathing. At 1:11 p.m., MHJ staff emergency intubated him and initiated cardiopulmonary resuscitation (CPR). MHJ staff ceased CPR at 1:59 p.m. and pronounced VOLKOV deceased.

Identified Deficiencies with ICE Detention Standards

ERAU reviewed the medical care BCDC provided VOLKOV, as well as their efforts to ensure he was safe and secure during his time in ICE custody. In the attached report, ERAU assessed BCDC's compliance with the ICE National Detention Standards (NDS) 2000 and documented 12 findings.

1. **Medical Care, Section (III)(D):** Upon intake, medical staff did not administer a PPD skin test to screen VOLKOV for TB.
2. **Medical Care, Section (III)(I):** Medical staff inconsistently documented the administration of medications on VOLKOV's MAR.
3. **Medical Care, Section (III)(L):** Medical staff did not obtain a signed consent form for the administration of psychotropic medications Thorazine and Ativan and inconsistently documented VOLKOV's refusal of treatment. Furthermore, the refusal forms that were in the medical record, often missed relevant information, e.g. the reason for refusal.
4. **Funds and Personal Property, Section (I):** The property inventory conducted upon VOLKOV's arrival to BCDC was inaccurate and incomplete, and the items present in VOLKOV's property post death was inconsistent with initial property inventory form.
5. **Detainee Classification System, Section (III)(C):** The initial custody classification conducted on June 26, 2017, lacked a supervisory review and approval.
6. **Detainee Classification System, Section (III)(A)(3):** All of VOLKOV's re-classification actions lacked a supervisory review.
7. **Suicide Prevention and Intervention, Section (III)(C):** Surveillance footage and facility logs evidence that BCDC corrections staff did not consistently conduct suicide watch rounds within the required 15-minute timeframe. In one instance, there was a 42-minute gap between rounds, and the officer falsely logged conducting two rounds.
8. **Special Management Unit, Section (III)(E)(1):** BCDC logs used to track VOLKOV's activities (e.g. showers, recreation, meals) were inconsistent and generally did not record officer identities or whether VOLKOV accepted or refused activities.
9. **Special Management Unit, Section (III)(D)(6):** There is no documentation that VOLKOV was offered a shower three times a week when he was housed in medical or booking.

10. **Special Management Unit, Section (III)(B):** Although VOLKOV was placed on medical observation on November 16, 2017, an administrative segregation order was not completed until November 17, 2017, and no exigent circumstances for the delay were noted.
11. **Special Management Unit, Section (III)(C):** A deputy failed to utilize the ICE Form I-885 to document administrative segregation reviews conducted on August 2, 2018, September 4, 2018, October 1, 2018, and November 1, 2018.
12. **Recreation, Section (III)(B)(1):** There is no documentation that VOLKOV had access to recreation one hour daily, five days a week.

ERAU also noted 23 areas of concern regarding VOLKOV's medical care, safety, and security at BCDC, although not violations of the ICE NDS 2000.

If you have any questions, please contact me or have a member of your staff contact OPR ERAU Unit Chief (b)(6); (b)(7)(C) at (202) 7 (b)(6); (b)(7)(C)

Enclosure

Guerman VOLKOV Detainee Death Review Report

cc:

Derek N. Benner

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

CONFINEMENT RECORD (CR)

Facility Name		EDC			
Inmate Name		Tran, Hwy		Inmate Number	037949945
Date of Placement	06-05-18	Time	13:35	Original Housing	D-103
Placement Ordered By	(b)(6); (b)(7)(C)			Tentative Release Date	

I. **TYPE OF CONFINEMENT:** ☐ Restrictive Housing (Skip Section II below) ☐ Segregation (Complete Section II below)

II. **SEGREGATION STATUS - INITIAL (Check One):**

- ☐ Disciplinary Segregation ☐ Administrative Segregation – PROTECTIVE CUSTODY
☒ Administrative Segregation ☐ Administrative Segregation – Involuntary PREA Placement

ANY TIME AN INMATE/RESIDENT'S STATUS CHANGES, ANOTHER 10-1A MUST BE COMPLETED

III. **REASON FOR PLACEMENT (Check One):**

- ☐ Disciplinary Infraction
☐ Separation from general population for the purpose of protection from other inmates/residents for reason of personal safety
☐ Poses a serious threat to life, property, self, staff, or other inmates/residents
☐ Poses a threat to the security of the orderly operation of the facility
☐ Administrative order from the Chief of Security or higher authority or contracting agency
☐ Involuntary PREA Placement – No alternative means of separation can be arranged (note reason why below)

Reason why no alternative means of separation can be arranged: _____

IV. **SPECIAL CONDITIONS/PRECAUTIONS:**

****If "YES", you must explain. Attach additional sheets, if necessary.**

Recreation/Exercise Requirements: ☐ NO ☐ YES: _____

Restrictions on Personal Property (imposed by the placing authority for cause): ☐ NO ☐ YES: _____

Known Assault Risk: ☐ NO ☐ YES: _____

Modified Restraint Procedures: ☐ NO ☐ YES: _____

Medical/Mental Health Conditions: ☐ NO ☒ YES: _____

Special Diet (medical or religious): ☒ NO ☐ YES: _____

Medication Requirements (current prescriptions): ☐ NO ☒ YES: _____

Additional Search Requirements: ☐ NO ☐ YES: _____

Other: ☐ NO ☐ YES: _____

V. Is the inmate/resident's behavior abnormal, aggressive, violent, or unusual? ☐ NO ☐ YES *If "YES", Explain: _____

VI. **ADMINISTRATIVE REVIEW:** This section must be completed for initial placement, not required for a change in status.

The review must be conducted by _____

Chief of Security/Unit Management or higher authority.

Printed Name	
Signature	

Title	Cohen		
Date	6.7.18	Time	0904

VII. **RELEASE:**

A. **Special Release Orders:**

B. **Ordered By:**

Printed Name		Title			
Signature		Date		Time	

All inmates/residents in segregation, regardless of status, and restrictive housing will be personally observed by an officer assigned to the unit twice per hour, but no more than forty (40) minutes apart, on an irregular schedule. AT ELOY DETENTION CENTER, IN ACCORDANCE WITH ICE PBND 2.12 SPECIAL MANAGEMENT UNITS (SMU), DETAINEES IN SMU SHALL BE PERSONALLY OBSERVED AND LOGGED AT LEAST EVERY THIRTY (30) MINUTES ON AN IRREGULAR SCHEDULE. Any unusual or bizarre behavior will be reported to the supervisor in charge. If unusual or bizarre behavior warrants, additional checks may be necessary, and additional sheets may be attached. The daily medical visit also will be documented on this form.

[illegible]

Morning: _____ Noon: _____ Evening: _____

AMERICAN
OVERSIGHT

STATE OF ARIZONA

CERTIFICATION OF VITAL RECORD

ORIGINAL
STATE COPY

STATE OF ARIZONA DEPARTMENT OF HEALTH SERVICES-BUREAU OF VITAL RECORDS CERTIFICATE OF DEATH

State File Number
102-2018-028120

1. DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST, SUFFIX) HUY, CHI, TRAN		2. AKA'S (IF ANY)		3. DATE OF DEATH 06/12/2018	
4. SEX MALE	5. SOCIAL SECURITY NUMBER 600-12-2610	6. DATE OF BIRTH 08/07/1970	7. AGE 47 YEARS		
8. CITY/TOWN, COUNTY AND ZIP OR LOCATION OF DEATH CASA GRANDE, PINAL, 85122					
9. PLACE OF DEATH (TYPE OF PLACE OF DEATH AND FACILITY NAME/ADDRESS) INPATIENT - BANNER CASA GRANDE MEDICAL CENTER					
10. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY) VIETNAM		11. MARITAL STATUS NEVER MARRIED		12. NAME OF SURVIVING SPOUSE PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST, SUFFIX) NOT LISTED	
13. DECEDENT'S USUAL RESIDENCE ADDRESS (STREET, CITY, COUNTY, STATE, ZIP) 3725 E DECATUR STREET, MESA, MARICOPA, AZ, 85205					
14. DECEDENT'S HISPANIC ORIGIN(S) NO, NOT SPANISH/HISPANIC/LATINO		15. DECEDENT'S RACE(S) CHINESE		16. EVER IN ARMED FORCES NO	
				17. OCCUPATION UNEMPLOYED	
18. FATHER'S NAME (FIRST, MIDDLE, LAST, SUFFIX) (b)(6), (b)(7)(C)			19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST, SUFFIX) (b)(6), (b)(7)(C)		
				21. RELATIONSHIP SISTER	
23. NAME AND ADDRESS OF FUNERAL FACILITY OR RESPONSIBLE PERSON MELDRUM MORTUARY 52 N MACDONALD, MESA, AZ, 85201					
26. METHOD(S) OF DISPOSITION BURIAL		27. NAME AND LOCATION OF 1ST DISPOSITION FACILITY CITY OF MESA CEMETERY, MESA, AZ, US		25. LICENSE NUMBER F1527	
28. NAME AND LOCATION OF 2ND DISPOSITION FACILITY					
MEDICAL CERTIFICATION SECTION CAUSE OF DEATH PART I					
29. A. IMMEDIATE CAUSE OF DEATH PENDING				30. APPROXIMATE INTERVAL UNKNOWN	
31. B. DUE TO OR AS A CONSEQUENCE OF				32. APPROXIMATE INTERVAL	
33. C. DUE TO OR AS A CONSEQUENCE OF				34. APPROXIMATE INTERVAL	
35. D. DUE TO OR AS A CONSEQUENCE OF				36. APPROXIMATE INTERVAL	
CAUSE OF DEATH PART II					
37. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I		38. INJURY? UNKNOWN	39. INJURY AT WORK? NO	40. MANNER OF DEATH PENDING INVESTIGATION	
		41. TIME OF DEATH 09:20	42. WAS AN AUTOPSY PERFORMED? YES	43. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? YES	
CAUSE AND MANNER CERTIFICATION					
ON THE BASIS OF EXAMINATION OR INVESTIGATION, AS APPLICABLE, THE DEATH OCCURRED AT THE TIME, DATE, AND PLACE, AND DUE TO THE CAUSE(S) AND MANNER STATED.		44. NAME OF PERSON COMPLETING CAUSE OF DEATH (b)(6), (b)(7)(C)		45. DATE CERTIFIED 06/14/2018	
46. CERTIFIER'S ADDRESS 570 W ADAMSVILLE ROAD, FLORENCE, AZ, 85132					

Date Registered: 06/18/2018

Date Issued: 07/06/2018

VS-49 Rev. 12/2017



This is a true certification of the facts on file with the Arizona Department of Health Services, Bureau of Vital Records, PHOENIX, ARIZONA.
Revised 07/2016

Krystal Colburn
KRYSTAL COLBURN
ASSISTANT STATE REGISTRAR



ARIZONA DEPARTMENT
OF HEALTH SERVICES

This copy not valid unless prepared on a form displaying the State Seal and impressed with the raised seal of the is

DHS-20-0638-C-000324

2020-10-11 00057 470

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE



U.S. Immigration
and Customs
Enforcement

JUL - 5 2019

MEMORANDUM FOR: Nathalie Asher
Executive Associate Director
Office of Enforcement and Removal Operations
(b)(6); (b)(7)(C)

THROUGH: (b)(6); (b)(7)(C)
Associate Director
Office of Professional Responsibility
(b)(6); (b)(7)(C)

FROM: (b)(6); (b)(7)(C)
Acting Assistant Director

SUBJECT: Findings for the Death of ICE Detainee
Huy Chi TRAN (A#037949945) (b)(7)(E)

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), has completed its review of the death of ICE detainee Huy Chi TRAN. TRAN died on June 12, 2018, while in ICE custody at the Banner Casa Grande Medical Center (BCGMC), in Casa Grande, Arizona (AZ). The Pinal County Medical Examiner documented TRAN's cause of death as sudden cardiac death¹ due to coronary artery disease.²

On June 25, 1984, the former U.S. Immigration and Naturalization Services (INS) admitted TRAN into the United States in San Francisco, California as an immigrant (i.e. child of an immigrant who is the brother or sister of a U.S. citizen). From June 1994 to July 2017, TRAN was arrested and/or convicted of various criminal offenses.³ An immigration judge ordered TRAN removed to Vietnam three times before the ICE Office of Enforcement and Removal Operations (ERO) Phoenix determined there was no significant likelihood of removal in the reasonably foreseeable future; therefore, ERO released him on an order of supervision on January 10, 2005. On July 17, 2017 a 287(g) officer lodged a detainer against TRAN while he was in Arizona Department of Corrections (ADOC) custody. On May 25, 2018, ADOC released TRAN into ERO Phoenix custody. On the same date, ERO Phoenix booked TRAN into the Tucson INS Hold Room in Tucson, AZ and then later that day, the Florence Staging Facility (FSF) in Florence, AZ. On May 28, 2018, ERO Phoenix transferred TRAN from FSF to the Eloy

¹ Sudden cardiac death is a sudden, unexpected death caused by loss of heart function.

² Coronary artery disease occurs when plaque grows within the walls of the coronary arteries until the blood flow to the heart's muscle is limited.

³ ERAU was unable to determine the disposition for approximately 17 of TRAN's arrests and/or offenses.

Detention Center (EDC) in Eloy, AZ, to pursue his removal to Vietnam.

On May 25, 2018, upon admission to FSF, a Licensed Vocational Nurse (LVN) conducted a medical pre-screen and documented TRAN arrived with the medications haloperidol and fluoxetine, both of which are antipsychotic medications. Consequently, the LVN determined TRAN had a sensitive medical condition needing immediate medical care in accordance with IHSC policy.⁴ On May 26, 2018, a Registered Nurse (RN) performed TRAN's medical and mental health intake screening, during which TRAN acknowledged receiving treatment for depression for the past 20 years. He also denied current suicidal ideations, homicidal thoughts, and hallucinations. Based on the findings, the medical provider, via telephone order, continued TRAN on the same medication regimen. The RN conducted an Abnormal Involuntary Movement Scale (AIMS)⁵ and noted a score of zero. On that same date, a Licensed Clinical Social Worker (LCSW) conducted TRAN's mental health follow-up and documented that TRAN denied current hallucinations but had hallucinated in the past. The LCSW documented TRAN's appearance as bizarre, poorly groomed, affect flat,⁶ and that he exhibited lethargic psychomotor activity.⁷ The LCSW diagnosed TRAN with schizophrenia,⁸ unspecified, and noted TRAN would continue his medications as prescribed.

On May 28, 2018, FSF transferred TRAN to EDC. Upon arrival to EDC, an ERO Deportation Officer (DO) assigned to EDC Intake that day, noted that TRAN arrived soaking wet and sweating profusely. The DO alerted a Supervisory Detention and Deportation Officer (SDDO) who confirmed that the air conditioning was working properly. The SDDO accompanied TRAN to the front of the medical pre-screen line, and the RN immediately conducted TRAN's medical pre-screen. The RN did not note profuse sweating as described by ERO staff in either pre-screen or intake screening. The RN recorded TRAN's intake assessment as abnormal due to his mental health issues and referred him to a mental health provider. Later that day, the same RN conducted TRAN's abbreviated intake medical screening. A Case Manager (CM) completed TRAN's initial custody classification and appropriately classified him as high; however, the CM signed for both the classification officer and supervisor and did not seek supervisory approval.

On this same date, a Nurse Practitioner (NP) performed TRAN's physical examination⁹ and documented on TRAN's reported mental health history and his lack of lower teeth and other upper teeth with no dental prosthesis. The NP conducted an AIMS assessment

⁴ See IHSC Policy 03-08, Section 4-3(a), dated January 19, 2015.

⁵ The AIMS assess the occurrence of tardive dyskinesia (TD), a side effect of taking antipsychotic medication. Initial AIMS results may serve as a baseline for future monitoring or may prompt ordering of medication to address symptoms of the disorder. A score of zero indicates no occurrence of TD observed. Therefore, due to TRAN being on antipsychotic drugs, the RN conducted the AIMS assessment.

⁶ Flat affect is a lack of emotional expressiveness.

⁷ Psychomotor activity are skills where movement and thinking are combined. This includes balance and coordination.

⁸ Schizophrenia is a serious mental disorder in which a person interprets reality abnormally, to include hallucinations, delusions, and extremely disordered thinking and behavior.

⁹ This exam is the initial health assessment of patients with chronic conditions, conducted by a provider.

and noted a score of zero. The NP continued TRAN on the same medication regimen until a mental health provider could assess him.

On May 30, 2018, medical staff administered TRAN his first doses of haloperidol and fluoxetine, two days after he reported taking his last dose.

On June 4, 2018, a psychiatrist assessed TRAN, diagnosing him with schizophrenia and an anxiety disorder. The psychiatrist continued TRAN on the same medication but submitted an order to the pharmacy to change the administration times from morning to noon for fluoxetine and evening for haloperidol. The psychiatrist documented an AIMS score of three and that TRAN was exhibiting extrapyramidal symptoms (EPS),¹⁰ which he noted Cogentin¹¹ could address. However, the psychiatrist did not write the Cogentin order, which he later stated was an oversight. Furthermore, on this date, TRAN signed a consent form for the haloperidol and fluoxetine for the first time since arriving to EDC.

On June 5, 2018, TRAN received morning doses of fluoxetine and haloperidol. Although the psychiatrist submitted an order to change the time of TRAN's medication the day prior, the pharmacy received the change request after it had closed; therefore, the pharmacy did not process the new medication orders until they opened that morning, which was after morning pill call. At noon pill call, TRAN received a second dose of fluoxetine.

During the EDC special needs meeting a Unit Manager followed-up on a mental health referral for TRAN she submitted to medical the previous day. At 12:31 p.m., a psychologist assessed TRAN and noted he was extremely slow moving, lethargic, exhibited rigid movements with occasional hand tremors, and was sweating on his forehead. The psychologist placed TRAN on mental health observation (MHO) from June 5 to June 7, 2018, with nursing checks twice daily and security welfare checks every 15 minutes. An RN signed off on TRAN's medical clearance for MHO. At 2:49 p.m., an officer escorted TRAN to the Bravo 600 unit in MHO. At 3:00 p.m., the officer issued linens to TRAN in his cell.

The officer assigned to observe TRAN while in MHO documented that he checked the detainee at 3:09 p.m., 3:23 p.m., 3:38 p.m., 3:52 p.m., and 4:06 p.m. Video surveillance, however, does not support the first three welfare checks documented. At 3:51 p.m., per video surveillance footage, the officer first observed TRAN as he looked into his cell. Then at 4:13 p.m. the officer noticed TRAN was unresponsive, and at 4:15 p.m., the officer called a medical emergency.

At 4:16 p.m., additional officers responded and started cardiopulmonary resuscitation (CPR). Medical staff arrived two minutes later and assisted with rescue breaths, applied automated external defibrillator (AED) pads and performed other lifesaving efforts. It

¹⁰ Extrapyramidal symptoms are drug-induced movement disorders which include acute and tardive symptoms.

¹¹ Cogentin is the brand name for benztropine, a drug used to treat symptoms of Parkinson's disease and the side effects of other drugs.

was later determined that medical staff applied the AED pads incorrectly, as they were only partially adhered. Medical staff performed CPR for 17 minutes until Emergency Medical Services (EMS) arrived at 4:33 p.m. and took over life-saving efforts. At 4:53 p.m., EMS transported TRAN to BCGMC and at 5:15 p.m., BCGMC initiated patient care.

Over the next seven days, doctors performed a series of tests to determine brain function and TRAN's capacity to breathe on his own. On June 12, 2018, BCGMC medical staff confirmed TRAN could not breathe on his own and pronounced brain death at 9:20 a.m. and cardiac death at 2:20 p.m.

On July 17, 2018, the Chief Medical Examiner of Pinal County signed the Forensic Examination Report and documented the cause of death as coronary artery disease.

ERAU reviewed the medical care EDC provided TRAN, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found EDC failed to comply with the following requirements of the ICE Performance Based National Detention Standards (PBNDS) 2011:

1. ICE PBNDS 2011, *Medical Care*, Section (II)(20), which states, "Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees." Although the EDC NP prescribed fluoxetine and haloperidol at intake on May 28, 2018, TRAN did not receive his first dose for two days, May 30, 2018.
2. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4), which states, "Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication's side effects shall be obtained." FSF and EDC medical staff did not obtain a signed consent form from TRAN for psychotropic medication prior to administration on May 26 and May 30, 2018, respectively. When TRAN finally signed a consent form on June 4, 2018 at EDC, side effects were not listed.
3. ICE PBNDS 2011, *Custody Classification System*, Section (V)(A)(4), which states, "Each detainee's classification shall be reviewed and approved by a first-line supervisor or classification supervisor." A supervisor did not approve the classification rating assigned to TRAN on May 28, 2018.
4. ICE PBNDS 2011, *Special Management Units*, section (V)(M), which states, "Close Supervision Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly." Per the psychologist's order, and following placement in MHO, CoreCivic officers were to conduct welfare checks on TRAN every 15 minutes. Surveillance footage evidence showed the CoreCivic officer on duty issued TRAN linens at 3:00 p.m. but

did not look into TRAN's cell again until 3:51 p.m. During the 51-minute period, the officer documented three welfare checks, none of which were supported by video surveillance.¹²

ERAU also noted several areas of concern, which are detailed in the attached report. If you have any questions, please contact me or have a member of your staff contact ERAU Acting Unit Chief (b)(6); (b)(7)(C) at (202) 73 (b)(6); (b)(7)(C)

Attachment

cc: Matthew Albence

Tae Johnson

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

¹² This officer resigned prior to ERAU's completion of this review (i.e. the week of July 17, 2018).

SYNOPSIS

On June 12, 2018, Huy Chi TRAN, a forty-seven-year-old citizen of Vietnam, died while in the custody of U.S. Immigration and Customs Enforcement (ICE) at Banner Casa Grande Medical Center (BCGMC) in Casa Grande, Arizona (AZ). The Pinal County Medical Examiner documented TRAN's cause of death as sudden cardiac death¹ due to coronary artery disease.²

TRAN was detained at Eloy Detention Center (EDC),³ in Eloy, AZ, from May 28, 2018, until his death. EDC is owned and operated by CoreCivic, formerly Corrections Corporation of America (CCA), under a Dedicated Intergovernmental Service Agreement (DIGSA). EDC is required to comply with the ICE Performance Based National Detention Standards (PBNDS) 2011, as revised in 2016. Medical care at EDC is provided by the ICE Health Service Corps (IHSC), with support from InGenesis contractors. At the time of TRAN's death, EDC housed approximately 889 male and 470 female detainees for periods in excess of 72 hours.

DETAILS OF REVIEW

From July 17 to 19, 2018, ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited EDC to review the circumstances surrounding TRAN's death. ERAU was assisted in its review by contract subject matter experts (SMEs) in correctional healthcare and security who are employed by Creative Corrections, a national management and consulting firm.⁴ As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to TRAN, in addition to conducting in-person interviews of individuals employed by CoreCivic, IHSC, InGenesis, and the local field office of ICE's Office of Enforcement and Removal Operations (ERO).

During the review, ERAU took note of any deficiencies observed in the detention standards as they relate to the care and custody of the deceased detainee and documented those deficiencies herein for informational purposes only. Their inclusion in this report should not be construed in any way as indicating the deficiencies contributed to the detainee's death. ERAU determined the following timeline of events, from the time TRAN entered ICE custody, through his detention at EDC, and eventual death at BCGMC.

¹ Sudden cardiac death is a sudden, unexpected death caused by loss of heart function.

² See Exhibit 1: Pinal County Forensic Examination Report, dated July 17, 2018; According to the American Heart Association (AHA), coronary artery disease occurs when plaque grows within the walls of the coronary arteries until the blood flow to the heart's muscle is limited.

³ Eloy Detention Center (EDC) is also known as Eloy Federal Contract Facility (EFCF).

⁴ See Exhibit 2: Creative Corrections Healthcare and Security Compliance Analysis.

IMMIGRATION AND CRIMINAL HISTORY⁵

On June 25, 1984, the former U.S. Immigration and Naturalization Service (INS) admitted TRAN into the United States in San Francisco, California, as an immigrant (i.e. child of an immigrant who is the brother or sister of a U.S. citizen).⁶

Between June 6, 1994 and October 25, 2000, the Superior Court of Arizona, Maricopa County, convicted TRAN for multiple crimes, detailed in **Table 1** of this report.

On November 9, 2000, INS Phoenix encountered TRAN at the Arizona Department of Corrections (ADOC), Arizona State Prison Complex (ASPC) Alhambra Reception Center (ARC) in Phoenix, AZ and lodged an Immigration Detainer-Notice of Action (Form I-247) with the facility.⁷

On March 25, 2003, a 287(g) officer encountered TRAN at ARC and issued a Warrant for Arrest of Alien/Notice to Appear (Form I-200).⁸ On March 29, 2003, the ADOC transferred TRAN to ERO Phoenix's custody. On the same date, ERO Phoenix served TRAN a Notice to Appear (Form I-862), charging removability pursuant to Section 237(a)(2)(A)(iii) of the Immigration and Nationality Act (INA), as amended, as an alien at any time after admission, convicted of an aggravated felony as defined in Section 101(a)(43)(F) of the INA, a crime of violence for which the term of imprisonment ordered was at least one year.⁹

On May 15, 2003, an immigration judge (IJ) found all of TRAN's applications for relief to be abandoned and ordered him removed to Vietnam. On the same date, TRAN's undated Application for Asylum and for Withholding of Removal (Form I-589) was marked as received.¹⁰

On June 16, 2003, TRAN filed an appeal with the Board of Immigration Appeals (BIA).¹¹ On October 31, 2003, the BIA remanded the case to the IJ for further proceedings.¹² On December 10, 2003, the IJ found all TRAN's applications for relief to be abandoned and again ordered him removed to Vietnam.¹³ TRAN reserved his right to appeal.

⁵ The listed charges are those for which ERAU was able to determine a disposition from TRAN's records. ERAU was unable to determine a disposition for approximately 17 of TRAN's other arrests and/or offenses, dating from October 1995 to April 2007.

⁶ See DHS Form I-213, Record of Deportable/Inadmissible Alien, dated July 17, 2017.

⁷ See INS Form I-247, Immigration Detainer – Notice of Action, dated November 9, 2000.

⁸ See INS Form I-200, Warrant for Arrest of Alien, dated March 25, 2003.

⁹ See INS Form I-862, Notice to Appear, dated March 29, 2003.

¹⁰ See United States Department of Justice (DOJ) Executive Office for Immigration Review (EOIR) Immigration Court: Order of The Immigration Judge, dated May 15, 2003; see also INS Form I-589, Application for Asylum and for Withholding of Removal, received on May 15, 2003.

¹¹ See BIA Inquiry System Case Appeal summary, marked as filed on June 16, 2003.

¹² See DOJ EOIR Decision of the Board of Immigration Appeals, dated October 31, 2003.

¹³ See EOIR U.S. Immigration Court, Eloy, Arizona, Decision and Order of the Immigration Court, dated December 10, 2003.

On January 8, 2004, TRAN filed an appeal with the BIA.¹⁴ On June 14, 2004, the BIA sustained TRAN's appeal and remanded the case back to the IJ for a decision.¹⁵

On September 21, 2004, the IJ denied TRAN's requests for asylum, withholding of removal, and deferral of removal, and ordered him removed to Vietnam. TRAN waived his right to appeal.¹⁶

On January 10, 2005, ERO Phoenix determined that no significant likelihood of removal in the reasonably foreseeable future existed and released TRAN from custody on an Order of Supervision (OSUP). TRAN reported to ERO as required four times between January 27, 2005 and April 20, 2005.¹⁷

On July 8, 2005, ERO Phoenix sent TRAN a Call-In Letter (Form G-56), ordering him to present himself at their office on July 28, 2005.¹⁸ On July 28, 2005, TRAN failed to appear at ERO Phoenix as ordered; therefore, his case was referred to the ERO Fugitive Operations Team for location and arrest, with no result.¹⁹

On August 15, 2006, Chandler Police Department in Chandler, AZ arrested TRAN for shoplifting. On August 18, 2006, Chandler Police Department released TRAN into ERO Phoenix custody. ERO Phoenix released TRAN under the original OSUP issued on January 10, 2005, to complete his criminal proceedings.²⁰

Between May 11, 2007 and April 8, 2009, the Superior Court of Arizona, Maricopa County, convicted TRAN for multiple crimes, detailed in **Table 2** of this report.

On August 27, 2008, ERO Phoenix encountered TRAN at the Maricopa County Jail and lodged a Notice of Action-Immigration Detainer (Form I-247A).²¹

On April 13, 2009, ERO Phoenix encountered TRAN at the ASPC ARC and lodged a Form I-247A.²²

On August 14, 2013, ADOC transferred TRAN to ERO Phoenix's custody. ERO Phoenix released TRAN from custody under his original OSUP issued on January 10, 2005, as there was

¹⁴ See BIA Inquiry System Case Appeal summary, marked as filed on January 8, 2004.

¹⁵ See EOIR Decision of the Board of Immigration Appeals, dated June 14, 2004.

¹⁶ See INS Form I-205, Warrant of Removal/Deportation, dated September 21, 2004; see also Form I-294, Warning to Alien Ordered Removed or Deported, dated September 21, 2004.

¹⁷ See INS Form I-220B, Order of Supervision, dated January 10, 2005 and INS Order of Supervision Addendum, dated January 10, 2005; see also ICE Significant Incident Report, dated June 14, 2018.

¹⁸ See ICE Significant Incident Report, dated June 14, 2018.

¹⁹ See ICE Order of Supervision Appointment, Failed to Appear stamp, dated July 28, 2005; see also ICE Significant Incident Report, dated June 14, 2018.

²⁰ There is no record of TRAN reporting to ERO Phoenix after this date.

²¹ See DHS Form I-247A, Immigration Detainer – Notice of Action, dated August 27, 2008.

²² See DHS Form I-247A, Immigration Detainer – Notice of Action, dated April 13, 2009. There is no documentation regarding TRAN's transfer from the Maricopa County Jail to ASPC ARC.

no significant likelihood of removal. TRAN did not appear at ERO Phoenix for his first scheduled appointment on February 12, 2014, or any subsequent scheduled meeting.²³

On March 16, 2015, Chandler Police Department arrested TRAN for Criminal Damage. On August 14, 2015, the Superior Court of Arizona, Maricopa County, sentenced TRAN to 120 days' incarceration and 3 years' probation.

On January 21, 2017, Chandler Police Department arrested TRAN for Disorderly Conduct and Criminal Damage. Also, on this date, ERO Phoenix encountered TRAN at the Maricopa County Sheriff's Office (MCSO) Jail and lodged a Form I-247A. TRAN remained in MCSO custody pending criminal proceedings.

On July 10, 2017, the Superior Court of Arizona, Maricopa County, sentenced TRAN to one year and six months in jail with a credit of 171 days, time served. On July 17, 2017, a 287(g) Designated Immigration Officer encountered TRAN at the ASPC ARC and lodged a Form I-247A.²⁴

On May 25, 2018, ADOC released TRAN to ERO Phoenix's custody. ERO Phoenix served TRAN a Notice of Revocation of Release with the intention of reviewing TRAN's likelihood of removal.²⁵ ERO Phoenix booked TRAN into the TUCSON INS Hold Room in Tucson, AZ, then, later that day, transferred him to the Florence Staging Facility (FSF) in Florence, AZ.²⁶

On May 28, 2018, ERO Phoenix transferred TRAN to EDC in Eloy, AZ, to pursue his removal to Vietnam.²⁷

²³ See ICE Form I-220B, Order of Supervision, dated August 14, 2013; *see also* ICE ENFORCE Alien Removal Module (EARM) system.

²⁴ See DHS Form I-247A, Immigration Detainer – Notice of Action, dated July 17, 2017.

²⁵ See ICE Tucson Field Office Notice of Revocation of Release, dated May 25, 2018; *see also* EARM system, Detention History, dated May 25, 2018.

²⁶ See EARM system, Detention History, dated May 25, 2018.

²⁷ See EARM system, Detention History, dated May 28, 2018.

NARRATIVE

On May 25, 2018, at approximately 7:22 p.m., upon TRAN's arrival at FSF, Licensed Vocational Nurse (LVN) (b)(6); (b)(7)(C) conducted a medical pre-screening and documented the following:²⁸

- TRAN spoke English fluently.
- TRAN's appearance, behavior, and breathing were normal.
- TRAN's state of consciousness was alert and there were no noticeable restrictions or difficulties of movement.
- TRAN arrived with haloperidol²⁹ (5 mg) and fluoxetine³⁰ (20 mg), both prescribed for morning dosing and self-dosed at the gate.³¹
- TRAN's pre-screening assessment was normal and his pre-screening disposition identified him as having time sensitive medical conditions needing immediate care, pursuant to IHSC policy.³²

On May 26, 2018, at 4:48 a.m., Registered Nurse (RN) (b)(6); (b)(7)(C) signed off on TRAN's intake screening³³ and documented the following:

- TRAN's vital signs (VS) were within normal limits.³⁴
- TRAN acknowledged receiving treatment for depression for the past 20 years but denied suicidal and homicidal thoughts or a history of experiencing hallucinations.
- TRAN denied the use of drugs, alcohol, and tobacco.
- TRAN denied dental issues.
- TRAN's tuberculosis (TB) screening was negative.³⁵

²⁸ See eClinicalWorks (eCW) Pre-Screen by LVN (b)(6); (b)(7)(C) dated May 25, 2018. ERAU approximated timing of medical events as best as possible. Medical times catalogued within the report are prioritized based on the time medical staff indicated a round time, VS, or electronically signed their note.

²⁹ Haloperidol, a generic for Haldol, is an antipsychotic medication used to treat certain types of mental disorders such as schizophrenia.

³⁰ Fluoxetine, a generic for Prozac, is a selective serotonin reuptake inhibitor that treats depression, obsessive-compulsive disorder, and panic disorders.

³¹ Due to the short amount of time TRAN was housed at the TUCSON INS Hold Room and the lack of medical documentation provided, ERAU was unable to confirm if he received any medications prior to May 26, 2018.

³² See IHSC Policy 03-08, Section 4-3 (a), dated January 19, 2015. Priority one detainees (PRI-1) are those identified with time-sensitive medical conditions needing immediate care, including but not limited to unconsciousness, altered level of consciousness, severely intoxicated or under the influence of drugs, medically or mentally unstable, suicidal/homicidal, and infectious/contagious.

³³ See eCW Initial Intake Assessment by RN (b)(6); (b)(7)(C), dated May 26, 2018.

³⁴ Normal temperature is 98.6; normal range for pulse is 60 to 100 beats per minute; normal range for respirations is 12 to 20 breaths per minute; and, normal blood pressure is 120/80 or less.

³⁵ TB is a potentially serious infectious bacterial disease that mainly affects the lungs. Symptoms of active TB include persistent coughing, coughing up blood, chest pain, unintentional weight loss, fatigue, fever, night sweats, chills and loss of appetite.

- RN (b)(6); (b)(7)(C) conducted an Abnormal Involuntary Movement Scale (AIMS)³⁶ and noted a score of zero.

RN (b)(6); (b)(7)(C) documented TRAN's intake screening as **abnormal**, referred him to a medical provider and noted she scheduled a physical exam.³⁷ R (b)(6); (b)(7)(C) received an order per IHSC Commander M (b)(6); (b)(7)(C) Physician's Assistant (PA), to continue TRAN's medications for three days.³⁸ RN (b)(6); (b)(7)(C) scheduled TRAN for a mental health appointment for May 29, 2018, and medically cleared TRAN for custody.

At 2:46 p.m., Licensed Clinical Social Worker (LCSW) (b)(6); (b)(7)(C) signed off on TRAN's mental health follow-up assessment³⁹ and documented the following:

- TRAN reported a history of depression and treatment over the last 20 years.
- TRAN stated that before taking his medications, he heard voices and saw things other people did not but denied any current hallucinations.
- TRAN's appearance was bizarre, he was poorly groomed, his affect flat,⁴⁰ and he exhibited lethargic psychomotor activity.⁴¹

LCSW (b)(6); (b)(7)(C) diagnosed TRAN with schizophrenia,⁴² unspecified, and noted that TRAN would continue to take medications as prescribed.⁴³ TRAN received his medications as prescribed while at FSF.⁴⁴ LCSW (b)(6); (b)(7)(C) noted a follow-up with TRAN on June 2, 2018.⁴⁵

On May 28, 2018, at 8:14 a.m., RN (b)(6); (b)(7)(C) signed TRAN's medical transfer summary and documented the following:⁴⁶

- TRAN's TB symptom screening was negative.

³⁶ The AIMS assess the occurrence of tardive dyskinesia (TD), a side effect of taking antipsychotic medication. Initial AIMS results may serve as a baseline for future monitoring or may prompt ordering of medication to address symptoms of the disorder. A score of zero indicates no occurrence of TD observed. Therefore, due to TRAN being on antipsychotic drugs, the RN conducted the AIMS assessment.

³⁷ There was no date noted for the physical exam and ERO transferred TRAN to EDC two days later.

³⁸ See eCW Initial Intake Assessment by RN (b)(6); (b)(7)(C) dated May 26, 2018. There were no additional details in the medical file regarding the date the order was completed.

³⁹ See eCW Follow-Up Mental Health Appointment by LCSW (b)(6); (b)(7)(C) dated May 26, 2018.

⁴⁰ A lack of emotional expressiveness.

⁴¹ Psychomotor activity are skills where movement and thinking are combined. This includes balance and coordination.

⁴² Schizophrenia is a serious mental disorder in which a person interprets reality abnormally, to include hallucinations, delusions, and extremely disordered thinking and behavior.

⁴³ See Florence Medical Administration Record (MAR).

⁴⁴ See eCW Follow-Up Mental Health Appointment by LCSW (b)(6); (b)(7)(C) dated May 26, 2018.

⁴⁵ ERAU could not confirm that medical scheduled the referenced follow-up appointment for June 2, 2018. ERAU notes ERO transferred TRAN to EDC the following day; while detained at EDC, medical staff completed mental health assessments, which are discussed herein.

⁴⁶ See eCW Transfer Summary by RN (b)(6); (b)(7)(C) dated May 28, 2018.

- RN (b)(6); (b)(7)(C) noted a diagnosis of schizophrenia and that TRAN arrived to FSF with the medications: haloperidol (5 mg) and fluoxetine (20 mg).
- RN (b)(6); (b)(7)(C) requested the receiving facility follow-up with TRAN regarding his medication.
- RN (b)(6); (b)(7)(C) medically cleared TRAN for travel and transfer to EDC.

At 9:26 a.m., TRAN arrived at EDC and was encountered by ICE ERO Deportation Officer (b)(6); (b)(7)(C) who was assigned to intake on this date.⁴⁷ DO (b)(6); (b)(7)(C) described TRAN as soaking wet from sweat and asked TRAN if he was okay but received no response.⁴⁸ DO (b)(6); (b)(7)(C) stated he asked the driver of the van and another detainee if the air conditioning had been on and working in the transport vehicle, to which they both replied yes. DO (b)(6); (b)(7)(C) then alerted his supervisor, Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) regarding his observations of TRAN.

At 9:28 a.m.,⁴⁹ SDDO (b)(6); (b)(7)(C) directed TRAN to the front of the medical pre-screening line due to his abnormal perspiration.⁵⁰ (b)(6); (b)(7)(C) conducted TRAN's pre-screening at this time and documented the following:⁵¹

- TRAN spoke English fluently.
- TRAN was alert and breathing normally but his appearance was anxious.
- TRAN denied pain or wanting to harm himself.
- RN (b)(6); (b)(7)(C) observed no skin abnormalities, no noticeable restrictions or difficulties with movement.
- TRAN stated he was currently taking medication for a health issue.
- A medical transfer summary accompanied TRAN from FSF.

Although RN (b)(6); (b)(7)(C) did not make note of the sweating that DO (b)(6); (b)(7)(C) observed, she marked his pre-screening disposition as PRI-1.

At approximately 10:43 a.m., RN (b)(6); (b)(7)(C) conducted a medical intake assessment and, among other items, documented the following:⁵²

- TRAN's VS were within normal limits.
- TRAN denied experiencing any current pain.
- TRAN denied dental issues.
- TRAN denied a history of suicide attempts or current suicidal ideations.

⁴⁷ See Video Surveillance, North Intake, Rear Exterior, dated May 28, 2018.

⁴⁸ ERAU interview with ICE DO (b)(6); (b)(7)(C) dated July 18, 2018.

⁴⁹ See Video Surveillance, North Intake, Rear Sallyport, dated May 28, 2018.

⁵⁰ ERAU interview with ICE SDDO (b)(6); (b)(7)(C) dated July 17, 2018.

⁵¹ See eCW Pre-Screen by RN (b)(6); (b)(7)(C) dated May 28, 2018. RN (b)(6); (b)(7)(C) noted the time of arrival as 9:25 a.m.; however, video surveillance confirms RN (b)(6); (b)(7)(C) encountered TRAN at 9:28 a.m.

⁵² See eCW Intake Appointment by RN (b)(6); (b)(7)(C) dated May 28, 2018. RN (b)(6); (b)(7)(C) noted she conducted an abbreviated intake screening as FSF completed a full intake screening on May 26, 2018.

- TRAN arrived with haloperidol (5 mg) and fluoxetine (20 mg) and reported last taking the medication the afternoon of May 27, 2018.⁵³
- RN Wilson planted a purified protein derivative (PPD) skin test.⁵⁴

(b)(6); (b)(7)(C) documented TRAN's intake screening as abnormal, referred him to a provider, and noted a physical exam was scheduled.⁵⁵ TRAN signed the IHSC Medical Consent Form, and RN Wilson medically cleared TRAN for custody.⁵⁶

At approximately 10:48 a.m., Correctional Office (b)(6); (b)(7)(C) booked TRAN into EDC.⁵⁷ TRAN acknowledged receipt of the ICE National Detainee Handbook,⁵⁸ facility-issued⁵⁹ property and allowable personal property.⁶⁰ Officer Calvert inventoried two checks totaling \$25.60 and deposited them into TRAN's commissary account.⁶¹ Officer Calvert recalled that TRAN appeared slow, drooled, had snot coming out of his nose, and did not clean himself after sneezing or coughing.⁶²

Case Manager (CM) (b)(6); (b)(7)(C) completed TRAN's initial custody classification and appropriately classified him as high.⁶³ (b)(6); (b)(7)(C) signed the form as both the classification officer and supervisor and did not seek out supervisory approval and signature. When asked why she did not have a supervisor review her work, (b)(6); (b)(7)(C) stated that the classification supervisor position was vacant at the time and since ICE designated TRAN as a high custody detainee, which she recommended adopting, it did not matter.⁶⁴

CM (b)(6); (b)(7)(C) also completed the Sexual Abuse Screening Tool form and within the Staff Observation/File Review section, circled "Yes" for "Detainee appears to be physically, developmentally, or mentally disabled." Furthermore, in the comments section, she wrote TRAN was, "slow, drools, sneezes boogers and spits/coughs."⁶⁵ (b)(6); (b)(7)(C) added she had to

⁵³ ERAU notes although TRAN states he received his medication the afternoon of May 27, 2018, the MAR at FSF shows he received both medications at 11:00 a.m.

⁵⁴ A purified protein derivative skin test is a solution is injected into the skin to determine whether a person has been infected with tuberculosis.

⁵⁵ Although RN (b)(6); (b)(7)(C) did not include a date for the physical exam within her note, a provider completed TRAN's physical exam the same day.

⁵⁶ See ICE Health Service Corps (IHSC) Medical Consent Form, dated May 28, 2018. Although TRAN's name was written in the Spanish language section of the form, it was confirmed by ICE and CoreCivic staff that he spoke English fluently.

⁵⁷ See Intake Surveillance Video, dated May 28, 2018.

⁵⁸ See Detainee Handbook Receipt, dated May 28, 2018.

⁵⁹ See Facility Issued Property Receipt, dated May 28, 2018.

⁶⁰ See Allowable Personal Property Inventory/Receipt, dated May 28, 2019.

⁶¹ See Transaction Receipts 9670302 and 9670303, dated May 28, 2018.

⁶² ERAU interview with Officer (b)(6); (b)(7)(C) dated July 17, 2018.

⁶³ See Exhibit 3: Initial Custody Classification Form 18-1B, dated May 28, 2018. (b)(6); (b)(7)(C) stated that although TRAN's initial classification scored at a medium custody level, because the ICE Risk Classification Assessment recommended a high custody classification level, she recommended overriding her own custody level score. She clarified that EDC always uses the custody classification level ICE recommends.

⁶⁴ ERAU interview with CM (b)(6); (b)(7)(C) dated July 19, 2018.

⁶⁵ See CCA Sexual Abuse Screening Tool, Form 14-2B-DHS/FRS, dated May 28, 2018. ERAU notes (b)(6); (b)(7)(C) intake screening entry makes no reference to the conditions observed by Officer (b)(6); (b)(7)(C)

ask TRAN questions two or three times before he would reply.⁶⁶ When CM (b)(6); (b)(7)(C) was asked about medical receiving the information from the Sexual Abuse Screening Tool form, she stated she was unsure how it was routed to medical or mental health staff. She added that because health care professionals evaluate detainees, she assumed they would identify any special needs. The form distribution designates a copy should be forwarded to classification staff and the Health Services Department for further evaluation and screening.⁶⁷

At approximately 12:46 p.m., Nurse Practitioner (NP) (b)(6); (b)(7)(C) conducted TRAN's initial physical examination and documented, among other details, the following information:⁶⁹

- TRAN's VS were within normal limits.
- TRAN reported a 17-year history of schizophrenia and anxiety disorder⁷⁰ for which he was taking Haldol⁷¹ and fluoxetine, with no adverse side effects.
- NP (b)(6); (b)(7)(C) completed an AIMS assessment, which resulted in a score of zero.⁷²
- TRAN denied drug use but stated he smoked one pack of cigarettes per day for 13 years with his last use over a month prior and drank two alcoholic drinks per week with last use one to two years ago.
- TRAN denied experiencing chest pain with exertion, shortness of breath, irregular heartbeat, palpitations, weakness, loss of appetite, or weight gain.
- TRAN's dental examination showed no lower teeth or upper teeth, and no dental prosthesis.⁷³
- TRAN's demeanor was appropriate for the encounter, his cognitive function appeared intact, his judgment and insight were good, and his thought process was logical and goal directed without suicidal ideation or delusions.
- NP (b)(6); (b)(7)(C) prescribed haloperidol (5 mg), and fluoxetine (20 mg) each morning for two weeks, pending psychiatric evaluation.⁷⁴

⁶⁶ ERAU Interview with CM (b)(6); (b)(7)(C) dated July 19, 2018.

⁶⁷ ERAU notes although this is not a deficiency, CM (b)(6); (b)(7)(C) did not route the form to medical in accordance with the instructions; therefore, medical never received the form.

⁶⁸ NP (b)(6); (b)(7)(C) employment at EDC ended prior to ERAU's site visit; therefore, the ERAU was unable to interview her.

⁶⁹ See eCW Initial PE-C Appointment by NP (b)(6); (b)(7)(C) dated May 28, 2018. (b)(6); (b)(7)(C) entered TRAN's VS for the PE-C at 11:46 a.m.

⁷⁰ Anxiety disorder is a medical condition that includes symptoms of intense anxiety or panic that are directly caused by a physical health problem.

⁷¹ (b)(6); (b)(7)(C) is a brand name for haloperidol.

⁷² During ERAU interview with (b)(6); (b)(7)(C) Psychiatrist, dated June 19, 2018, he stated only properly trained healthcare professionals should administer an AIMS test. There was no documentation of AIMS training in (b)(6); (b)(7)(C) record; however, she may have been trained in its administration as part of her education.

⁷³ A dental prosthesis is device such as dentures used to restore or reconstruct defects in the mouth such as missing teeth, missing parts of teeth, and missing soft or hard structures of the jaw and palate. ERAU notes no other medical documentation listed issues with TRAN's teeth or the mouth. Furthermore, although (b)(6); (b)(7)(C) documented the dental issues, she did not order a soft diet for TRAN.

⁷⁴ (b)(6); (b)(7)(C) called and discussed these medications with (b)(6); (b)(7)(C) an IHSC Psychiatrist assigned to the Krome North Service Processing Center in Miami, Florida, but she did not document discussion of the potential side effects of these medications with TRAN, nor did she obtain his consent to take them. As discussed later in the report, EDC medical staff did not obtain TRAN's consent to psychotropic medication until June 4, 2018.

(b)(6); (b)(7)(C) ordered lab studies for completion on May 31, 2018,⁷⁵ which included thyroid studies,⁷⁶ lipid panel,⁷⁷ comprehensive metabolic panel (CMP),⁷⁸ complete blood count (CBC) with differential,⁷⁹ platelet count,⁸⁰ and hemoglobin A1c.⁸¹ Due to TRAN's mental health history, (b)(6); (b)(7)(C) documented TRAN's physical exam as abnormal and referred him to a mental health provider.

At 11:49 a.m., security staff initially assigned TRAN to housing unit Delta 100, cell 125, an upper tier and bunk;⁸² however, TRAN's cellmate⁸³ told Correctional Officer (b)(6); (b)(7)(C) assigned to the unit on this date, that TRAN was unable to climb to the top bunk and needed to be moved.⁸⁴ Officer (b)(6); (b)(7)(C) stated he contacted the Unit Counselor (name unknown), who told him they could not move TRAN at that time because it was cell count and there would be no manager available to sign off on the move. Officer (b)(6); (b)(7)(C) recalled moving TRAN's mattress to the cell floor until they could assign him to a low bunk on a lower tier. Officer (b)(6); (b)(7)(C) mentioned TRAN would not make eye contact with him during their interaction.

At 6:54 p.m., CoreCivic staff moved TRAN to a low bunk in cell 103 located on the lower level of the Delta 100 housing unit.⁸⁵ TRAN's cellmate stated that TRAN never mentioned feeling sick to him, but he did observe TRAN walking slowly and taking him a long time to get up from his bunk.⁸⁶ The cellmate also added he had to wake TRAN for breakfast and lunch every day and would observe him falling asleep in the dayroom while watching TV.

On May 30, 2018, during morning pill call, medical staff administered TRAN the doses of haloperidol and fluoxetine,⁸⁷ more than two days after he reported taking his last doses.⁸⁸

At 3:00 p.m., RN (b)(6); (b)(7)(C) read TRAN's PPD test as negative.⁸⁹

⁷⁵ See Lab Order, dated May 31, 2018.

⁷⁶ Thyroid studies are a series of blood tests used to measure how well the thyroid gland is working to produce major hormones.

⁷⁷ Lipid panel is a panel of blood tests which serve as initial screening for abnormalities in cholesterol and triglycerides.

⁷⁸ A CMP is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes, and how well the kidneys and liver are working.

⁷⁹ CBC with differential is a blood test that gives doctors information about the cells in a patient's blood and the concentration of various proteins and minerals.

⁸⁰ Platelet count is a blood test which measures the number of blood-clotting cells.

⁸¹ Hemoglobin A1c is a blood test that provides a three-month average of glucose concentration in the blood.

⁸² See EDC Inmate Housing History with Cellmates for Huy TRAN, dated June 13, 2018.

⁸³ ERAU was unable to interview TRAN's first cellmate, as ICE released him on June 8, 2018, according to ICE's ENFORCE Alien Removal Module (EARM) system.

⁸⁴ ERAU interview with Officer (b)(6); (b)(7)(C) dated July 17, 2018.

⁸⁵ See EDC Inmate Housing History with Cellmates for Huy TRAN, dated June 13, 2018; *see also* ERAU interview with Officer (b)(6); (b)(7)(C) dated July 17, 2018.

⁸⁶ ERAU interview with TRAN's cellmate, dated July 19, 2018. TRAN's cellmate remained his cellmate until the day of his medical emergency.

⁸⁷ Because NP (b)(6); (b)(7)(C) did not sign her initial PE-C assessment note until 5:50 p.m., it delayed the pharmacy's receipt of TRAN's medication order, which generally closed at 4:30 p.m. (b)(6); (b)(7)(C) did not document whether she intended for medical staff to administer medication from the intake supply pending fulfillment by the pharmacy.

⁸⁸ See Exhibit 4: EDC Medical Administration Record (MAR) for Huy Chi Tran, dated May 2018.

⁸⁹ See eCW Progress Note by RN (b)(6); (b)(7)(C) dated May 30, 2018.

On May 31, 2018, at 1:57 a.m., CoreCivic staff escorted TRAN to medical for lab work.⁹⁰

At some point during his shift,⁹¹ (b)(6); (b)(7)(C) instructed TRAN to empty his property box so he could replace the lock. (b)(6); (b)(7)(C) recalled TRAN sat on his bunk and stared at him, unable to empty the box which only contained a pair of socks and underwear. Officer (b)(6); (b)(7)(C) recalled TRAN walked like a “zombie” as if he was “sleepwalking.”

On June 1, 2018, medical staff received the results of TRAN’s laboratory tests. The results were all within normal limits, except for elevated calcium, sodium, and Thyroxine (T4).⁹²

On June 4, 2018, at 2:58 p.m., (b)(6); (b)(7)(C) psychiatrist, conducted TRAN’s mental health exam and documented the following:⁹³

- TRAN was alert, awake and oriented to time, place, and person.
- TRAN denied an increased sense of embarrassment, depressed mood, feelings of hopelessness or helplessness, and suicidal ideations.
- TRAN reported that although his auditory hallucinations started at age 20, he did not start medical treatment until two years ago. TRAN stated the voices would tell him to do things. TRAN also reported that he experienced visual hallucinations in the past and believed others could insert thoughts in his mind. TRAN added that since taking Haldol, it had been more than a year since he experienced visual or auditory hallucinations.
- TRAN denied thought broadcasting⁹⁴ or withdrawal and described his anxiety as restlessness and being uncomfortable around people.
- TRAN reported receiving outpatient treatment at Southwest Network in Chandler, AZ from 2013 to 2017 and treatment while in prison from 2017 to 2018.
- TRAN stated he did not take his medication for three months prior to an incident involving threats he made against his sister with a knife.
- TRAN reported last consuming alcohol two years ago, two cans per weekend, but denied illicit drug abuse. He admitted to smoking one pack of cigarettes a day for the past 13 years.
- (b)(6); (b)(7)(C) described TRAN as cooperative, tremulous, and showing mild psychomotor retardation.⁹⁵ TRAN demonstrated minimal arm swinging while walking and an intense, sustained stare.

⁹⁰ See TSH+Free T4, Lipid Panel, Comprehensive Metabolic Panel, and CBC With Differential Platelet Lab collection reports, dated May 31, 2018; see also CoreCivic Incident Investigation Report, Milestone video surveillance timeline, dated June 19, 2018.

⁹¹ On this date, Officer (b)(6); (b)(7)(C) worked the 6:00 a.m. to 2:00 p.m. shift.

⁹² See Laboratory Results, dated June 1, 2018. Elevation in sodium and calcium levels may result from dehydration. A T4 test is a blood test that identifies thyroid issues.

⁹³ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 4, 2018. (b)(6); (b)(7)(C) did not sign the progress note until 4:57 p.m.

⁹⁴ Thought broadcasting is the belief others can hear or are aware of an individual’s thoughts.

⁹⁵ Psychomotor retardation refers to a slowing down of thoughts and a reduction of physical movements in an individual.

- TRAN's speech showed prolonged latent response periods, and his thought process was slow and impoverished.⁹⁶
- TRAN's mood was euthymic⁹⁷ and his affect blunt.
- TRAN was a poor historian, with inconsistencies in his reports of mental illness and medication treatment.

(b)(6); (b)(7)(C) completed an AIMS assessment and noted an overall score of three.⁹⁸ The assessment findings were schizophrenia and anxiety disorder, both unspecified. (b)(6); (b)(7)(C) continued TRAN on his prescribed medications; however, he rewrote the prescription administration times from morning to noon for fluoxetine and night for haloperidol. Dr. (b)(6); (b)(7)(C) explained that staff wake detainees around 4:00 a.m. if they receive morning doses of medication, and he felt it was necessary for TRAN to have uninterrupted sleep.⁹⁹ (b)(6); (b)(7)(C) documented that he discussed the risks, benefits, and alternatives to Haldol and fluoxetine with TRAN.¹⁰⁰ In his notes, (b)(6); (b)(7)(C) documented that TRAN exhibited extrapyramidal symptoms (EPS),¹⁰¹ which a Cogentin¹⁰² trial could address.¹⁰³ TRAN signed a consent form for haloperidol, fluoxetine, and Cogentin.¹⁰⁴

(b)(6); (b)(7)(C) directed medical staff to obtain TRAN's records from the ADOC and Southwest Network outpatient clinic.¹⁰⁵ (b)(6); (b)(7)(C) scheduled a psychiatric follow-up appointment for July 2, 2018.¹⁰⁶

On this date (time unknown), Delta 100 Unit Manager (UM) (b)(6); (b)(7)(C) submitted a Request for Mental Health Review which described TRAN as seeming distraught, eating very slowly, and not responding to unit staff when offered help.¹⁰⁷ (b)(6); (b)(7)(C) recalled TRAN caught her attention the day prior when he was taking a long time to eat a meal.¹⁰⁸ (b)(6); (b)(7)(C) stated Assistant Shift Supervisor (b)(6); (b)(7)(C) offered TRAN the opportunity to take his meal tray

⁹⁶ According to (b)(6); (b)(7)(C) impoverished responses were short, usually yes or no, without elaboration; ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

⁹⁷ Euthymic refers to a tranquil mood.

⁹⁸ According to the Encyclopedia of Mental Disorders, items on the AIMS test are rated on a scale severity from zero to four with a rating of one as minimal severity. (b)(6); (b)(7)(C) documented an overall score of three, but he applied level one scores for four symptoms; therefore, the correct overall score was four.

⁹⁹ ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

¹⁰⁰ See eCW Progress Note, (b)(6); (b)(7)(C) dated June 4, 2018. (b)(6); (b)(7)(C) listed the risks associated with taking the prescribed medications as followed: fluoxetine as dry mouth, headaches, increased agitation/anxiety and nausea; Haldol as dry mouth, headaches, TD, malignant syndrome, sexual psychosis, depression, anxiety, irritability, homicidality, suicidality, and EPS.

¹⁰¹ EPS are drug-induced movement disorders which include acute and tardive symptoms.

¹⁰² Cogentin is the brand name for benztropine, a drug used to treat symptoms of Parkinson's disease and the side effects of other drugs.

¹⁰³ Although (b)(6); (b)(7)(C) documented that he would start TRAN on Cogentin to treat EPS, he did not write the order; he stated this was an oversight; ERAU interview with (b)(6); (b)(7)(C) dated July 19, 2018.

¹⁰⁴ See Exhibit 5: ICE Health Service Corps Consent for Psychotropic Medications for Adults, dated June 4, 2018.

¹⁰⁵ See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 4, 2018. Medical staff did not receive the requested records until after TRAN's death.

¹⁰⁶ See eCW Pending Appointment, dated June 7, 2018.

¹⁰⁷ See Request for Mental Health Review form, dated June 4, 2018.

¹⁰⁸ ERAU interview with (b)(6); (b)(7)(C) dated July 18, 2018.

back to his housing unit, so he did not have to rush eating; however, TRAN declined and left with the other detainees. (b)(6); (b)(7)(C) stated she was concerned other detainees would bully him and that he walked like a zombie. (b)(6); (b)(7)(C) stated she delivered the mental health referral to an officer in medical herself because she considered it a priority.

On June 5, 2018, TRAN received morning doses of fluoxetine and haloperidol. Although Dr. (b)(6); (b)(7)(C) submitted an order to change the time of TRAN's medication the day prior, the pharmacy received the change request after it had closed.¹⁰⁹ Therefore, the pharmacy did not process the new medication orders until they opened that morning, which was after morning pill call. At noon pill call, TRAN received a second dose of fluoxetine per the order change.¹¹⁰

Also, on the morning of June 5, 2018, U (b)(6); (b)(7)(C) followed-up on her mental health referral from the previous day during an EDC special needs meeting, which generally occurs every Tuesday morning.¹¹¹ She recalled during the meeting that (b)(6); (b)(7)(C) psychologist, said she was uncertain if she had received the referral but that medical would check.

At approximately 12:31 p.m.,¹¹² (b)(6); (b)(7)(C) conducted a mental health follow-up pursuant to (b)(6); (b)(7)(C)'s mental health review request and documented the following:¹¹³

- TRAN presented as depressed and apathetic. He exhibited flat affect with alogia.¹¹⁴
- TRAN was lethargic, moved extremely slow, and exhibited stilted movements.¹¹⁵ TRAN acknowledged that he had been moving more slowly overall in the last few weeks.
- TRAN made inconsistent eye contact and stared off into space while seeming disengaged.
- TRAN was soft spoken and hesitant in his responses.
- TRAN got out of his seat twice during the session, and when asked if he was alright, said he needed to move, without further explanation. (b)(6); (b)(7)(C) encouraged TRAN to step out into the hallway for a moment to briefly walk around.
- TRAN was sweating on his forehead, and his hands appeared to be shaking towards the end of the session.
- TRAN initially denied symptoms of depression; however, after (b)(6); (b)(7)(C) pointed out that his presentation was inconsistent with his self-report, he acknowledged experiencing some depression.

¹⁰⁹ Commande (b)(6); (b)(7)(C) Chief Pharmacist, stated pharmacy hours are 8:00 a.m. to 4:30 p.m. and can extend to 6:00 p.m. ERAU could not confirm if the pharmacy hours were extended on June 4, 2018. ERAU interview with Commande (b)(6); dated July 18, 2018.

¹¹⁰ See Medication Administration Record, dated June 5, 2018.

¹¹¹ ERAU interview with (b)(6);, dated July 18, 2018. ERO personnel, healthcare staff, unit managers, and security supervisors generally attend the meeting the weekly EDC special needs meeting.

¹¹² See Video Surveillance Footage, Medical South Hallway, dated June 5, 2018.

¹¹³ See eCW Mental Health Referral Follow-up Appointment, (b)(6); (b)(7)(C) dated June 5, 2018. ERAU notes no VS were taken during this encounter; although not required per policy, Creative Corrections advised VS are a key function in the early detection of a life-threatening issue.

¹¹⁴ Alogia is a general lack of additional, unprompted content seen in normal speech.

¹¹⁵ Stilted movements refer to stiff or rigid movements, as if they are walking on stilts.

- TRAN denied past and current auditory or visual hallucinations.¹¹⁶
- TRAN stated that he had been consistently taking his psychotropic medication.
- TRAN reported attending recreation but said that he spent his time sitting. He stated that he talked to other detainees in his pod but also acknowledged that he had difficulty conversing with others, as he had felt nervous for the past several weeks. He was unable to clarify why he felt nervous.
- TRAN denied thoughts of self-harm, plan and intent.
- TRAN exhibited longer pauses between responses toward the end of the session and appeared somewhat distracted. At one point, TRAN asked why (b)(6); (b)(7)(C) was asking the questions she was asking.
- TRAN was cooperative overall, though he ultimately said that he did not want to continue talking.

Based on her assessment, (b)(6); (b)(7)(C) ordered TRAN's placement on mental health observation from June 5 to June 7, 2018 and completed a Special Needs Form directing nursing checks twice daily and welfare checks by security staff every 15 minutes.¹¹⁷ (b)(6); (b)(7)(C) marked the form as priority and scheduled a mental health follow-up appointment for June 7, 2018.¹¹⁸ (b)(6); (b)(7)(C) stated she determined TRAN should be placed in Bravo 600 because it was a more restricted environment; therefore, he could be more closely monitored.¹¹⁹

In response to (b)(6); (b)(7)(C) order, RN (b)(6); (b)(7)(C) provided medical clearance for TRAN's placement in administrative segregation for mental health observation.¹²⁰ (b)(6); (b)(7)(C) stated she only conducted a review of TRAN's record and did not assess him in person or input a medical clearance assessment in TRAN's medical record. Captain (b)(6); (b)(7)(C), Health Services Administrator (HSA), confirmed that medical should assess detainees in-person before medically clearing them for segregation.¹²¹

At 1:35 p.m., Captain (b)(6); (b)(7)(C) approved the segregation order.¹²²

At 2:49 p.m., Sergeant (b)(6); (b)(7)(C) escorted TRAN to the Bravo 600 Unit.¹²³ Sergeant Mercado recalled that upon arrival to escort TRAN, the medical officer informed him TRAN was anxious.¹²⁴ Sergeant (b)(6); (b)(7)(C) stated TRAN would repeatedly stand up and ask if he could

¹¹⁶ ERAU notes this is inconsistent with TRAN's initial intake at FSF on May 26, 2018, during which he reported experiencing auditory and visual hallucinations prior to taking his psychotropic medication.

¹¹⁷ See ICE Special Needs Form for Huy Chi Tran, dated June 5, 2018. (b)(6); (b)(7)(C) informed the ERAU review team she handed the form to medical staff.

¹¹⁸ See eCW Mental Health Follow-up Appointment, scheduled for June 7, 2018.

¹¹⁹ ERAU interview with (b)(6); (b)(7)(C) dated July 18, 2018.

¹²⁰ See Exhibit 6: Confinement Record Form, dated June 5, 2018. ERAU notes RN (b)(6); (b)(7)(C) did not input a medical clearance assessment into TRAN's medical record; she only documented the clearance on the Confinement Record Form placed in the detention file.

¹²¹ ERAU's second interview with HSA (b)(6); (b)(7)(C) July 19, 2018.

¹²² See Exhibit 6: Confinement Record Form, dated June 5, 2018.

¹²³ See Surveillance Video, Medical South Hallway, dated June 5, 2018.

¹²⁴ ERAU interview with CoreCivic Sergeant (b)(6); (b)(7)(C) July 18, 2018.

leave. Sergeant (b)(6); (b)(7)(C) informed TRAN they were moving him to another unit so medical could keep a closer eye on him.

Unless otherwise noted, the following movements are based on both the CoreCivic Report completed by the Facility Investigator and EDC Milestone video surveillance footage.¹²⁵

At 2:54 p.m., TRAN arrived to Bravo 600 with Sergeant Mercado.

At 2:56 p.m., Correctional Officer (b)(6); (b)(7)(C) escorted TRAN to cell 606; Correctional Officer (b)(6); (b)(7)(C) was also assigned to Bravo 600 on this date, specifically to conduct constant watch on the detainee on suicide watch in cell 605, next door.

At 3:00 p.m., Officer (b)(6); (b)(7)(C) entered TRAN's cell with a bag of linens and exited 35 seconds later.¹²⁶ From the time Officer (b)(6); (b)(7)(C) placed TRAN in his cell and the medical emergency logged at 4:15 p.m., Officer (b)(6); (b)(7)(C) documented he conducted welfare checks on TRAN at 3:09 p.m., 3:23 p.m., and 3:38 p.m.; however, video surveillance shows that from 3:00 p.m. to 3:47 p.m., Officer (b)(6); (b)(7)(C) is in the vicinity, or walked past TRAN's cell, on five separate occasions but never looked in to determine TRAN's welfare.¹²⁷ (b)(6); (b)(7)(C) confirmed he received TRAN's Special Needs Form and was aware he was to check on TRAN every 15 minutes.¹²⁸ When the Facility Investigator asked Officer (b)(6); (b)(7)(C) about the discrepancies between his log entries and the video evidence, he stated the times may have been off because he does not make entries right away.¹²⁹ Officer (b)(6); (b)(7)(C) claimed that he had looked into TRAN's cell as he walked by and every time TRAN was moving and breathing. Officer (b)(6); (b)(7)(C) claimed TRAN was sitting on the edge of his bed for the first two documented security checks and, on the next check, was lying on his stomach with his arms tense and one leg elevated.

At 3:45 p.m., Officer (b)(6); (b)(7)(C) placed an orange card¹³⁰ on TRAN's cell door but does not look in. At 3:47 p.m., Officer (b)(6); (b)(7)(C) placed an orange card on the cell door next to TRAN's cell and spoke to Officer (b)(6); (b)(7)(C).

¹²⁵ See CoreCivic Investigation and Timeline, dated June 18, 2018; see also EDC Milestone video surveillance footage, dated June 5, 2018.

¹²⁶ See Surveillance Video, Bravo 600 East, dated June 5, 2018. During EDC Facility Investigator (b)(6); (b)(7)(C) interview with Officer (b)(6); (b)(7)(C) he stated he entered TRAN's cell with bedding, but TRAN did not say a word and seemed to be shaking a little.

¹²⁷ *Id*; see also Exhibit 7: Confinement Watch Log, dated June 5, 2018.

¹²⁸ ERAU interview with EDC Investigator Potter, dated July 18, 2018; see CoreCivic Incident Investigative Report Statement by Officer (b)(6); (b)(7)(C), dated June 5, 2018. ERAU notes Officer (b)(6); (b)(7)(C) resigned on June 14, 2018.

¹²⁹ Officer (b)(6); (b)(7)(C) recounted that during his shift, there were no Medication Suicide Observation Checklists (IHSC-835 form) to document the 15-minute rounds, so he gathered and completed the Confinement Watch Log and the Confinement Activity Record. Officer (b)(6); (b)(7)(C) noted he requested more copies of the IHSC-835 form from Officer (first name unknown) (b)(6); (b)(7)(C). Therefore, ERAU notes that a Confinement Watch Log is utilized as the reference document for rounds documented by Officer (b)(6); (b)(7)(C) on June 5, 2018. See CoreCivic Incident Investigative Report Statement by Officer (b)(6); (b)(7)(C) dated June 5, 2018.

¹³⁰ An orange card is used by security staff to signify when a detainee is in segregation for medical observation purposes.

At 3:51 p.m., Officer L (b)(6) looked into TRAN's cell and marked the clipboard.¹³¹ He then stood at the door and looked in the cell again. Officer (b)(6); (b)(7)(C) then moved from cell 605 to look in to TRAN's cell. Officer (b)(6); (b)(7)(C) then opened the door to TRAN's cell walked in, walked back out, and closed the door. At 3:55 p.m., Officer I (b)(6) left the east side of the Unit for the west side and returned at 4:04 p.m. After delivering a meal tray to another cell, he opened the food portal in TRAN's cell door and walked away. At 4:06 p.m., Officer (b)(6); (b)(7)(C) handed Officer (b)(6); (b)(7)(C) a sack meal for the detainee in cell 605 and then placed a meal tray on TRAN's food portal. After Officer (b)(6); (b)(7)(C) moved away to deliver a tray to another cell, Officer (b)(6); (b)(7)(C) appeared to look into TRAN's cell.

At 4:08 p.m., Officer (b)(6); (b)(7)(C) again appeared to look into TRAN's cell. At 4:11 p.m., Officer (b)(6); (b)(7)(C) while on his way back to the officer's station, stopped briefly at TRAN's cell before moving on but did not look in.

At 4:12 p.m., Officer (b)(6); (b)(7)(C) returned to TRAN's cell and looked directly in. Officer (b)(6); (b)(7)(C) removed the tray from the portal and exited the east side of Bravo 600. Officer I (b)(6); (b)(7)(C) returned to TRAN's cell at 4:13 p.m., opened the door, entered then exited quickly, leaving the door ajar. Officer (b)(6); (b)(7)(C) recalled he entered the cell, touched TRAN's leg and hand, then shook his back; he stated TRAN's back was warm. Officer (b)(6); (b)(7)(C) said that he then called out to TRAN and heard Officer Hall tell him to call a medical emergency. Officer (b)(6); (b)(7)(C) exited TRAN's cell and started to walk away but immediately returned and called a medical emergency.

At 4:15 p.m., Officer (b)(6); (b)(7)(C), while on his radio, moved toward the front of the east side of Bravo 600 and motioned to the detainee in the dayroom to return to his cell. Another officer arrived and escorted the detainee to his cell as Officer (b)(6); (b)(7)(C) returned to TRAN's cell and opened the door wider.

At 4:16 p.m., Correctional Counselor (b)(6); (b)(7)(C) and Correctional Officer (b)(6); (b)(7)(C) responded to the medical emergency. Officer (b)(6); (b)(7)(C) who was the designated camera operator for the emergency response team on this date, carried a handheld video camera.¹³² Officer N (b)(6); (b)(7)(C) stated she called out to TRAN three times from the doorway, but he did not respond. None of the officers entered the cell; Officer (b)(6); (b)(7)(C) stated they did not enter for their safety as TRAN was a level three male detainee and could be feigning illness.¹³³

Lieutenant (Lt.) (b)(6); (b)(7)(C) and Correctional Officer (b)(6); (b)(7)(C) arrived seconds later and entered the cell. (b)(6); (b)(7)(C) affirmed that when he arrived, Counselor (b)(6); (b)(7)(C)

¹³¹ See Exhibit 7: Confinement Watch Log, dated June 5, 2018. ERAU notes Officer (b)(6); (b)(7)(C) documented a welfare check time of 3:52 p.m.

¹³² ERAU Interview with Officer (b)(6); (b)(7)(C), dated July 18, 2018. For the first 46 seconds there is sound but no video as the lens cover would not fully open. When (b)(6); (b)(7)(C) arrived, he assisted in opening the jammed lens cover. ERAU Interview with Lieutenant (b)(6); (b)(7)(C), dated July 17, 2018, confirmed the lens cover was not operating properly, and it required maintenance after the emergency response.

¹³³ ERAU interview with Officer (b)(6); (b)(7)(C), dated July 18, 2018. EDC Policy 10-100, Segregation/Restrictive Housing Unit Management, Section 10-100.4, (E)(2)(c), states that staff members equal to the number of inmates/residents assigned to the cell will be present prior to opening any occupied cell door.

and Officer (b)(6); (b)(7)(C) were standing outside of TRAN's cell.¹³⁴ The counselor and both officers then proceeded into the cell. (b)(6); (b)(7)(C) recalled TRAN was laying on his stomach, face down, and when he rolled TRAN onto his right side, he was, stiff, cold to the touch, had a yellow/reddish discharge coming from his nose, and was not breathing. (b)(6); (b)(7)(C) instructed security staff to begin cardiopulmonary resuscitation (CPR), to include rotating performance of chest compressions every four series to avoid fatigue.¹³⁵ (b)(6); (b)(7)(C) stated he then radioed for central control to call 911.¹³⁶

At 4:17 p.m., (b)(6); (b)(7)(C) stepped out of the cell to speak into his radio as RN (b)(6); (b)(7)(C) and Correctional Officer (b)(6); (b)(7)(C) arrived. RN (b)(6); (b)(7)(C) documented that TRAN was lying on the bed, unresponsive and not breathing, while officers performed CPR.¹³⁷ (b)(6); (b)(7)(C) applied a pulse oximeter to TRAN's right index finger which recorded an oxygen saturation¹³⁸ of 48 percent. She also noted she found a faint, irregular pulse on his right wrist.

At 4:18 p.m., NP (b)(6); (b)(7)(C) and two other nurses arrived on scene with a gurney and emergency bag.¹³⁹ (b)(6); (b)(7)(C) documented (b)(6); (b)(7)(C) took over as lead of the emergency response. (b)(6); (b)(7)(C) stated that because the officers were performing chest compressions and manual breaths well, he let them continue.¹⁴⁰ (b)(6); (b)(7)(C) checked TRAN's left wrist and noted he did not find a pulse.

Although the Central Control Log notated 911 was called at 4:21 p.m., the Eloy Fire District Prehospital Care Report indicated that at 4:19 p.m., the Eloy Fire District dispatched Emergency Medical Services (EMS) to EDC.¹⁴¹ (b)(6); (b)(7)(C) removed the automated external defibrillator (AED)¹⁴² from its case and attempted to apply the AED pads under TRAN's shirt.¹⁴³ He then asked a nurse to call for another provider.

At 4:20 p.m. (b)(6); (b)(7)(C) responded to the provider request, followed by Physician Assistant (PA) Marion Memmott at 4:22 p.m.¹⁴⁴ (b)(6); (b)(7)(C) cut TRAN's shirt, which revealed the AED pads were not properly placed or adhered on TRAN's upper abdomen. PA (b)(6); (b)(7)(C)'s medical record entry confirmed this observation and described the pads as partially adhered.¹⁴⁵ RN

¹³⁴ ERAU interview with (b)(6); (b)(7)(C) dated July 17, 2018.

¹³⁵ See Handheld Video, dated June 5, 2018.

¹³⁶ ERAU interview with (b)(6); (b)(7)(C) dated July 17, 2018.

¹³⁷ See eCW Progress Note, by RN (b)(6); (b)(7)(C) dated June 5, 2018.

¹³⁸ Oxygen saturation refers to the amount of oxygen found in the blood. Normal oxygen saturation levels range from 95 to 100 percent; any reading under 90 percent is considered hypoxia, i.e., when the body does not have enough oxygen.

¹³⁹ See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 5, 2018.

¹⁴⁰ ERAU interview with (b)(6); (b)(7)(C) dated July 17, 2018.

¹⁴¹ See Eloy Fire District Prehospital Care Report, dated June 5, 2018; *see also* Central Control Log, dated June 5, 2018.

¹⁴² An AED is a portable electronic device that delivers an electric shock through the chest to the heart. The shock potentially stops an irregular heart beat and allows a normal rhythm to resume following a sudden cardiac arrest.

¹⁴³ See Handheld Video, dated June 5, 2018.

¹⁴⁴ See eCW Progress Note by (b)(6); (b)(7)(C) and eCW Progress Note by PA Memmott, both dated June 5, 2018.

¹⁴⁵ See eCW Progress Note by (b)(6); (b)(7)(C), dated June 5, 2018. For an AED machine to provide accurate analysis and effective shock during a sudden cardiac arrest, AED pads must make proper contact with the skin. Proper placement of AED pads is one pad on the front of the chest, above the right nipple, and the other pad on the left side

Pallateri then performed a sternal rub, with no response. (b)(6); (b)(7)(C) both documented the AED machine analyzed the patient multiple times during resuscitation but did not detect a shockable rhythm.

When (b)(6); (b)(7)(C) arrived, she placed an ambubag¹⁴⁶ over TRAN's face to administer oxygen, while officers continued chest compressions. The ambubag would not seal properly even with assistance from (b)(6); (b)(7)(C) holding the mouth piece. (b)(6); (b)(7)(C) took over the ambubag and vocalized it was not sealing. (b)(6); (b)(7)(C) then suggested tilting TRAN's head back, which allowed the ambubag to seal properly. During the emergency response, medical could not detect TRAN's blood pressure (bp) and his oxygen saturation and pulse fluctuated.¹⁴⁷ TRAN's blood glucose¹⁴⁸ was elevated at 208 and his peripheral pulse¹⁴⁹ ranged from a low 50 beats per minute (bpm) to an elevated 115 bpm. When security staff ceased chest compressions, the pulse oximeter device had no reading.¹⁵⁰ Throughout the emergency response, there were five attempts made by the three responding providers to establish an intravenous (IV) line, all of which were unsuccessful.¹⁵¹

At approximately 4:24 p.m., (b)(6); (b)(7)(C) ceased recording the medical emergency response efforts prior to EMS' arrival.¹⁵² (b)(6); (b)(7)(C) confirmed that when he reported to the scene, he told (b)(6); (b)(7)(C) have Officer (b)(6); (b)(7)(C) stop recording because he believed medical procedures were a Health Insurance Portability and Accountability Act (HIPAA)¹⁵³ concern.¹⁵⁴ When asked if he considered CPR a medical procedure, he replied that he never recorded CPR during his corrections career.

At 4:30 p.m., EMS responders arrived via ambulance at the EDC rear gate.¹⁵⁵ At 4:33 p.m., EMS responders entered the east side of Bravo 600.¹⁵⁶ Once EDC staff finished their round of

of the chest, below the breast area. Although the pads were later repositioned, their placement remained imperfect throughout the emergency response. During his interview with ERAU, NI (b)(6); (b)(7)(C) stated he did not know whether the AED pads had expired, which could have caused the gel on the pads to be dry and not adhere properly to the skin. His assumption was that the pads did not stick because TRAN's skin was moist and it did not occur to him to dry TRAN's skin or check the emergency bag for new pads. The emergency bag inventory did not include an extra set of AED pads.

¹⁴⁶ Ambubag is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

¹⁴⁷ Creative Corrections advised that during an emergency response, VS can fluctuate due to the administration of CPR.

¹⁴⁸ Blood glucose is the amount of glucose, a sugar that comes from foods we eat, that is found in the blood. A normal blood glucose level is roughly 70 to 100.

¹⁴⁹ Peripheral pulse is a pulse palpable in the hands and legs.

¹⁵⁰ See eCW Progress Note by (b)(6); (b)(7)(C) dated June 5, 2018.

¹⁵¹ An intravenous line is a portal, established by a hollow-bore needle and connected to plastic tubing, through which fluids and medications can be administered directly into the vein.

¹⁵² ERAU interview with Lieutenant (b)(6); (b)(7)(C), July 17, 2018.

¹⁵³ According to 45 Code of Federal Regulations (CFR) Parts 160 and 164, U.S. Department of Health and Human Services (HHS), HIPAA sets the standards for privacy of individually identifiable health information. Creative Corrections advised that HIPAA does not apply to those in custody of the Federal Government.

¹⁵⁴ ERAU interview with Captain (b)(6); (b)(7)(C) dated July 19, 2018.

¹⁵⁵ See EDC Rear Gate Logbook Entry at 1630, June 5, 2018.

¹⁵⁶ See Surveillance Video, Bravo 600 East, dated June 5, 2018.

CPR, EMS responders took over lifesaving efforts.¹⁵⁷ EMS responders documented that TRAN showed an idioventricular rhythm (IVR)¹⁵⁸ with no pulse and was in pulseless electrical activity (PEA).¹⁵⁹ At 4:35 p.m., EMS responders successfully started an interosseous¹⁶⁰ IV line in the anterior tibial area¹⁶¹ of the left leg and administered both Narcan¹⁶² (2 mg) and two doses of epinephrine¹⁶³ (1 mg).¹⁶⁴ PA (b)(6); (b)(7)(C) documented that EMS responders placed their own AED leads on TRAN and were able to obtain a weak pulse.¹⁶⁵

At 4:44 p.m., EMS responders placed TRAN on a gurney and departed the east side of Bravo 600.

At 4:45 p.m. (b)(6); (b)(7)(C) documented that the cardiac monitor showed sinus rhythm¹⁶⁶ before EMS moved TRAN to the ambulance.¹⁶⁷ EMS responders specifically documented a sinus tachycardia, which is sinus rhythm at a rate higher than 100 beats per minute.¹⁶⁸ At 4:53 p.m., the ambulance exited EDC for BCGMC.¹⁶⁹

Sergeant (b)(6); (b)(7)(C) assigned Correctional Officers A (b)(6); (b)(7)(C) to hospital detail; Officer (b)(6); (b)(7)(C) drove the chase vehicle and Officer (b)(6); (b)(7)(C) rode in the ambulance with TRAN.¹⁷⁰ Officer (b)(6); (b)(7)(C) recalled that the ambulance drove with both lights and sirens activated and arrived at the hospital within approximately 15 minutes.¹⁷¹

At 5:14 p.m., the ambulance arrived at BCGMC.¹⁷² Officer (b)(6); (b)(7)(C) stated that upon arrival to the emergency room (ER), BCGMC staff placed TRAN on a respirator in ER Room 2 and heard them say TRAN had a low pulse.¹⁷³ At 5:20 p.m., medical staff stabilized TRAN.¹⁷⁴ At 6:16 p.m., BCGMC staff transported TRAN to have a computed tomography (CT) scan, the

¹⁵⁷ See Eloy Fire District Prehospital Care Report, dated June 5, 2018.

¹⁵⁸ An idioventricular rhythm is an independent cardiac rhythm caused by repeated discharge of impulses at a rate of less than 60 beats per minute.

¹⁵⁹ PEA is when the monitor will show electrical activity in the heart but there will be no palpable pulse.

¹⁶⁰ Interosseous refers to marrow within bones.

¹⁶¹ The anterior tibial area of the leg is also called the shin.

¹⁶² Narcan is a drug used by emergency responders to reverse the effects of a narcotic overdose.

¹⁶³ Epinephrine is a hormone produced by the adrenal glands, which functions to increase cardiac output and to raise glucose levels in the blood.

¹⁶⁴ (b)(6); (b)(7)(C) explained that EMS responders most likely administered Narcan because it is a routine EMS procedure; ERAU interview with NP (b)(6); (b)(7)(C), dated July 17, 2018.

¹⁶⁵ See Emergency Response Note by PA (b)(6); (b)(7)(C), dated June 5, 2018.

¹⁶⁶ A sinus rhythm is a normal heart beat, both with respect to heart rate and rhythm. During a sinus rhythm, the heart rate is between 60 and 100 beats per minute.

¹⁶⁷ See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 5, 2018.

¹⁶⁸ See Eloy Fire District Prehospital Care Report, dated June 5, 2018.

¹⁶⁹ See CoreCivic Incident Investigation Report, Milestone video surveillance timeline, dated June 19, 2018; *see also* EDC Rear Gate Log entry at 1653, dated June 5, 2018.

¹⁷⁰ See EDC Incident Statement by Officer (b)(6); (b)(7)(C) dated June 12, 2018.

¹⁷¹ ERAU Interview with Officer (b)(6); (b)(7)(C) dated July 17, 2018.

¹⁷² See Hospital Logbook, dated June 5, 2018. ERAU notes the Eloy Fire District Prehospital Care Report states the ambulance arrived at the BCGMC at 5:11 p.m.

¹⁷³ ERAU interview with Officer (b)(6); (b)(7)(C) dated July 17, 2018.

¹⁷⁴ See Hospital Log book, dated June 5, 2018.

documented findings from which were negative.¹⁷⁵ At 8:16 p.m., BCGMC staff moved TRAN to the intensive care unit (ICU) room 8. A BCGMC provider documented a diagnosis of acute cardiopulmonary arrest¹⁷⁶ with return of spontaneous circulation,¹⁷⁷ and suspected anoxic brain injury.¹⁷⁸

Following the medical emergency, EDC Chief of Security Chance Leeds, notified the EDC Warden via memo that he met with all EDC responders to assess how staff was coping and reminded them the Employee Assistance Program was available.¹⁷⁹

Unless otherwise noted, the events detailed from June 6 through June 12, 2018, are referenced from the hospital log maintained by CoreCivic Officers on hospital duty.

On June 6, 2018, the following events occurred:

- At 4:05 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN was on a ventilator and was receiving hypothermia therapy.¹⁸⁰ His most recent VS were a heart rate of 80 bpm, bp of 97/76, ventilator setting respiratory rate¹⁸¹ of 24, and a ventilator oxygen saturation of 98 percent. His medication treatment included Anectine,¹⁸² propofol,¹⁸³ Levophed,¹⁸⁴ Zosyn,¹⁸⁵ and normal saline.
- At 5:57 a.m., BCGMC staff took an X-ray of TRAN.
- At 6:45 a.m., BCGMC staff notified CoreCivic officers they were keeping TRAN under observation for 24 hours and cooling him down due to his cardiac arrest episode. BCGMC staff planned to warm TRAN back to regular temperature for further evaluation.
- At 10:15 a.m., BCGMC staff took labs. The doctor remarked that TRAN did not look promising but that they would have better insight into his medical state the next day.
- At 12:25 p.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged and BCGMC scheduled rewarming¹⁸⁶ for 9:30 p.m.¹⁸⁷ His most

¹⁷⁵ A CT scan is an X-ray which produces computerized cross-sectional images of specific areas of the body.

¹⁷⁶ Cardiopulmonary arrest, or cardiac arrest, is the abrupt loss of heart function, breathing and consciousness.

¹⁷⁷ Spontaneous circulation is when a normal heart rhythm and pulse returns.

¹⁷⁸ An anoxic brain injury is an injury caused by a complete lack of oxygen being provide to the brain, which results in the death of brain cells after approximately four minutes of oxygen deprivation. *See* BCGMC Emergency Department Pertinent Report, dated June 14, 2018.

¹⁷⁹ *See* CISM Response to Incident #2018-0902-079-I, dated June 18, 2018. EDC Chief of Security Leeds is a member of the CoreCivic Critical Incident Stress Management (CISM) Team.

¹⁸⁰ Hypothermia therapy is a treatment used for patients who have a cardiac arrest. The body's temperature is lowered to around 89 to 93 degrees, using cooling devices, in an attempt to reduce damage to the brain. *See* eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 6, 2018.

¹⁸¹ Ventilator respiratory rate is the set rate for delivering breaths per minute. The ventilator can adjust as the patient's respiratory rate changes, if the rate drops below the set rate the ventilator will adjust to breathe that rate for the patient.

¹⁸² Anectine is a muscle relaxant.

¹⁸³ Propofol is a type of drug which causes relaxation and sleepiness before and during medical procedures.

¹⁸⁴ Levophed is the brand name for norepinephrine, a drug used to treat low blood pressure and heart failure.

¹⁸⁵ Zosyn is an antibiotic medication used to treat infections.

¹⁸⁶ BCGMC targeted a temperature of 98.6 degrees Fahrenheit. The goal was to maintain that temperature for 72 hours.

¹⁸⁷ *See* eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 6, 2018.

recent VS were a heart rate of 91 bpm, bp of 93/65, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 98 percent. TRAN's labs showed an elevated aspartate transferase (AST) and alanine transaminase (ALT)¹⁸⁸ and that he was positive for clostridium difficile infection (C-diff),¹⁸⁹ with blood in his stool. TRAN's CT scan and drug screen were negative. BCGMC staff planned to take TRAN off paralytic medication the following day.

- At 5:26 p.m., Captain (b)(6); (b)(7)(C) approved a visit by TRAN's father. In follow-up calls, Captain (b)(6); (b)(7)(C) also approved visits by TRAN's mother and sister.
- At 7:57 p.m., TRAN's mother and father arrived to visit; they left at 9:39 p.m.

On June 7, 2018, the following events occurred:

- At 2:00 a.m., BCGMC staff reversed sedation.
- At 2:04 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN remained unresponsive with no reflexes. BCGMC staff initiated the rewarming process the night before, discontinued paralytic medications, and prescribed Versed,¹⁹⁰ Protonix,¹⁹¹ normal saline, Flagyl,¹⁹² and Zosyn intravenously and vancomycin¹⁹³ via an orogastric (OG) tube.¹⁹⁴ BCGMC staff scheduled TRAN to see an intensivist¹⁹⁵ later that day. TRAN's most recent VS were a heart rate of 109 bpm, bp of 103/66, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 96 percent.
- At 3:30 a.m., the doctors' tests results were negative, showing no higher brain function. The doctors' planned to return the next morning for further evaluation.
- At 9:25 a.m., TRAN's parents visited and doctors informed them that they were not optimistic about their son's recovery. TRAN's parents left at 10:50 a.m.
- At 11:13 a.m., EDC RN (b)(6); (b)(7)(C) documented, that per BCGMC, TRAN's condition remained unchanged.¹⁹⁶ TRAN had no pupillary reflex,¹⁹⁷ no pain response, and exhibited no signs of waking. BCGMC staff discontinued Versed earlier in the day, and he remained on the other medications. A neurologist waited to perform an electroencephalogram (EEG)¹⁹⁸ until medical staff discontinued the other medications. TRAN now showed evidence of kidney injury. TRAN's most recent VS were a heart rate of 109 bpm, bp of 132/85, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 97 percent. TRAN's core body temperature was 98.8 degrees Fahrenheit.

¹⁸⁸ AST and ALT are enzymes found in the liver. Their ratio is commonly used to measure liver health.

¹⁸⁹ C-diff is an inflammation of the colon caused by the bacteria Clostridium difficile.

¹⁹⁰ Versed is a brand name for midazolam, a sedative medication used to help patients feel relaxed or sleepy before a medical procedure.

¹⁹¹ Protonix is a brand name for pantoprazole, a drug used to treat gastroesophageal reflux disease and a damaged esophagus.

¹⁹² Flagyl is a brand name for metronidazole, a drug used to treat infections.

¹⁹³ Vancomycin is a drug used to treat infections.

¹⁹⁴ An OG tube is a small tube placed in the mouth and end with the tip in the stomach, to administer feeding, medication or to remove the contents of the stomach. See eCW Hospital Update, by (b)(6); (b)(7)(C) dated June 7, 2018.

¹⁹⁵ An intensivist is a physician who specializes in the care of critically-ill patients, most often in the intensive care unit (ICU).

¹⁹⁶ See eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 7, 2018.

¹⁹⁷ Pupillary reflex refers to the changes in diameter of the pupils when exposed to light.

¹⁹⁸ An electroencephalogram (EEG) is a test used to record and monitor electrical activity of the brain.

- At 12:20 p.m., the ICU doctor stated TRAN may not wake up.
- At 1:45 p.m., nurses stated there was a very faint pupil reaction to light, a slight difference from the morning when there was none.

On June 8, 2018, the following events occurred:

- At 1:38 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN remained unresponsive except for a sluggish pupillary reflex to the left eye.¹⁹⁹ Blood tests and an EEG were planned for this date. TRAN's most recent VS were a heart rate of 100 bpm, bp of 114/65, ventilator setting respiratory rate of 24, a ventilator oxygen saturation of 94 percent, and a body temperature of 98.6 degrees Fahrenheit.
- At 10:45 a.m., a BCGMC doctor asked who could authorize TRAN's dialysis; the officer on watch advised the doctor that ICE could authorize the dialysis.
- At 11:33 a.m., a BCGMC doctor arrived to evaluate TRAN and his family arrived for visitation.
- At 12:00 p.m., a BCGMC doctor updated the family on TRAN's condition and treatment plan.
- At 1:10 p.m., BCGMC staff asked TRAN's family to leave so they could implant the dialysis²⁰⁰ tubing, which they planted in TRAN's neck at 1:45 p.m.
- At 7:55 p.m., TRAN's family returned and then departed at 10:00 p.m.

On June 9, 2018, the following events occurred:

- At 3:37 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's responsive state and medications remained the same.²⁰¹ TRAN received dialysis the previous day, but BCGMC staff extracted no fluids. BCGMC staff started feedings through the OG tube late on June 8, 2019 to stabilize TRAN's glucose levels. Again, neurology planned to perform an EEG once medical staff discontinued all other medications and improvement was observed. TRAN's most recent VS were a heart rate of 96 bpm, bp of 105/66, ventilator setting respiratory rate of 24, a ventilator oxygen saturation of 95 percent and a body temperature of 97.3 degrees Fahrenheit. The labs showed a decrease in TRAN's AST and ALT and an increase in his creatinine, blood urea nitrogen (BUN)²⁰² and CO2.
- At 9:20 a.m., BCGMC staff began TRAN's dialysis, which ended at 6:00 p.m.
- Between 10:35 a.m. and 7:35 p.m., six family members visited TRAN.
- At 1:06 p.m., EDC RN (b)(6); documented that per BCGMC, TRAN's condition remained unchanged.²⁰³ BCGMC staff planned to perform an EEG and brain stem testing in two days. TRAN's most recent VS were a heart rate of 96 bpm, bp of 105/66, ventilator setting respiratory rate of 24, and a ventilator oxygen saturation of 97 percent.²⁰⁴

¹⁹⁹ See eCW Hospital Update, by RN (b)(6); dated June 8, 2018.

²⁰⁰ Dialysis is the clinical purification of blood as a substitute for the normal function of a kidney.

²⁰¹ See eCW Hospital Update, by RN (b)(6); dated June 9, 2018. An addendum was added at 3:38 a.m.

²⁰² BUN is a medical test that measures the amount of urea nitrogen found in blood. The liver produces urea in the urea cycle as a waste product of the digestion of protein.

²⁰³ See eCW Hospital Update, by RN (b)(6); dated June 9, 2018.

²⁰⁴ If provided, RN (b)(6); did not document TRAN's body temperature within the progress note.

- At 8:23 p.m., TRAN's sister arrived and stayed until 11:00 p.m.

On June 10, 2018, the following events occurred:

- At 1:08 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰⁵ His pupils were fixed and dilated, he had no pain response, and exhibited no signs of waking. TRAN's most recent VS were a heart rate of 93 bpm, bp of 120/67, ventilator setting respiratory rate of 24, a ventilator oxygen saturation of 94 percent and a body temperature of 97.7 degrees Fahrenheit. BCGMC staff's treatment goal was to continue monitoring his neurological status.
- At 12:12 p.m., TRAN's sister arrived and departed at 1:33 p.m.
- At 5:00 p.m., TRAN's parents arrived and his sister later returned. The last visitor left at 10:40 p.m.

On June 11, 2018, the following events occurred:

- At 6:31 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰⁶ TRAN remained on dialysis and medical staff planned to perform a CT scan to determine if any brain changes had occurred from the baseline scan completed on June 5, 2018. TRAN's VS were within normal limits, except for an increased heart rate of 103 bpm and an elevated bp of 160/110.
- At 9:00 a.m., medical staff conducted a test to determine if TRAN could breathe on his own; it was determined he could not.
- At 9:25 a.m., a family member arrived, and others continued to arrive throughout the day.
- At 9:55 a.m., BCGMC doctors informed TRAN's sister that there was little chance he would survive.
- At 10:21 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged.²⁰⁷ BCGMC staff ordered a CT scan. TRAN's VS remained within normal limits, except for an elevated blood pressure of 154/106.
- At 11:15 a.m., a BCGMC doctor spoke with TRAN's family members about the possibility of organ donation if there was no brain function after testing.
- At 11:55 a.m., BCGMC staff conducted an echocardiogram.²⁰⁸
- At 2:55 p.m., BCGMC staff conducted a neural X-ray.²⁰⁹
- At 4:42 p.m., BCGMC staff started TRAN's dialysis, which ended at 7:08 p.m.

June 12, 2018, Day of Death

- At 1:42 a.m., EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, TRAN's condition remained unchanged, VS were within normal limits and MRI results were pending.²¹⁰

²⁰⁵ See eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 10, 2018.

²⁰⁶ See eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 11, 2018.

²⁰⁷ See eCW Hospital Update, by RN (b)(6); (b)(7)(C) dated June 11, 2018.

²⁰⁸ An echocardiogram is a test using ultrasound to make pictures of the heart.

²⁰⁹ A neural X-ray refers to a particular kind of brain X-ray used to determine proof of brain death.

²¹⁰ See eCW Hospital Update, RN (b)(6); (b)(7)(C) dated June 11, 2018.

- At 8:43 a.m., Correctional Officer (b)(6); (b)(7)(C) a recorded BCGMC staff conducted a test to determine if TRAN showed any brain activity.²¹¹
- At 11:42 a.m., BCGMC RN (b)(6); (b)(7)(C) notified Officer (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) pronounced TRAN brain dead²¹² at 9:20 a.m.²¹³ Officer (b)(6); (b)(7)(C) stated this was the first he heard of TRAN's death.²¹⁴
- At 11:43 a.m., Officer (b)(6); (b)(7)(C) called Shift Supervisor (b)(6); (b)(7)(C) to notify him that although medical staff had pronounced TRAN deceased at 9:20 a.m., they just informed him of the news.
- At 2:00 p.m., Officers (b)(6); (b)(7)(C) relieved Officers (b)(6); (b)(7)(C) (b)(6); (b)(7)(C). At 2:30 p.m., the Pinal County Medical Examiner arrived to take TRAN's fingerprints.
- At 2:40 p.m., BCGMC medical staff removed TRAN from life support and pronounced his cardiac death.²¹⁶
- At 3:43 p.m., BCGMC RN (b)(6); (b)(7)(C) completed a Banner Health AZ Human Remains Release form and documented the diagnosis as anoxic encephalopathy,²¹⁷ acute respiratory failure,²¹⁸ and acute renal failure.²¹⁹ Additionally, (b)(6); (b)(7)(C) (first name unknown), a representative from the Medical Examiner's office, signed for custody of TRAN's body.²²⁰
- At 3:55 p.m.,²²¹ EDC RN (b)(6); (b)(7)(C) documented that per BCGMC, medical staff conducted an EEG at 7:29 a.m. that showed no brain activity.²²² BCGMC staff confirmed these findings through apneic testing.²²³ RN (b)(6); (b)(7)(C) further documented a BCGMC doctor declared TRAN brain dead at 9:20 a.m. and that TRAN's family members were notified of his passing and were expected to arrive at the hospital that afternoon. Medical staff planned to discontinue the ventilator at that time.
- At 3:59 p.m., (b)(6); (b)(7)(C) departed the hospital with TRAN's remains.

²¹¹ ERAU telephonic interview with Officer (b)(6); (b)(7)(C) July 18, 2018.

²¹² Brain death is irreversible brain damage causing the end to independent breathing.

²¹³ See D. Houston Incident Statement, dated June 12, 2018.

²¹⁴ ERAU telephonic interview with Officer (b)(6); (b)(7)(C) July 18, 2018.

²¹⁵ Both Officers (b)(6); (b)(7)(C) submitted incident statements on June 12, 2018; however, the times they provide in their statements are not consistent with entries in the hospital log they kept. Within this report, entries made in the hospital log are used.

²¹⁶ See Exhibit 1: Pinal County Forensic Examination Report, dated July 17, 2018. Cardiac death is when the heart stops beating.

²¹⁷ Anoxic encephalopathy is a condition where brain tissue is deprived of oxygen and there is a global loss of brain function.

²¹⁸ Acute respiratory failure occurs when fluid builds up in the air sacs in the lungs. When this happens, the lungs cannot release oxygen into the blood.

²¹⁹ Acute renal failure occurs when the kidneys suddenly lose the ability to eliminate excess salts, fluids, and waste material from the blood. See Banner Health AZ Human Remains Release Form, dated June 12, 2018.

²²⁰ See Banner Health AZ Human Remains Release Form, dated June 12, 2018.

²²¹ Although the note is marked that it was entered at 3:55 p.m., this may indicate the time the RN signed the note and not the actual time the hospital provided information as TRAN was taken off the ventilator at 2:40 p.m.

²²² See eCW Telephone Encounter, by (b)(6); (b)(7)(C) dated June 12, 2018.

²²³ (b)(6); (b)(7)(C) testing is an essential component in the clinical determination of brain death. The main objective of apnea testing is to prove the absence of respiratory control system reflexes in the brainstem when intense physiologic stimulation to breathe takes place.

Post Death Events

On June 13, 2018, Phoenix Field Office Director (FOD) Enrique Lucero signed a letter to TRAN's family offering his condolences for their loss.²²⁴

On June 19, 2018, the Consulate General of Vietnam in San Francisco wrote that TRAN's family received his body and conducted his burial. They requested ICE clarify the cause of death and share other information related to TRAN's death.²²⁵

The Facility Investigator signed the Incident Investigation Report she began at Warder (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) quest on June 5, 2018.²²⁶

On June 20, 2018, EDC staff mailed TRAN's property and funds to his father in Mesa, AZ and on June 21, 2018, the package was received and signed for.²²⁷

On July 6, 2018, the State of Arizona Certification of Vital Record issued a Certificate of Death documenting TRAN's immediate cause of death as pending investigation.²²⁸

On July 17, 2018, Chief Medical Examiner (b)(6); (b)(7)(C) ID, signed the completed forensic examination report, stating the cause of death was coronary artery disease.²²⁹

MEDICAL CARE AND SECURITY REVIEW

ERAU reviewed the medical care EDC provided TRAN, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found deficiencies in EDC's compliance with certain requirements of the ICE PBNDS 2011 (as revised in 2016).

1. ICE PBNDS 2011, *Medical Care*, Section (II)(20), which states, "Prescriptions and medications shall be ordered, dispensed and administered in a timely manner and as prescribed by a licensed health care professional. This shall be conducted in a manner that seeks to preserve the privacy and personal health information of detainees."
 - Although the NP (b)(6); (b)(7)(C) prescribed TRAN fluoxetine and haloperidol at intake on May 28, 2018, TRAN did not receive his first dose of either medication until May 30, 2018. If TRAN received a dose from the intake supply, medical staff did not document the administration of the medications. NP (b)(6); (b)(7)(C) ended her employment with EDC prior to the site visit; therefore, ERAU could not discuss this issue with NP (b)(6); (b)(7)(C) to determine whether the break in medication was determined acceptable.

²²⁴ See Written correspondence from Phoenix FOD Enrique M. Lucero, dated June 13, 2018.

²²⁵ ERAU notes EDC was unable to confirm a follow-up response to the Vietnam Consulate.

²²⁶ See CoreCivic Incident Investigation Report, dated June 19, 2018.

²²⁷ See U.S. Postal Service Certified Mail Receipt.

²²⁸ See Exhibit 8: State of Arizona Certification of Vital Record: Certificate of Death, dated July 6, 2018.

²²⁹ See Exhibit 1: Pinal County Forensic Examination Report, dated July 17, 2018.

2. ICE PBNDS 2011, *Medical Care*, Section (V)(AA)(4), which states, “Prior to the administration of psychotropic medications, a separate documented informed consent, that includes a description of the medication’s side effects shall be obtained.”
 - Medical staff did not obtain a signed consent form from TRAN at FSF for psychotropic medications started on May 26, 2018.
 - Medical staff did not obtain a signed consent form from TRAN at EDC for psychotropic medications started on May 30, 2018 until June 4, 2018. The signed consent form documents the psychiatrist discussed the side effects with TRAN but does not list any side effects. The side effects were, however, listed in the psychiatrist’s encounter note.
3. ICE PBNDS 2011, *Custody Classification System*, Section (V)(A)(4), which states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”
 - A supervisor did not approve the classification rating assigned to TRAN on May 28, 2018.
4. ICE PBNDS 2011, *Special Management Units*, Section (V)(M), which states, “Close Supervision Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly.”
 - Per the psychologist’s order, due to placement on MHO, CoreCivic officers were to conduct welfare checks on TRAN every 15 minutes. Surveillance footage evidence showed the CoreCivic officer on duty issued TRAN linens at 3:00 p.m. but did not look into TRAN’s cell again until 3:51 p.m. During the 51-minute period, the officer documented three welfare checks, none of which were supported by video surveillance.

AREAS OF CONCERN

ERAU noted the following generalized concerns regarding TRAN’s medical care:

- Because the pharmacy did not receive (b)(6); (b)(7)(C) orders to change the administration times of TRAN’s medication during pharmacy hours, the pharmacy did not process his orders until the next day, after TRAN already received his once-daily dose of fluoxetine. As a result, he received twice the prescribed daily dose of fluoxetine.
- (b)(6); (b)(7)(C) did not order Cogentin to treat TRAN’s EPS symptoms as intended. He stated that his failure to order Cogentin was an oversight.
- EDC medical staff did not take TRAN’s VS during his mental health appointments on June 4, 2018 and June 5, 2018. Although policy did not require VS, Creative Corrections advised they are a key factor in the early detection of life-threatening conditions.

- CoreCivic staff observed TRAN unresponsive in his SMU cell within approximately three hours after the psychologist ordered his assignment to MHO. The segregation medical clearance completed by RN (b)(6); (b)(7)(C) consisted only of a medical record review. Per HSA (b)(6); (b)(7)(C) medical should assess detainees in-person before medically clearing them for segregation. As RN (b)(6); (b)(7)(C) did not conduct an in-person assessment, she did not obtain TRAN's VS nor did she conduct an assessment of his physical condition.
- During the medical emergency response, the medical team leader did not place the AED pads in the proper position and did not dry TRAN's skin before attempting placement after noticing his skin was moist. The pads did not adhere, rendering the AED ineffective in analyzing heart activity. ERAU cannot determine whether the pads did not adhere because they had expired or because TRAN was perspiring. The emergency bag inventory did not list AED pad expiration dates, nor did it include a second set of pads. Thorough inventories of emergency bag contents, to include review of AED pad expiration dates and a second set of pads, helps to ensure necessary equipment is available and operable during medical emergency events.
- (b)(6); (b)(7)(C) physical examination entry included documentation that TRAN had no lower teeth and was missing other upper teeth, but she did not order a special diet to assure TRAN's nutritional intake was adequate.

ERAU noted the following concerns related to safety and security:

- After Office (b)(6); (b)(7)(C) called the medical emergency, the first security responders arrived within an estimated three minutes. They stood at the cell but did not enter to render aid. Despite (b)(7)(E) and one correctional counselor being present, one responding officer stated they did not enter out of concern for their safety. (b)(6); (b)(7)(C) and another male officer arrived on scene shortly thereafter and entered the cell, followed by the initial responders. Following the emergency response (b)(6); (b)(7)(C) clarified to the responding officers that when (b)(7)(E) are present, regardless of the gender of the detainee or responders, they should enter the cell.
- For the first 46 seconds of the medical emergency recording, the handheld camera lens cover would not fully open. Following the medical emergency (b)(6); (b)(7)(C) sent the handheld camera out for repair of the slide action that jammed to correct the identified malfunction.
- When Captain (b)(6); (b)(7)(C) arrived on site, he asked Office (b)(6); (b)(7)(C) to stop recording the medical emergency, prior to EMS arriving, as he believed it was a HIPAA violation. Captain (b)(6); (b)(7)(C) incorrectly viewed the recording of CPR as a HIPAA violation, as Creative Corrections advised that HIPAA does not apply to those in custody of the Federal Government.

TABLE ONE		
Offense	Conviction Date	Sentence
Disorderly Conduct	June 6, 1994	12 months of probation
Shoplifting	December 5, 1996	Fined \$320.00
Shoplifting	December 4, 1996	Fined \$300.00
Disorderly Conduct	August 22, 1997	Three years of probation
Disorderly Conduct	April 30, 1999	Three years of probation
Driving with License Suspended; Failure to Appear/Failure to Pay	November 18, 1999	18 days incarceration
Aggravated Assault	October 25, 2000	3 years, 6 months incarceration (credit 210-days' time served)
Aggravated Assault		Three years of probation

TABLE TWO		
Offense	Conviction Date	Sentence
Disorderly Conduct	May 11, 2007	120 days incarceration
Criminal Damage		One year of probation
Shoplifting	May 11, 2007	One year of probation
Criminal Damage (Two Counts)	November 10, 2008	90 days incarceration
Aggravated Assault	April 8, 2009	Five years' incarceration (credit 224-days' time served)

EXHIBITS

1. Pinal County Forensic Examination Report, dated July 17, 2018.
2. Creative Corrections Healthcare and Security Compliance Analysis.
3. Initial Custody Classification Form 18-1B, dated May 28, 2018.
4. EDC Medical Administration Record (MAR) for Huy Chi Tran, dated May 2018.
5. Immigration Health Services Corp Consent Form for Psychotropic Medications for Adults, dated June 4, 2018.
6. Confinement Record Form, dated June 5, 2018.
7. Confinement Watch Log, dated June 5, 2018.
8. State of Arizona Certification of Vital Record: Certificate of Death, dated July 6, 2018.



PINAL COUNTY

WIDE OPEN OPPORTUNITY

FORENSIC EXAMINATION REPORT
HUY-CHI TRAN
PINAL COUNTY ME CASE #18-303
CASA GRANDE POLICE DEPARTMENT
CASE #18-00036663

Pinal County

JUL 17 2018

Medical Examiner

Report of Examination

ME Case number: 18-303
Agency, number: CGPD, 18-00036663
Decedent: Huy-Chi Tran
Date of birth: August 7, 1970
Date of death: June 12, 2018
Date of examination: June 14, 2018
Time of examination: 1000 hours
Investigator: (b)(6); (b)(7)(C)
Forensic Technician: (b)(6); (b)(7)(C)
Present at examination: Chief (b)(6); (b)(7)(C) ICE

Cause of Death: Coronary artery disease
Manner of Death: Natural

July 17, 2018

Date Signed

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

J
Chief Medical Examiner

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

REPORTED CIRCUMSTANCES OF DEATH

The decedent was a 47-year-old unmarried Asian male who was an inmate at a prison in Eloy, Arizona. On June 5, 2018, he was found unresponsive in his single-man cell. Resuscitative efforts were initiated on scene, and the decedent was transported to Banner Casa Grande Medical Center. He was placed on life support in the Intensive Care Unit. When there was no response to treatment, those measures were removed. Brain death was pronounced at 0920 hours on June 12, 2018. He was then taken off of the ventilator, and cardiac death was pronounced at 1440 hours on June 12, 2018.

Past Medical/Social History

According to Banner Health Medical records

The decedent was reportedly found unconscious in his cell, and had been down for an unknown period of time. He received chest compressions for 10 minutes before EMS arrival. He was found to be in PEA, and received two rounds of epinephrine. A heartbeat subsequently returned and he was transported to Banner Casa Grande Medical Center. After admission he was diagnosed with clostridium difficile in the stool. He was declared brain dead. His condition continued to decline until death was pronounced on June 12, 2018.

- A. Acute kidney injury, likely due to severe hemodynamic acute tubular necrosis from cardiac arrest
- B. Anoxic brain injury
- C. Cardiogenic shock
- D. Acute respiratory failure
- E. Schizophrenia
 - a. Haloperidol
 - b. Fluoxetine
- F. Metabolic acidosis/respiratory alkalosis
- G. Possible clostridium difficile infection
- H. Leukocytosis
- I. Thrombocytopenia, possibly antibiotic related
- J. Gastrointestinal bleeding
- K. Status post cardiac arrest, on hypothermia protocol
- L. Acute renal and hepatic failure
- M. CT of the brain on June 5, 2018
 - a. No intracerebral arterial or venous activity
- N. Subsequently declared brain dead, initial CT of head negative for trauma
- O. Initial urine drug screen unremarkable
- P. CT of head in June 5, 2018
 - a. No acute intracranial abnormality identified
 - b. Findings suggestive of chronic sinusitis

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

- c. Presumed enteric tube appears coiled at the level of the nasopharynx

According to the medical records from Banner Casa Grande Medical Center

"This 47-year-old male was seen for evaluation 4B and nonresponsive. Medical staff responded to medical emergency call at 14:15 hours. Patient has no pulse and is not breathing, no reaction noted with sternal rub. Oxygen saturation was 48% at room air. Ambulance bagging with oxygen at 15 L/m was initiated while CPR was being done. Patient's shirt was cut in the middle of and AED pads were applied. Nursing staff attempted to obtain the patient's blood pressure but was unable to get a reading. Blood glucose was checked with a glucose which shows 280 mg/dL. Peripheral intravenous catheter insertion was attempted twice without success. Oxygen saturation reading was between 48% to 93% with peripheral pulse ranging from 50-115 during CPR. Provided examined oral cavity for up structuring and was returned. CPR lasted 17 minutes before the paramedics arrived. AED shocked the patient multiple times during the resuscitation but without a shockable rhythm. EMS assume resuscitation on 1633 hrs. IV was started via intravenous route. Patient was given Narcan and epinephrine. Cardiac monitor showed sinus rhythm. Patient was transferred to the ambulance en route to Banner Casa Grande Medical Center."

INITIAL EXTERNAL EXAMINATION

The body is received in a zippered body pouch secured by evidence seal number 00002659.

CLOTHING AND PERSONAL EFFECTS

All property is documented on the property sheet that is separate in the file.

EVIDENCE OF MEDICAL INTERVENTION

There is an endotracheal tube present in the mouth. There is an orogastric tube present in the mouth. There is a central line present on the right neck. There is a central line present on the left neck. There is an oval shaped compression pad present on the midline chest. There are two defibrillator pads present on the front of the chest. There are multiple EKG leads present on the front of the chest. There is a foley catheter in place. There is a pulse oximeter probe affixed to the right index finger. There are multiple needle puncture marks present on the left antecubital fossa. There is a needle puncture mark present on the right antecubital fossa.

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

EVIDENCE OF TRAUMA

There are bluish contusions on the midline lower chest from cardiopulmonary resuscitation. There are bilateral anterior rib fractures. There is a vertical fracture of the lower sternum with intercostal muscle contusion. There are mild infiltrative hemorrhages in the mediastinum.

These injuries, having been once described, will not be repeated.

SCARS, TATTOOS, AND OTHER IDENTIFYING BODY FEATURES

There are no significant scars or tattoos identified.

GENERAL EXTERNAL EXAMINATION

The body is cold to touch, subsequent to refrigeration. Rigor mortis is fully developed. Posterior red-purple lividity is partially fixed.

The body is that of a normally developed Asian male, measuring 68 inches in length and weighing 192 pounds. The general appearance is compatible with the reported age of 47 years. Scalp hair is black. The irises are brown, and there is no jaundice or lesions of sclera or conjunctivae. The nose is unremarkable. There is facial hair of a beard and mustache. The ears are unremarkable. The mouth is unremarkable. Teeth are natural. The neck is unremarkable. There are no palpable axillary, cervical, abdominal, or inguinal masses. The chest and back are symmetrical and unremarkable.

Body hair is normal in amount and distribution of an average male adult. The abdomen is mildly protuberant. The external genitalia, anus, and perineum are unremarkable. The extremities are symmetrical, without significant clubbing, edema, or deformity. Fingernails are intact.

INTERNAL EXAMINATION

The body is opened by a standard Y-shaped thoracoabdominal incision. All viscera occupy their appropriate anatomic relationships. Subcutaneous adipose tissue ranges up to 3 cm in thickness over the abdominal wall. Serous surfaces are smooth and glistening throughout. There are no adhesions or significant free fluid accumulations in the body cavities.

CARDIOVASCULAR SYSTEM

The pericardium is unremarkable. The heart weighs 490 grams. The heart occupies its usual mediastinal site, and has a smooth epicardial surface. The external configuration is not remarkable. All major vessels arise in their appropriate anatomic relationships. The coronary ostia are normally placed and

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

are patent. The coronary arteries arise normally, are distributed in a right dominant pattern, and contain severe atherosclerotic changes, with stenosis ranging from 30% in the proximal right coronary artery, 20% in the distal right coronary artery, 75% in the left circumflex artery, 30% in the left anterior descending coronary artery, and 50% in the left main coronary artery. The atria and ventricles are of normal caliber, and are free of gross anomalies and thrombi. The myocardium is red-brown and firm, with focal red areas in the upper part of the interventricular septum measuring 1 x 0.5 x 2.5 cm. The dark red area is close to the atrial ventricular valve. A histologic section from this area is obtained. This is consistent with acute myocardial ischemia. The rest of the myocardium is grossly unremarkable. The ventricular thicknesses are as follows: left ventricle 1.2 cm, interventricular septum 1.1 cm, right ventricle 0.2 cm, with 0.7 cm epicardial fatty tissue present.

The endocardium is unremarkable. The cardiac valve circumferences are appropriate for the caliber of the cardiac chambers. The cardiac valves have thin, pliable leaflets that are free of fusion, vegetations, or significant fenestrations.

The aorta is of normal caliber, with all major arterial branches arising in their appropriate anatomic relationship. The intimal surfaces contain mild atherosclerotic changes in the abdominal aorta, without aneurysm formation or dissection. No systemic venous abnormalities or thrombi are present.

RESPIRATORY SYSTEM

The upper airway, larynx, and trachea are patent, with no evidence of edema, ulceration, or obstruction. There is a small amount of gastric contents present in the trachea. The right lung weighs 640 grams and the left lung weighs 630 grams. The pleural surfaces are smooth and glistening. The parenchyma is well expanded. Sectioning reveals pink to red-purple tissue with no areas of induration, consolidation, hemorrhage, or gross scarring. The bronchi and pulmonary vessels are patent and of normal caliber.

DIGESTIVE SYSTEM

The tongue is unremarkable. The oropharynx is grossly normal and unobstructed. The esophagus is of normal caliber, with a smooth, gray-white mucosal lining. The gastroesophageal junction is well defined. The stomach has intact mucosal surfaces. The lumen contains 900 mL of brown fluid with a large amount of partially digested food. There are multifocal mucosal hemorrhages in the gastric lumen. There is no evidence of bleeding in the gastric lumen. There are no areas of mucosal ulceration, erosion, or scarring. The small and large intestines are not remarkable. The appendix is present in the right lower quadrant and is unremarkable. The tan-gray, lobular pancreas has no focal abnormalities. The pancreatic ducts are patent and of normal caliber.

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

HEPATOBIILIARY SYSTEM

The 2190 gram liver has a smooth capsule, covering red-brown parenchyma with focal mottled appearance. The liver tissue appears to be friable. The cut surfaces show no diffuse or focal abnormalities. The intrahepatic and extrahepatic biliary ducts are unremarkable. The gallbladder contains viscid olive green bile, and is free of calculi. The gallbladder mucosa is grossly normal.

GENITOURINARY SYSTEM

The right kidney weighs 200 grams and the left kidney weighs 230 grams. The kidneys are similar in shape, with intact capsules covering smooth, red-brown parenchyma. The capsules strip with ease. The cut surfaces show poorly defined corticomedullary junctions. The calyces, pelves, and ureters are unremarkable. The renal vessels are patent and of normal caliber.

The urinary bladder contains no urine. There is approximately 20 mL of dark yellow urine in the foley catheter bag. The mucosal surfaces are flat and pink-tan. The prostate gland appears to be slightly enlarged with multiple nodules.

RETICULOENDOTHELIAL SYSTEM

The 170 gram spleen has an intact, smooth, and glistening capsule covering dark purple, moderately soft parenchyma. Regional lymph nodes have their usual distribution and appearance.

ENDOCRINE SYSTEM

The thyroid and adrenal glands are grossly not remarkable.

NECK

The cervical spine, hyoid bone, and thyroid cartilage are intact and unremarkable. An anterior layer by layer neck dissection reveals focal hemorrhages on the surface of the left omohyoid muscle measuring 2 x 0.2 cm and on the left sternohyoid muscle surface measuring 1 x 0.2 cm. These hemorrhages appear to be superficial and do not involve the muscular parenchyma. There is no other hemorrhage in the strap muscles or soft tissues of the neck.

MUSCULOSKELETAL SYSTEM

The bony framework, supporting musculature, and soft tissues are grossly normal.

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

NERVOUS SYSTEM

The scalp is reflected in the usual fashion. There are no contusions, lacerations, or abrasions of the scalp or subscalpular structures. There are no skull fractures. The pituitary gland is unremarkable. The cerebral vessels are intact, with no malformation, aneurysm, thrombosis, or significant atherosclerotic narrowing. The cranial nerves are grossly normal.

The dura and dural sinuses are unremarkable except for a thrombus in the superior sagittal sinus. There are no epidural, subdural, or subarachnoid hemorrhages. The brain weighs 1470 grams. The leptomeninges are thin and clear. The cerebral hemispheres are symmetrical, extremely soft, and disintegrate upon removal from the cranial cavity. The external landmarks for the superior cerebral surfaces are unremarkable with normal convolutional patterns, however the gyri appear to be edematous, with narrowing of the sulci. There are no uncal, subfalcial, transtentorial, or tonsillar herniations. Multiple sections of cerebrum, cerebellum, and brain stem reveal poorly defined gray-white borders and the brain tissue is extremely soft, consistent with anoxic encephalopathy. The ventricular system is symmetrical and compressed.

TOXICOLOGY SPECIMENS

Samples of the following are collected and some submitted for toxicological testing.

- Vitreous fluid.
- Blood.
- Urine.
- Heart tissue.
- Admission specimens

The toxicology report is separate in the file.

MICROSCOPIC EXAMINATION

Multiple microscopic sections are reviewed. Apart from information listed below, histology findings correspond to the gross diagnoses and provide no further information.

Cassettes:

Heart: Multiple focal myocardial ischemia and necrosis with mild neutrophil infiltrates.

Lungs: Multiple microscopic foci and pneumonia; focal atelectasis; marked increase of macrophages.

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

FINAL SUMMARY

Based on the forensic examination findings and investigative history as available to me, it is my opinion that Huy-Chi Tran, a 47-year-old Asian male, died as a result of coronary artery disease.

The manner of death is natural.

As with all death investigations, opinions expressed herein are amenable to change should new, reliable, and pertinent information come to light.

The Pinal County Medical Examiner's Office is required by statute (A.R.S. § 11-594(A) (2) and (4)) to certify the cause and manner of death following completion of the death investigation of each case over which it assumes jurisdiction, and to promptly execute a death certificate, on a form provided by the state registrar of vital statistics, indicating the cause and manner of death. The form provided by the state registrar of vital statistics includes five manners of death: homicide, suicide, accident, natural, and undetermined. The determination of manner of death is a forensic determination by the pathologist predicated upon the totality of all then-known forensic evidence and other circumstances surrounding the cause of death; it is not a legal determination of criminal or civil responsibility of any person(s) for the death. The significant findings below may not be a complete list of the decedent's medical history.

Significant findings

- I. Sudden cardiac death due to coronary artery disease
 - a. Cardiopulmonary arrest, status post resuscitation
 - b. Myocardial ischemia and necrosis
 - c. Multiple organ failure
 - i. Multiple microscopic foci of pneumonia
 - ii. Myocardial ischemia and necrosis
 - iii. Acute renal failure
 - iv. Anoxic brain injury
 - v. Cardiogenic shock
 - vi. Acute respiratory failure
 - vii. Metabolic acidosis
 - viii. Possible clostridium difficile infection
 - ix. Thrombocytopenia
 - x. History of gastrointestinal bleeding
 - xi. Hepatic failure
 - xii. CT of the brain revealed no acute intracranial hemorrhage
 - xiii. Anoxic encephalopathy
- II. Schizophrenia
- III. Toxicology negative
- IV. No evidence of trauma

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

Laboratory Case Number: 3149324	Subject's Name: TRAN, HUYCHI
Client Account: 14185 / PCME01 Physician: Report To: Pinal County AZ Med Exam Office ATTN: Pinal County 570 W. Adamsville Road Florence, AZ 85132 FX: 520-866-7296	Agency Case #: 18-303 Date of Death: 06/12/2018 Test Reason: Other Investigator: (b)(6) Date Received: 06/18/2018 Date Reported: 06/26/2018

Laboratory Specimen No: 40728713	Date Collected: 06/14/2018 10:30
Container(s): 01:RTB Blood, ILIAC	Test(s): 70530 Drugs of Abuse Panel, Blood

Analyte Name	Result	Concentration	Units	Therapeutic Range	Loc
AMPHETAMINES	Negative				
BARBITURATES	Negative				
BENZODIAZEPINES	Negative				
CANNABINOIDS	Negative				
COCAINE/METABOLITES	Negative				
FENTANYL	Negative				
METHADONE/METABOLITE	Negative				
OPIATES	Negative				
OXYCODONE/METABOLITE	Negative				
PHENCYCLIDINE	Negative				
PROPOXYPHENE/METABOLITE	Negative				
ALCOHOL	Negative				
Methanol	Negative				
Ethanol	Negative				
Acetone	Negative				
Isopropanol	Negative				
ANALGESICS	Negative				
BUPRENORPHINE	Negative				
STIMULANTS	Negative				
TRAMADOL/METABOLITE	Negative				

Specimens will be kept for two year from the date received.

The Specimen identified by the Laboratory Specimen Number has been handled and analyzed in accordance with all applicable requirements.

Laboratory Director

TRAN, HUYCHI

Case Reviewer

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

.D., F-ABFT

Laboratory Case #: 3149324
Print Date/Time: 06/26/2018, 10:02

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

Page: 1 of 1

DETAINEE DEATH REVIEW: Huy Chi TRAN, A037949945
Healthcare and Security Compliance Analysis
Eloy Federal Contract Facility
Eloy, Arizona

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Huy Chi TRAN while in the custody of the Eloy Federal Contract Facility in Eloy, Arizona. A site visit was conducted July 17-19, 2018 by ERAU staff (b)(6); (b)(7)(C), Management and Program Analyst and team leader, (b)(6); (b)(7)(C), Inspection and Compliance Specialist, and Creative Corrections contract personnel (b)(6); (b)(7)(C) Security Subject Matter Expert and (b)(6); (b)(7)(C), RN, Healthcare Subject Matter Expert. Contractor participation was requested to assess compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011, revised 2016, governing medical care and security operations.

This report is a collaborative effort on the part of the SMEs who participated in the site visit and (b)(6); (b)(7)(C) Program Manager for the OPR/ERAU contract. Included in this report is a case synopsis, description of the facility and its healthcare services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of detainee TRAN's medical record and detention file; tour of the medical clinic, housing unit, and intake area; interviews of staff; and review of policies, video surveillance footage, and available incident related documentation.

SYNOPSIS

Huy Chi TRAN, 47 years old, was admitted to the Florence Special Processing Center on May 25, 2018 and was transferred to the Eloy Federal Contract Facility three days later, on May 28, 2018. He reported a long term history of schizophrenia and depression for which treated with psychiatric medications. A medical provider examined TRAN the day he was admitted and after consultation with a psychiatrist, ordered the medications which arrived with TRAN, Haldol and fluoxetine, pending psychiatric review. The medications were started the second day after they were ordered.

Pursuant to referrals from the provider and the intake nurse, the facility psychiatrist evaluated TRAN on June 4, 2018. The psychiatrist continued the medications, changing the administration times from morning to later in the day, and documented his intent to order Cogentin on a trial basis to address observed side effects of Haldol. The Cogentin was not ordered; the orders changing administration times for Haldol and fluoxetine were not processed until the next day, June 5, 2018. As a result of the delay, TRAN received two doses of fluoxetine within four hours. Determination of whether he was given two doses of Haldol is not possible due to ambiguous entries on the medication administration record.

The same day, June 5, 2018, a psychologist directed detainee TRAN's placement in the special management unit for mental health observation. The psychologist's evaluation resulted from a referral by security staff following observation that the detainee appeared lethargic and generally non-responsive to communications.

Approximately 75 minutes after TRAN was placed in segregation, he was found unresponsive in his cell and medical emergency was called. Prior to the medical emergency, the officer documented but did not conduct monitoring rounds every 15 minutes as ordered by the psychologist. Response to the emergency call by security and medical personnel was swift, although there was a brief delay while the first three security responders, all women, waited for male responders before entering the cell. Cardiopulmonary resuscitation was initiated by officers and 911 was called immediately. Officers continued chest compressions after medical staff arrived and performed life-saving efforts until paramedics took over care.

TRAN was taken by ambulance to the local hospital and was admitted to the intensive care unit. He remained on life support for one week, during which he was visited by family. Death was pronounced at 9:20 a.m. on June 12, 2018. The autopsy report cites cardiac arrest as the cause of death.

FACILITY DESCRIPTION

The Eloy Federal Contract Facility has been owned and operated by CoreCivic, formerly Corrections Corporation of America, since 1994. The facility is a dedicated Intergovernmental Service Agreement facility housing both male and female ICE detainees. The capacity is 1500. The population on the date of detainee TRAN's death was 1359, including 889 males and 470 females.

The facility has a double fence with razor wire on top and between the fences. The interior fence is equipped with stun technology to deter escapes. Staff and visitors enter from the main lobby, first placing their belongings through an x-ray machine, then passing through a metal detector. All persons entering the secure section of the facility must display a staff or visitor identification badge. Video surveillance cameras positioned throughout the facility monitor and record events.

The direct supervision model of detainee supervision is in place in general population housing units. Meals are served to general population detainees in a central dining hall. The control center is located off the main entrance and is staffed at all times by (b)(7)(E) handles radio traffic, the logbook and the shift report. The other officer controls doors and monitors cameras. During an emergency, the officer is able to access video from the closest camera in the area.

On each shift, a team of officers is designated to serve on the Emergency Response Team (ERT). As defined in CoreCivic Policy and Procedure 9-16, Emergency Response Team, the ERT is comprised of five members who respond to emergency calls with a specific piece of equipment such as a handheld video camera, fire extinguisher and cardiopulmonary resuscitation (CPR) valve. The ERT responded when medical emergency was called for detainee TRAN.

HEALTHCARE SERVICES

Eloy Federal Contract Facility received accreditation by the National Commission on Correctional Health Care (NCCCHC) in March 2015 and was audited for reaccreditation on May 31 and June 1, 2018. The health services department is staffed 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor InGenesis Medical Staffing. The staffing plan authorizes 79 total positions, ten of which are commissioned officers of the U.S. Public Health Service. They include the Health Services Administrator (HSA), two assistant HSAs, one advanced practice provider¹, a nurse manager, two pharmacists, program manager, registered dental hygienist, and registered nurse (RN). There are two General Schedule (GS) for Federal Pay physician positions, one of which is the designated Clinical Director (CD). According to the HSA, the CD position has been vacant for four years. Until the position is filled, IHSC regional and headquarters physicians share responsibility for clinical oversight. InGenesis positions include a staff physician, psychiatrist, 21 RNs, an administrative assistant, seven advanced practice practitioners, five behavioral health professionals, one dentist, one dental assistant, 12 licensed practical nurses (LPN), six medical records technicians, two pharmacy technicians, and a radiology technician. Part time contract positions include one pharmacist and one psychiatrist; as needed positions include four RNs and two LPNs. The HSA reported that in addition to the CD position, the GS staff physician position was vacant at the time of the site visit.

The reviewer confirmed the credentials of healthcare staff were current and primary source verified. Training records for all medical and security personnel involved in the emergency response include documentation of cardio pulmonary resuscitation training in the past year.

The facility uses IHSC's e-Clinical Works (eCW) electronic medical record system. The reviewer notes that times the encounters were actually conducted are not available; therefore, medical encounter times identified in this report reflect system-generated time stamps documenting when associated vital signs were taken or providers electronically signed their notes.

DETENTION SUMMARY

Per the Telnate Report of telephone calls, detainee TRAN attempted seven phone calls during his detention, two of which were completed. Both completed calls were placed on May 29, 2018 and

¹ Advanced practice providers include nurse practitioners and physician assistants.

lasted seven and five minutes respectively. The calls were conducted in a language believed to be Vietnamese. Detainee TRAN had no visits. There was no documentation he filed any requests or grievances, and no record of any disciplinary reports.

Detainee TRAN was classified high custody by ERO. Although he qualified for medium custody based on the CoreCivic classification system, his rating was overridden to high based on the rating applied by ERO. TRAN was first assigned to a top bunk on an upper tier in a general population unit; then, within approximately six hours, he was moved to a lower bunk on the bottom tier because he had difficulty climbing to the top bunk. On the eighth day of his detention at EFCF, TRAN was transferred to the special management unit for mental health observation. He was in the special management unit for approximately 75 minutes before medical emergency was called.

SUMMARY OF EVENTS

Florence Service Processing Center (FSPC)

Friday, May 25, 2018

A medical pre-screen documented by (b)(6); (b)(7)(C) LVN notes detainee TRAN's time of arrival at the staging facility was 7:22 p.m. He was medically cleared for travel/transfer, with instruction to the receiving facility to follow up with his mental health diagnosis and treatment.

Saturday, May 26, 2018

At 4:48 a.m. (b)(6); (b)(7)(C) RN completed the intake screen, noting detainee TRAN had been treated for depression for the past 20 years. He denied any suicidal history or current thoughts of self-harm. Vital signs entered at 4:46 a.m. were as follows: temperature 98.4, pulse 69, respirations 16, and blood pressure 109/75, all within normal limits. He height was five feet, four inches and he weighed 177.3 pounds. He was referred to the medical provider and medically cleared for custody.

A mental health note completed by (b)(6); (b)(7)(C) LCSW at 2:46 p.m. documents detainee TRAN was referred to her by medical staff. He reported a history of depression for the past 20 years but denied any past suicide attempts. He was not exhibiting any signs of a serious mental disorder or condition, and he denied auditory or visual hallucinations. Follow up appointment was scheduled for June 2, 2018.

Eloy Federal Contract Facility

Monday, May 28, 2018

Video surveillance footage from the north intake rear sallyport shows detainee TRAN exited a van with three other detainees at 9:26 a.m. At 9:28 a.m., Supervisory Deportation and Detention

Officer (SDDO) (b)(6); (b)(7)(C) is seen pointing to direct TRAN to enter the hallway. On interview, SDDO (b)(6); (b)(7)(C) recalled he directed TRAN to the hallway because the detainee was “sweating profusely” and he wanted the nurse to see him first for medical pre-screening. SDDO (b)(6); (b)(7)(C) said that when he asked TRAN if he was alright, he did not respond. He commented that a lot of detainees do not respond to questions because they are upset when they arrive. Other than perspiring, TRAN “seemed fine” to SDDO (b)(6); (b)(7)(C). During interview of ICE Deportation Officer (b)(6); (b)(7)(C) he confirmed SDDO (b)(6); (b)(7)(C) moved detainee TRAN to the head of the line so he would be the first to see the nurse. He recalled TRAN was sweating so much that he asked another detainee if the air conditioning was working in the van. The detainee stated it was. Officer (b)(6); (b)(7)(C) said that he asked TRAN if he was okay but received no response. He commented the detainee looked like he “was somewhere else.”

RN (b)(6); (b)(7)(C) was assigned to intake this date. On the video, she is seen speaking with detainee TRAN at 9:28 a.m. and at 9:30 a.m., he signed some paperwork and entered the Intake area. Over the course of the next hour, TRAN was pat searched, walked through a medical detector, was given a property box, showered, changed into a facility uniform, and was placed in a holding cell with three other detainees. Once in the cell, he ate a sack meal. The EFCF Receiving and Discharge Log documents the time of his booking was 9:45 a.m.

At 10:10 a.m., RN (b)(6); (b)(7)(C) signed a pre-screening note documenting TRAN was alert and his behavior and breathing were normal, but his appearance was anxious. The note also documents he spoke English fluently, that a medical transfer summary accompanied him from another facility, and that he was taking medications for current health problems. The pre-screening disposition was priority one.

Note: The video does not show any interaction between TRAN and medical personnel between 9:28 a.m. and 10:30 a.m. when he left the holding cell, ostensibly for medical intake screening (see below). Therefore, the reviewers conclude RN (b)(6); (b)(7)(C) pre-screening note documents her interaction with TRAN at 9:28 a.m. RN (b)(6); (b)(7)(C) made no reference to the profuse sweating observed by SDDO (b)(6); (b)(7)(C).

The transfer summary referenced by RN (b)(6); (b)(7)(C) was prepared at FSPC on the day TRAN was transferred and admitted to EFCF. The summary documents a diagnosis of schizophrenia and that he arrived at FSF with haloperidol² 5 milligrams (mg) to be taken once daily and fluoxetine³ 20 mg, also to be taken once daily. The summary includes the note, “Please follow up at receiving facility medication attached.” (b)(6); (b)(7)(C) RN, documents TRAN’s statement, “I have been treated for depression for past 20 years”. He denied suicidal or homicidal thoughts or history of hallucinations. He stated he had arrived with haloperidol and fluoxetine, both prescribed for morning dosing. He denied a history of attempting to harm himself or others or of being a victim

² Haloperidol, commonly known by the trade name Haldol, is an antipsychotic medication.

³ Fluoxetine treats depression and anxiety.

of physical or sexual assault. He denied smoking or having ever used alcohol or illicit drugs. The screen for symptoms of tuberculosis was negative, and he denied any dental problems. Vital signs entered at 4:46 a.m., were all within normal limits, as follows: temperature 98.4, pulse 69, respirations 16, blood pressure 109/75, and oxygen saturation 96. He denied pain, and he was found to be absent of adverse side effects related to use of the two psychotropic medications. The examination noted normal physical and emotional characteristics, with no disabilities, no disorganization of thoughts or behaviors, no agitation, and no barriers to communication. The skin assessment showed no abnormalities. The intake assessment was abnormal, he was referred to a medical provider for a complex physical examination, and he was medically cleared for custody.

At **10:30 a.m.**, TRAN is seen on video exiting the holding cell to see the nurse, presumably for intake screening.

Note: (b)(6); (b)(7)(C) entered an abbreviated intake screening in eCW, explaining during interview that she did not complete a full screening because TRAN was screened at FSF two days earlier.

Vitals signs entered at **10:43 a.m.** were all within normal limits, as follows: temperature 98.8, pulse 92, respirations 18, blood pressure 120/78, and oxygen saturation 95. His height was 64 inches; his weight was 176.4 pounds. He denied pain. His vision tested at 20/70 in the left eye, 20/100 in the right eye, and 20/70⁴ in both eyes. RN (b)(6); (b)(7)(C) did not document whether TRAN was wearing corrective lenses or whether he was asked if he wore them in the past.

Note: Captain (b)(6); (b)(7)(C), HSA, stated during interview that detainees who are found to have vision deficits are either referred to optometry or are given a commissary form for purchase of reading glasses in a designated strength. A copy of the form is then filed in the medical record. Neither an optometry referral nor a commissary form were located in TRAN's record.

In her screening note, RN (b)(6); (b)(7)(C) described detainee TRAN as appropriate in behavior, in no acute distress, well developed, and well-nourished. He reported taking Haldol and fluoxetine for depression for a period of five years, and that he last took medications the previous afternoon. He denied hallucinations, anxiety, and depression. No symptoms of tuberculosis infection were observed and a purified protein derivative skin test was planted. The test was read as negative two days later. The assessment finding was "abnormal intake screening, referred to medical provider." In the Notes section of her intake screening entry, RN (b)(6); (b)(7)(C) wrote that telephone encounters were sent to a provider and mental health for further evaluation. The telephone encounters provided to reviewers on site, were sent to NP (b)(6); (b)(7)(C) psychiatrist.

⁴ 20/20 vision is considered normal, based on being able to see an object at 20 feet away. If vision is not 20/20, corrective lenses may be necessary.

Note: As discussed below, TRAN was examined by (b)(6); (b)(7)(C) later the same day; Dr. (b)(6); (b)(7)(C) evaluated TRAN on June 4, 2018.

Patient education brochures were provided and the detainee said he understood the teaching and instruction. TRAN signed a consent for general treatment.

During interview, (b)(6); (b)(7)(C) explained that detainees who arrive with medications or with mental health issues are a priority and TRAN met both criteria. She stated her first impression was that he was okay but then noted he did not seem to fit in with the other detainees. She did not know if it was because they were Spanish speaking and TRAN spoke English, or if TRAN was simply anxious.

The video shows TRAN returned to the holding cell at **10:39 a.m.** He exited the holding cell at **10:48 a.m.** and reported to the Intake desk where his property was inventoried and documents were signed. Intake Officer (b)(6); (b)(7)(C) recalled during interview that detainee TRAN appeared “slow, he drooled and he didn’t clean himself.” She also stated he had “snot coming out of his nose.” She said she was not concerned about possible contagion because she assumed medical staff would have separated him from other detainees if he presented a health risk.

Officer (b)(6); (b)(7)(C) confirmed TRAN spoke and understood English. She commented that his fingertips were black and when asked if he smoked, he said he did. She took his fingerprints and photograph and entered his property in the computer. The property records show he arrived with one shirt and one pair each of underwear, pants, socks and shoes. He was allowed to maintain possession of various paperwork he brought with him. He signed acknowledgement of understanding that EFCF may monitor his mail and non-attorney phone calls. He also signed a receipt for the National ICE Detainee Handbook. The detainee provided the name (b)(6); (b)(7)(C) with a Phoenix area phone number as his emergency contact.

Detainee TRAN’s funds were inventoried by Officer (b)(6); (b)(7)(C) and another officer. He arrived with two checks in the amounts of \$24.47 and \$1.13. The total, \$25.60, was deposited into a commissary account. The Receiving and Discharge Checklist documents completion of all mandated admission processes, including that he was given the opportunity to make a telephone call and was issued linens, uniforms, hygiene items, the Prison Rape Elimination Act (PREA) Pamphlet and PREA Zero-Tolerance Policy. Officer (b)(6); (b)(7)(C) said that after she completed the intake processes she is responsible for, she sent the detainee to classification.

Case Manager (b)(6); (b)(7)(C) completed a CoreCivic Initial Custody Classification form, applying a total of six points. Per the form, six points qualified TRAN for a rating of moderate. Because high custody was documented on the ICE ENFORCE Application Suite Risk Classification Assessment Detailed Summary provided by ERO, (b)(6); (b)(7)(C) recommended override of moderate to high custody. She signed her recommendation and the section, “Assistant

Warden/Administrator Review and Comments of Discretionary Over-Ride” approving her own action. When asked why she did not have a supervisor review her work, (b)(6); (b)(7)(C) stated that the classification supervisor position was vacant at the time and that “ICE had him Max” so it did not matter. Asked if she recalled detainee TRAN, she said she did because he had “snot” all over his face and did not wipe it off. She described him as “disgusting.” She said he was “very slow” and she had to ask each question two or three times before he replied.

(b)(6); (b)(7)(C) also completed the Sexual Abuse Screening Tool form and circled YES next to the question, “Detainee/resident appears to be physically, developmentally, or mentally disabled?” In the comments section, she wrote, “Slow, drools. Sneezes boogers + spits/cough”. In the check box for known victimization history or risk, Not Applicable is checked. When asked about the routing of this form, including whether it was shared with medical or mental health staff, Ms. Francois stated she was not sure. She added that because health care professionals evaluate detainees, she assumed they would identify any special needs. The form distribution designates a copy should be forwarded to the Health Services Department and a copy placed in the medical file.

Note: There is no evidence a copy of the form was forwarded to medical.

Note: (b)(6); (b)(7)(C)’s intake screening entry makes no reference to the conditions observed by (b)(6); (b)(7)(C).

The video shows that at **11:00 a.m.**, detainee TRAN sneezed and was handed a tissue by the officer before he was returned to the holding cell. At **11:04 a.m.**, he was handed a second sack meal. He laid on a bench until called out at **11:07 a.m.**, returning two minutes later. He laid on the bench for most of time in the holding cell, exiting at **11:42 a.m.**

At **11:52 a.m.**, TRAN walked through Intake in a dark blue uniform signifying high custody and was provided with an identification bracelet. Per report of facility investigator (b)(6); (b)(7)(C) completed following TRAN’s death, he left intake at **11:56 a.m.** and was moved to North Medical. There, he waited until **12:47 p.m.** when escorted to an examination room for evaluation by NP (b)(6); (b)(7)(C)

Vital signs associated with NP (b)(6); (b)(7)(C) encounter with TRAN, entered at 12:46 p.m., were all within normal limits, as follows: temperature 98.8, pulse 92, respirations 16, blood pressure 120/78, and oxygen saturation 96. He denied pain. (b)(6); (b)(7)(C)’s medical record entry documents TRAN spoke fluent English. He reported a 17-year history of schizophrenia and anxiety disorder for which he was taking Haldol and fluoxetine with no adverse side effects. (b)(6); (b)(7)(C) g

⁵ NP Ochieng was not interviewed by the review team. The HSA stated that for reasons unrelated to TRAN, her employment at EFCF ended prior to the site visit.

completed an Abnormal Involuntary Movement Scale (AIMS)⁶ to assess tardive dyskinesia, applying a score of zero.

Note: Tardive dyskinesia, a disorder characterized by involuntary movements, is a possible side effect of long term use of antipsychotic medications. Initial AIMS results may serve as a baseline for future monitoring or may prompt ordering of medication to address symptoms of the disorder. During interview of (b)(6); (b)(7)(C) Medical Doctor/Doctor of Osteopathy, Psychiatrist, he stated the AIMS test should be administered by properly trained healthcare professionals. There was no documentation of AIMS training in (b)(6); (b)(7)(C)'s record; however, she may have been trained in its administration as part of her education.

TRAN reported tobacco use, one pack per day for 13 years, with his last use over a month ago. He denied drug abuse and said he consumed two drinks per week; most recently, one to two years ago. He denied experiencing chest pain with exertion, shortness of breath, irregular heartbeat, palpitations, weakness, loss of appetite, or weight gain. The general examination noted all normal findings, including normal heart sounds. Dental examination found TRAN had no upper or lower teeth, and no dental prosthesis.

Note: (b)(6); (b)(7)(C) did not note the detainee had no teeth on the intake screening form. As noted, the FSF screening form documents he had no dental problems.

Note: There is no documentation (b)(6); (b)(7)(C) ordered a soft diet to assure safe and adequate nutritional intake.

In the "Psych" section of the form's General Examination section, (b)(6); (b)(7)(C) entered normal findings, including that TRAN was cooperative and oriented to person, place, and time. He had good eye contact and was cooperative with the examination. His demeanor was appropriate for the encounter; cognitive function appeared intact; judgment and insight was good; and his thought process was logical and goal directed without suicidal ideation or delusions. (b)(6); (b)(7)(C) documented patient education included information on good hydration, hygiene, and access to medical, dental, and mental health care.

Note: The observations of CoreCivic intake personnel relating to slow movement and responses and mucous and spittle on TRAN's face were not noted by NP Ochieng.

Prescribed treatment included Haldol 5 mg, one tablet orally for 14 days and fluoxetine 20 mg orally each morning for two weeks pending psychiatric evaluation. (b)(6); (b)(7)(C) wrote that the medications were discussed in a telephone call with (b)(6); (b)(7)(C) SC psychiatrist. She completed a mental health referral and signed her note at 5:50 p.m.

⁶ The AIMS scale assesses occurrence of tardive dyskinesia in patients receiving neuroleptic medications.

Note: The medication administration record (MAR) documents TRAN was given the first doses of Haldol and fluoxetine on May 30, 2018, two days and an unknown number of hours after he reported taking his last. The fact that (b)(6); (b)(7)(C) did not sign her May 28, 2018 note until 5:50 p.m. suggests she likely did not enter her medication orders until after the pharmacy closed, which would have delayed their processing until after morning medication administration time on May 29, 2018. Initial administration of the medications pursuant to (b)(6); (b)(7)(C)'s order was therefore, 5:00 a.m. on May 30, 2018. Whether or not (b)(6); (b)(7)(C) intended for TRAN to be given medication from the intake supply pending fulfillment of her orders cannot be determined based on documentation.

Note: (b)(6); (b)(7)(C) did not document discussion of the potential side effects of the medications with TRAN, nor did she obtain his specific consent to take them. He signed consent on June 4, 2018, six days after the medications were started.

A telephone encounter initiated by (b)(6); (b)(7)(C) at 6:04 p.m. documents, "Encounter for general adult medical examination with abnormal findings", and lists lab studies to be done on May 31, 2018 to include thyroid studies⁷, lipid panel⁸, comprehensive metabolic panel (CMP)⁹, complete blood count (CBC) with differential¹⁰ and platelet count¹¹, and hemoglobin A1c¹². Laboratory results reported on June 1, 2018, showed all normal results, with the exception of very mild elevations in calcium and sodium levels¹³.

Note: (b)(6); (b)(7)(C) makes no reference to ordering lab tests in her encounter note.

Per Investigator (b)(6); (b)(7)(C) report, TRAN left the examination room at 1:22 p.m. and walked to the Delta Unit. Delta Unit Manager (b)(6); (b)(7)(C) informed the review team that at the time, the Delta Unit housed detainees classified medium high and high. Delta Unit is comprised of five separate pods off a main vestibule. The "desk officer" assigned to the vestibule controls slider doors to each pod. The five pods are numbered from left to right starting with pod D100. The pods are directly supervised by an officer posted in each dayroom between 5:00 a.m. and 10:00 p.m. From 10:00 p.m. to 5:00 a.m. (b)(7)(E) assigned to the unit share responsibility for making rounds in each pod. Each unit has a unit manager and two correctional counselors.

⁷ Thyroid studies are a series of blood tests used to measure how well the thyroid gland is working to produce major hormones.

⁸ Lipid panel is a panel of blood tests which serve as initial screening for abnormalities in cholesterol and triglycerides.

⁹ A CMP is a blood test that gives doctors information about the body's fluid balance, levels of electrolytes, and how well the kidneys and liver are working.

¹⁰ CBC with differential is a blood test that gives doctors information about the cells in a patient's blood and the concentration of various proteins and minerals.

¹¹ Platelet count is a blood test which measures the number of blood-clotting cells.

¹² Hemoglobin A1c is a blood test that provides a three-month average of glucose concentration in the blood.

¹³ Elevation in sodium and calcium levels may result from dehydration.

The pod to which detainee TRAN was assigned, D100, has 25 two-person rooms. Rooms 101 through 112 are on the lower tier and are numbered from left to right; rooms 113 through 125 are on the upper tier and are also numbered from left to right. There is a staircase in the middle of the tiers. The pod has a central dayroom with six metal tables, each of which has eight attached seats. There are individual shower stalls located along the right side. Telephones, televisions and a microwave oven are also available in the dayroom.

Detainee TRAN was initially assigned to the upper bunk in cell 125. According to Officer (b)(6); (b)(7)(C) who was assigned as to D100 this date, the other detainee assigned to cell 125 reported TRAN was unable to climb to the top bunk and needed to be moved. Officer (b)(6); (b)(7)(C) told the review team that detainee TRAN was, "in La La Land." He stated TRAN would look "right through you and made no eye contact." (b)(6); (b)(7)(C) contacted one of the unit counselors and was told he could not move TRAN because the time for count was approaching. Officer (b)(6); (b)(7)(C) then instructed detainee TRAN to place his mattress on the floor of the cell until transfer could be arranged. He recalled that the other detainee¹⁴ in the cell was upset and stated, "I can't live with this guy."

Phone records show that between **3:21 p.m.** and **5:05 p.m.**, detainee TRAN attempted four telephone calls. None were successfully completed.

Per Investigator (b)(6); (b)(7)(C) report, TRAN moved to cell 103 on the lower level at **7:06 p.m.** Cell 103 has a metal door with a viewing window in the upper portion. A metal desk is attached to the left wall; a window with bars is on the back wall. The bunk bed set is on the back right wall and toward the front is a porcelain toilet and sink. A distress button near the door alerts at the pod officer's desk and in central control.

The review team interviewed TRAN's cellmate in cell 103, (b)(6); (b)(7)(C). He stated detainee TRAN told him he was from China. For the first four days they were housed together, TRAN did not shower. Detainee (b)(6); (b)(7)(C) stated he told TRAN that other detainees were complaining that their cell stunk and he needed to shower. Detainee TRAN said he did not have any soap, so (b)(6); (b)(7)(C) informed him soap was available for free in the showers. Detainee TRAN took a shower that day and every two days thereafter. (b)(6); (b)(7)(C) stated he woke TRAN for breakfast and lunch each day and did not recall TRAN ever leaving the unit for activities such as library or recreation. (b)(6); (b)(7)(C) reported that on only one occasion did TRAN go to the dayroom to watch television and he fell asleep in his chair. Detainee (b)(6); (b)(7)(C) stated that detainee TRAN never mentioned feeling sick, but he did observe TRAN walked slowly and it took him a long time to get up from his bunk. (b)(6); (b)(7)(C) said he thought the slow movements may have been related to TRAN's culture but looking back, he realized TRAN "probably was sick."

¹⁴ The review team did not interview this detainee because according to Investigator (b)(6); (b)(7)(C) report, he was released on June 8, 2018.

Tuesday, May 29, 2018

Detainee TRAN signed a Unit Admission and Orientation Acknowledgement form. Investigator (b)(6); (b)(7)(C) report documents he left the unit for recreation at **9:16 a.m.** and returned at **11:23 a.m.** He also left the unit for all three meals and for pill call¹⁵.

At **4:58 p.m.**, he unsuccessfully attempted a telephone call. He completed a call at **7:06 p.m.** which lasted five minutes and another at **7:58 p.m.** which lasted seven minutes. Both were made to the number listed for his emergency contact.

Wednesday, May 30, 2018

Investigator (b)(6); (b)(7)(C) report documents TRAN left the unit for all three meals and for pill call. He also went to visitation from **12:16 p.m.** to **1:19 p.m.** SDDO (b)(6); (b)(7)(C) informed the review team that he met with his assigned DO at this time (b)(6); (b)(7)(C).

Thursday, May 31, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit and went to medical at **1:57 a.m.** He also attended all three meals and reported for pill call.

Note: There is no documentation of a medical or mental health encounter this date.

Officer (b)(6); (b)(7)(C) turned to work after two days on leave. He recalled that TRAN came out of his cell and sat in a chair to watch a movie with other detainees. Soon, detainee TRAN's head was down and appeared to be either sleeping or daydreaming. (b)(6); (b)(7)(C) stated another detainee walked behind TRAN and flicked the back of his neck with his finger. (b)(6); (b)(7)(C) stated TRAN did not react and he told the other detainee to leave TRAN alone.

At some point during his shift, (b)(6); (b)(7)(C) stated that a new lock had to be placed on detainee TRAN's property box. Officer (b)(6); (b)(7)(C) instructed TRAN to empty the box so he could temporarily remove the box from the cell and replace the lock. He stated detainee TRAN just sat on the bunk and stared at him. Officer (b)(6); (b)(7)(C) recalled the property box contained no personal property and no commissary; just a pair of socks and underwear. Officer (b)(6); (b)(7)(C) stated it would have taken "two minutes" to empty the box but detainee TRAN could not do it. He stated detainee TRAN "walked like a zombie, like he was sleepwalking."

Friday, June 1, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit for all three meals and for pill call. He also went to visitation. Per SDDO (b)(6); (b)(7)(C) detainee TRAN met with DO (b)(6); (b)(7)(C) the facility's travel document request/consulate liaison officer.

¹⁵ Pill call refers to times medications are given to detainees by nursing staff.

Saturday, June 2, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit for all three meals and for pill call. He also played a game with other detainees in the dayroom and briefly watched television.

Sunday, June 3, 2018

Investigator (b)(6); (b)(7)(C) report documents the detainee left the unit for all three meals and for pill call.

UM (b)(6); (b)(7)(C) stated on interview that detainee TRAN first came to her attention this date because he took a long time to eat his meal in the dining hall. She stated that at one point, the captain offered TRAN the opportunity to take his meal tray back to the unit so he need not rush to eat. TRAN declined and left with the other detainees. UM (b)(6); (b)(7)(C) stated the detainee was "almost zombie like" and had "tunnel vision."

Monday, June 4, 2018

Investigator (b)(6); (b)(7)(C) report documents TRAN left the unit for all three meals and for pill call. He also spent approximately one hour in the dayroom with the other detainees.

UM (b)(6); (b)(7)(C) completed a mental health referral this date stating, "He seems very distraught, yesterday I observed Tran while he was eating very slow. When asked by the Assistant Shift Supervisor (b)(6); (b)(7)(C) if he would like to take his tray back to the unit he stated "No" Tran does not respond to unit staff when help is offered to him." UM (b)(6); (b)(7)(C) stated on interview that she delivered the referral to the officer in medical because she considered it urgent. She shared she has a special needs child so she is particularly alert and sensitive to persons with special needs.

At 1:02 p.m., detainee TRAN left Delta Unit for medical, arriving at 1:06 p.m. At 2:58 p.m., he went with the psychiatrist to his office. At 3:30 p.m., he walked in the hallway while the psychiatrist watched him and then returned to the psychiatrist's office.

Detainee TRAN's evaluation was conducted by (b)(6); (b)(7)(C). In his medical record entry, Dr. (b)(6); (b)(7)(C) documented he completed a "face-to-face, with sound privacy" assessment to address TRAN's history of schizophrenia with medication treatment. He explained during interview that the encounter was conducted in his office, with a Core Civic officer standing outside his door in full view of the detainee. Although described as alert, awake and oriented to time, place, and person, (b)(6); (b)(7)(C) found TRAN was a poor historian, with inconsistencies in his reports of mental illness and medication treatment.

Note: TRAN's vital signs were not taken for this encounter.

In the social history section of his note (b)(6); (b)(7)(C) wrote that TRAN was born in Vietnam but at the age of 12, he and his family escaped their country and moved to Thailand. At age 14, he migrated to the United States and went as far as the twelfth grade in school. His work history consisted of working in a warehouse for one week.

TRAN reported he began hearing voices at age 20 but started medication treatment just two years ago. He stated he used to hear voices “telling him to do things.” He also reported that he experienced visual hallucinations in the past and that he believed others can insert thoughts in his mind. TRAN stated since taking Haldol, “its [*sic*] been more than a year since he last heard voices, seeing things, or thought that people can insert thoughts in his mind.” He denied thought broadcasting¹⁶ or withdrawal, and described his anxiety as restlessness and being uncomfortable around people. He reported taking fluoxetine for anxiety. TRAN denied chest pain, dizziness, increased sense of embarrassment, depressed mood, feelings of hopelessness or helplessness, and suicidal ideation, intent or plan.

TRAN reported he received outpatient treatment at Southwest Network in Chandler, AZ from 2013 to 2017; also, that he was treated while in prison from 2017 to 2018. (b)(6); (b)(7)(C) stated his criminal history included aggravated assault and disorderly conduct, and that his last conviction involved threats made against his sister with a knife. TRAN reported he did not take his medication for three months prior to the incident. He last used alcohol two years ago, two cans per weekend, but denied illicit drug abuse. He admitted to smoking one pack of cigarettes per day for the past 13 years.

The mental status findings described TRAN as cooperative, tremulous, and showing mild psychomotor retardation¹⁷. He demonstrated minimal arm swinging while walking and was described as having an intense, sustained stare. His speech showed prolonged latent response periods, and his thought process was “slow and impoverished¹⁸.” His mood was described as euthymic¹⁹ and his affect as blunt. TRAN’s thought content showed no suicidal or homicidal ideation, intent or plan, and his insight and judgment were determined fair.

The examination findings included an AIMS assessment which resulted in a documented score of three.

Note: Although (b)(6); (b)(7)(C) wrote that the total score was three, he applied level one scores for four symptoms²⁰. The correct score was four.

The assessment findings were schizophrenia and anxiety disorder. (b)(6); (b)(7)(C) continued fluoxetine and Haldol in the same doses for treatment of anxiety and schizophrenia, respectively, but rewrote the orders to change administration times. Instead of morning administration, fluoxetine was to be given at noon and Haldol at night. (b)(6); (b)(7)(C) explained during interview

¹⁶ Thought broadcasting is the belief others can hear or are aware of an individual’s thoughts.

¹⁷ Psychomotor retardation refers to a slowing down of thoughts and a reduction of physical movements in an individual.

¹⁸ According to (b)(6); (b)(7)(C), impoverished responses were short, usually yes or no, without elaboration.

¹⁹ Euthymic refers to a tranquil mood.

²⁰ According to the Encyclopedia of Mental Disorders, items on the AIMS test are rated on a scale severity from zero to four. A rating of one is minimal severity.

that patients who receive morning doses are awakened at 4:00 a.m., and he felt it was necessary for TRAN to have uninterrupted sleep. (b)(6); (b)(7)(C) wrote in his note that he discussed the risks, benefits and alternatives to fluoxetine and Haldol with TRAN. The risks associated with fluoxetine listed in the note were dry mouth, headache, increased agitation/anxiety and nausea. Dry mouth and headache were also listed as risks associated with Haldol, as were tardive dyskinesia, malignant syndrome (MS)²¹, and sexual psychosis, ~~depression~~ anxiety, irritability, homicidality, suicidality, and extrapyramidal symptoms (EPS)²². (b)(6); (b)(7)(C)'s note includes his observation that TRAN was, in fact, exhibiting EPS "which will be addressed with cogentin²³ trial." Detainee TRAN signed a consent form for both Haldol and fluoxetine.

Note: The consent form states potential side effects were explained to TRAN but does not list them. As noted previously, TRAN did not sign a consent before the psychiatric medications were started on May 30, 2018.

Note: Consistent with his note, (b)(6); (b)(7)(C) ordered discontinuation of the initial fluoxetine and Haldol orders in favor of a new prescriptions changing administration times to noon and night, respectively. However, Commander (b)(6); (b)(7)(C) Chief Pharmacist, stated during interview that because the orders were written after normal pharmacy hours, they were not processed until after TRAN was given early morning doses of both medications the next day, June 5, 2018. According to the MAR, he was erroneously given a second dose of fluoxetine at 12:00 p.m. per the new prescription. The same error did not occur with respect to Haldol; however, the MAR includes both a note stating an evening dose of Haldol was not given due to "Detainee at hospital" and a 4:00 p.m. entry consisting of a partially circled letter A that HSA (b)(6); (b)(7)(C) was unable to interpret. This documentation on the MAR suggests the medication may have been offered had TRAN not been taken to the hospital before its administration was due. As detailed below, a medical emergency was called at 4:15 p.m., resulting in TRAN's transport to the hospital.

Note: Although (b)(6); (b)(7)(C) documented in his note that Cogentin was to be started for treatment of EPS, he did not write the order. He stated during interview that failure to write the order was an oversight. The reviewer notes that if Cogentin had been ordered, and unless ordered stat, the medication would not have been given until the next day because as discussed above, the pharmacy was closed when (b)(6); (b)(7)(C) wrote medication orders resulting from his encounter with TRAN.

²¹ Malignant Syndrome is a rare, but life-threatening, idiosyncratic reaction to neuroleptic medications characterized by fever, muscular rigidity, altered mental status, and autonomic dysfunction. It often occurs shortly after the initiation of neuroleptic treatment, or after dose increases.

²² Extrapyramidal symptoms are drug-induced movement disorders which include acute and tardive symptoms.

²³ Cogentin is the brand name for benztropine, a drug to treat Parkinson symptoms and side effects of other drugs.

(b)(6); (b)(7)(C) directed that TRAN's records from the Arizona Department of Corrections and Southwest Network outpatient clinic be requested. Psychiatric follow-up was scheduled for four weeks.

Note: The requested records were received by EFCF; however, (b)(6); (b)(7)(C) informed the review team they were not provided prior to TRAN's death.

The video shows TRAN exited the psychiatrist's office at **3:42 p.m.** and returned to Delta Unit at **3:49 p.m.**

Tuesday, June 5, 2018

Investigator (b)(6); (b)(7)(C) report documents detainee TRAN left the unit for breakfast, lunch and pill call. He twice placed a chair in front of the TV but appeared to fall asleep with his head down.

UM (b)(6); (b)(7)(C) informed the review team that she discussed TRAN at a morning meeting convened by the Warden to discuss detainees with special needs. She stated meetings for this purpose are held weekly and attended by ERO personnel, healthcare staff, unit managers and security supervisors. UM (b)(6); (b)(7)(C) stated she reported she had submitted a referral and health care staff noted his name.

Per Investigator (b)(6); (b)(7)(C) report, an officer went to TRAN's cell at **12:15 p.m.** and the detainee left the unit for medical thereafter. Video footage shows he entered the medical waiting room at **12:22 p.m.** At **12:31 p.m.**, he followed (b)(6); (b)(7)(C) psychologist, down the hallway and into her office.

(b)(6); (b)(7)(C) stated on interview that she received a "vague referral" from CoreCivic which stated he seemed distressed at lunch.

(b)(6); (b)(7)(C) As discussed above, (b)(6); (b)(7)(C) submitted a written referral the day before. (b)(6); (b)(7)(C) stated detainee TRAN walked very slowly and seemed "sluggish." As they walked to her office, she kept looking behind her to make sure he was following. He sat slowly in a chair but kept his arms in the air. She said he made "inconsistent eye contact", was "staring off into space", and seemed "disengaged." (b)(6); (b)(7)(C) described him as soft spoken and hesitant in his responses. She recalled asking him multiple times if he was OK and he replied, "I'm fine." He got up and walked around a few times while in the office.

(b)(6); (b)(7)(C) medical record entry documents the same information. Following is the text of her narrative note:

“[Patient] presented as depressed and apathetic. He exhibited flat affect with alogia²⁴. Additionally, he presented as extremely slow moving, lethargic, and exhibited rigid movements with occasional hand tremors. [Patient] gout *[sic]* out of his seat twice during this session, and when asked if he was alright, said that he ‘needed to move,’ without further explanation. [Patient] was encouraged to step out into the hallway for a moment to walk briefly. It appeared that [patient] was sweating on his forehead, and his hands appeared to be shaking toward the end of the session. Initially [patient] denied [symptoms] of depression; however, later in the discussion, after pointing out that his presentation was inconsistent with his self-report, he later acknowledged experiencing ‘some depression *[sic]*. [Patient] acknowledged that he has been moving more slowly overall, which began in the last few weeks. [Patient] denied issues with sleep or appetite. [Patient] denied past and current [auditory visual hallucinations]. It should be noted that during his initial intake on 5/2/18 at Florence, he reported experiencing [auditory visual hallucinations] prior to taking his psychotropic medication. [Patient] said that he has been consistently taking his psychotropic medication. [Patient] exhibited longer pauses between responses toward the end of the session. He appeared somewhat distracted. At one point, [patient] asked why he was being asked these questions. [Patient] was cooperative overall, though he ultimately said that he didn’t want to talk anymore. In terms of coping mechanisms, [patient] reported that he attends recreation, but said that he spends his time sitting. He said that he talks to other males in his pod, but also acknowledged that he has had difficulty conversing with others, as he feels nervous, for the past several weeks. He was unable to identify why he felt nervous. [Patient] denied thoughts of self-harm, plan, and intent.”

Note: Given the physical symptoms TRAN exhibited, referral to a prescribing provider may have been prudent.

(b)(6); (b)(7)(C) note states TRAN was to be placed on mental health observation status with nursing checks twice daily and checks by Core Civic every 15 minutes. She also directed follow-up in two to three days.

(b)(6); (b)(7)(C) stated that she determined the detainee should be placed in Bravo 600 so he would be in a more restricted environment and could be monitored more closely. The review team was informed this unit houses special needs detainees with sex-based crimes who cannot safely be housed in the general population, and detainees needing mental health observation and suicide watch. Consistent with her medical record entry, (b)(6); (b)(7)(C) completed a Special Needs Form directing twice daily nursing checks and checks by the unit officer every 15 minutes. (b)(6); (b)(7)(C) informed the review team that she handed the form to the medical officer.

²⁴ Alogia is a poverty of speech, in which a general lack of additional, unprompted content is seen in normal speech.

Based on the Special Needs Form, an administrative segregation order was approved by Captain (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) stated that before a detainee can be placed in segregation for medical observation, both a Special Needs Form and medical clearance are required. Medical clearance is documented on TRAN's administrative segregation order by way of a stamp signed by RN (b)(6); (b)(7)(C).

Note: The medical record does not document medical clearance for segregation. During interview, (b)(6); (b)(7)(C) acknowledged that she reviewed TRAN's record, only, and did not assess him in person. Asked about documenting clearance in the medical record, she said that if she did not make an entry, she was supposed to. HSA (b)(6); (b)(7)(C) confirmed that detainees being placed in segregation are to be seen in person.

Video shows TRAN exiting D (b)(6); (b)(7)(C) office at **1:07 p.m.**, then reversing course and returning to her office. At **1:10 p.m.** an officer arrived and he, along with the psychologist, escorted TRAN down the medical corridor where the officer appears to instruct him to take a seat. At **2:50 p.m.** Senior Correctional Officer (Sergeant) (b)(6); (b)(7)(C) arrived to escort detainee TRAN to Bravo 600 Unit. Sergeant (b)(6); (b)(7)(C) stated TRAN was seated in front of the medical officer who informed him TRAN was anxious. Sergeant (b)(6); (b)(7)(C) said the detainee kept standing up and asked if he could leave. When Sergeant (b)(6); (b)(7)(C) said yes, TRAN asked where he was going. The sergeant told him he was being moved to another unit so medical could keep a closer eye on him. Sergeant (b)(6); (b)(7)(C) stated the detainee was "not all there" and seemed like someone "burnt out on drugs."

Video footage shows detainee TRAN was escorted into Bravo 600 Unit at **2:54 p.m.** and to cell 606 at **2:56 p.m.** by Officer (b)(6); (b)(7)(C) the officer assigned to the unit. Bravo 600 has 24 cells, 12 to the left of the officer's station, designated as the west side, and 12 on the right, designated as the east side. Sex offenders are housed on the west side; detainees on mental health observation status and suicide watch are housed on the east side. The east and west sides are accessed through separate gates.

Detainee TRAN's cell, 606, is the second cell on the east side. The cell is solid steel with a window on the top half and a food/handcuff portal on the lower half. A concrete slab is located in the center of the cell with a mattress placed on top. On the rear wall is a window with bars. A stainless steel combination sink and toilet fixture is located to the right front of the cell. The east side dayroom has steel tables and affixed stools, a shower stall to the left of the entryway and an outdoor recreation area at the rear.

The EFCF Post Orders for the Bravo 600 officer require that the officer, "conduct any special watches as directed by medical staff" and that all security checks be "properly documented and logged." EFDC Policy 10-100, Segregation/Restrictive Housing Unit Management, states that all detainees housed in SMU "will be personally observed by an officer." EFCF does not have an electronic system for recording security rounds; therefore, officers document cell checks on the

Confinement Watch Logs posted on clipboards outside each cell and in the unit logbook. Between TRAN's placement in cell 606 at 2:56 p.m. and the medical emergency logged at 4:15 p.m., Officer (b)(6); (b)(7)(C) documented on TRAN's Confinement Watch Log that he checked on him at 3:09 p.m., 3:23 p.m., 3:38 p.m., 3:52 p.m., and 4:06 p.m.

As detailed below, video evidence does not support that Officer (b)(6); (b)(7)(C) made the first three checks documented. Investigator (b)(6); (b)(7)(C) informed the review team that Officer (b)(6); (b)(7)(C) resigned from CoreCivic on June 14, 2018, and shared that he would have been terminated had he not resigned. In her report, Investigator Potter discussed her interview of Officer (b)(6); (b)(7)(C) prior to his resignation. He confirmed he received the Special Needs Form and was aware detainee TRAN was to be checked every 15 minute checks. When Investigator (b)(6); (b)(7)(C) asked Officer (b)(6); (b)(7)(C) about the discrepancies between his log entries and the video evidence, he stated the times may have been off because he does not make entries right away. He claimed he looked into TRAN's cell as he walked by and that every time, the detainee was moving and breathing. Per Investigator (b)(6); (b)(7)(C) report, Officer (b)(6); (b)(7)(C) stated TRAN was sitting on the edge of his bed for the first two documented security checks and on the next check, was laying on his stomach with his arms tense and one leg elevated.

Based on the reviewer's analysis of housing unit video, Officer (b)(6); (b)(7)(C) entered TRAN's cell with a bag at **3:00 p.m.** exiting 35 seconds later. Per Investigator (b)(6); (b)(7)(C) report, the bag contained linens. Officer (b)(6); (b)(7)(C) informed her that when he brought TRAN his bedding, the detainee did not say a word and seemed to be shaking a little.

Over the course of the next 51 minutes, video shows Officer (b)(6); (b)(7)(C) in the vicinity or walking past detainee TRAN's cell on five occasions, never looking in to confirm the detainee's welfare. At **3:15 p.m.**, he marked clipboards at three nearby cells but does not look in any of the three. After marking the clipboards, he passed TRAN's cell at **3:17 p.m.** without stopping. At **3:27 p.m.**, Officer (b)(6); (b)(7)(C) is seen at the clipboard by TRAN's cell but does not look in. At **3:45 p.m.**, the video shows Officer (b)(6); (b)(7)(C) placing an orange card on TRAN's cell door to indicate he was on medical observation status but again, he does not look in the cell. At **3:47 p.m.**, Officer (b)(6); (b)(7)(C) placed an orange card on the cell door next to TRAN's, 605, and spoke to Officer (b)(6); (b)(7)(C) who was assigned to constant watch vigil for the detainee assigned to the cell. At **3:51 p.m.** Officer (b)(6); (b)(7)(C) is seen on video looking into TRAN's cell and marking the clipboard. He then stood at the door looking in. Officer (b)(6); (b)(7)(C) then moved from cell 605 to look in TRAN's cell, after which Officer (b)(6); (b)(7)(C) opened then closed the door to the cell. He did not enter.

Officer (b)(6); (b)(7)(C) left the east side at **3:55 p.m.** He returned at **4:04 p.m.** and after delivering a meal tray to another cell, opened the food portals in TRAN's and another detainee's cells. At **4:06 p.m.**, Officer (b)(6); (b)(7)(C) handed Officer (b)(6); (b)(7)(C) sack meal for the detainee on suicide watch and placed a meal tray on TRAN's food portal. After Officer (b)(6); (b)(7)(C) moved away to deliver a tray to another cell, Officer (b)(6); (b)(7)(C) appears to look in TRAN's cell. At **4:08 p.m.** when Officer (b)(6); (b)(7)(C) passed the sack meal to the detainee on suicide watch, TRAN's tray remained on the food portal. Officer

Hall then looked again into TRAN's cell. At **4:11 p.m.**, Officer (b)(6); (b)(7)(C) delivered a meal to another cell. On his way back to the officer's station, he stopped at TRAN's cell briefly before moving on, but does not look in. A minute later, **4:12 p.m.**, Officer (b)(6); (b)(7)(C) returned to the cell and looked directly in. He turned (b)(6); (b)(7)(C) peak to a detainee in the dayroom, then returned his gaze to inside TRAN's cell. Officer (b)(6); (b)(7)(C) removed the tray from the portal and exited the east side. He returned at **4:13 p.m.** and opened the cell door. He entered then exited quickly, leaving the door ajar. Investigator (b)(6); (b)(7)(C) report documents that Officer (b)(6); (b)(7)(C) told her that when he entered the cell, he touched TRAN's leg then touched his hand and shook his back. He noted the detainee's back was warm. Officer L (b)(6); (b)(7)(C) said he then yelled out to TRAN and heard Officer (b)(6); (b)(7)(C) tell him to call a medical emergency. The video shows that after Officer (b)(6); (b)(7)(C) exited the cell, he started to leave the immediate vicinity then returned to the cell and spoke into his radio.

Note: The reviewer concludes that when Officer (b)(6); (b)(7)(C) is seen speaking into his radio, he called medical emergency. The time entered in the Confinement Watch Log, likewise, the Central Control log, was 4:15 p.m., reasonably close to the time shown on video.

The video shows Officer (b)(6); (b)(7)(C) moving away from TRAN's cell at **4:14 p.m.** and at **4:15 p.m.**, he moved toward the front of the east side, motioning to the detainee in the dayroom to return to his cell. Another officer arrived and escorted the detainee to his cell as Officer (b)(6); (b)(7)(C) returned to TRAN's cell and opened the door wider.

Correctional Counselor (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were first to respond to the medical emergency call, arriving at **4:16 p.m.** Officer (b)(6); (b)(7)(C) who was the designated camera operator for the ERT this date, carried a handheld video camera. None of the three entered the cell. Upon interview and in their statements to Investigator (b)(6); (b)(7)(C) they all stated they did not enter for their own safety. They noted TRAN was a level three male detainee and they could not be certain he was not feigning illness. Officer (b)(6); (b)(7)(C) reported that when she arrived, she passed Officer (b)(6); (b)(7)(C) who was exiting the area. He pointed to cell 606 and said, "This is the cell." She called out to TRAN three times from the doorway but he did not respond.

Note: EFDC Policy, Segregation/Restrictive Housing Unit Management, 10-100, section 10-100.4, (E)(2)(c) states, "Staff members equal to the number of inmates/residents assigned to the cell will be present prior to opening any occupied cell door."

Per the video footage, Lieutenant (b)(6); (b)(7)(C) arrived 22 seconds later and entered the cell. Officers (b)(6); (b)(7)(C) followed. Lieutenant (b)(6); (b)(7)(C) confirmed that when he arrived on the unit (b)(6); (b)(7)(C) were standing outside the cell. He said that when he and Officer (b)(6); (b)(7)(C) entered TRAN's cell, he was laying on his stomach with his face in the pillow. Lieutenant (b)(6); (b)(7)(C) reported that when he rolled the detainee onto his right side, TRAN was "cold to the touch and stiff." He recalled that a yellow/reddish discharge was coming from the detainee's nose and that the detainee was not breathing. He stated on interview that he instructed security staff to begin CPR, later instructing that they rotate

performance of chest compressions after every four series to avoid fatigue. Officer (b)(6); (b)(7)(C) conducted the first round. Lieutenant (b)(6); (b)(7)(C) said that after directing initiation of CPR, he immediately radioed Central Control to direct calling 911. The video shows he stepped out of the cell at **4:17 p.m.** and spoke into his radio, presumably to direct the 911 call.

Note: Although the Central Control log documents the call was not made until 4:21 p.m., the Eloy Fire District Prehospital Care Report document (b)(6); (b)(7)(C) was dispatched at 4:19 p.m., suggesting the call was made quickly after Lieutenant (b)(6); (b)(7)(C) direction. The Central Control log details other events with times inconsistent with video evidence. Because the officers in Control were not in a position to directly witness events, the reviewer concludes the entries were made as information was reported and do not reflect the times events occurred. For that reason, Central Control log entries are not included in the below recounting of events unless not documented elsewhere.

The video shows RN (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) arrived at **4:17 p.m.** At **4:18 p.m.**, three additional medical staff are seen on video entering the east side with a gurney and the emergency bag. They included NP (b)(6); (b)(7)(C) and two nurses. At **4:20 p.m.**, NP (b)(6); (b)(7)(C) arrived, followed at **4:22 p.m.** by PA (b)(6); (b)(7)(C). At **4:23 p.m.**, Captain (b)(6); (b)(7)(C) arrived and stood outside the cell for one minute before leaving. He stated during interview that he stayed only briefly because Lieutenant (b)(6); (b)(7)(C) had the incident under control.

Video taken by Officer (b)(6); (b)(7)(C) with the handheld camera captures events within the cell. For 46 seconds there was sound but no video. Officer (b)(6); (b)(7)(C) explained on interview that the lens cover would not fully open, necessitating Lieutenant (b)(6); (b)(7)(C)'s assistance before the camera started recording video. Despite the delay, the video captures emergency response efforts by security and medical staff, detailed below. The video ends after eight minutes and 43 seconds, prior to arrival of emergency medical services (EMS) responders. Lieutenant (b)(6); (b)(7)(C) stated that he instructed Officer (b)(6); (b)(7)(C) to stop recording after he asked Captain (b)(6); (b)(7)(C) if the event should be recorded. Captain (b)(6); (b)(7)(C) confirmed that when he reported to the scene, he told the lieutenant to stop recording because "it was a medical procedure." When asked if he considers CPR a medical procedure, he replied that never in his career in corrections has he recorded CPR.

As noted, RN (b)(6); (b)(7)(C) was the first medical responder to arrive on scene. In her medical record entry, she wrote TRAN was laying on the bed, unresponsive and not breathing; also, that officers had started CPR. The video from the handheld camera shows she applied a pulse oximeter²⁵ to the detainee's right index finger which, according to her note, resulted in a very low finding of 48 percent. She noted a sternal rub was performed without effect, and a faint irregular pulse was found on the right wrist.

²⁵ A pulse oximeter is a small piece of equipment placed on the finger to measure pulse oxygen.

NP (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) is seen on the video entering the cell 46 seconds after (b)(6); (b)(7)(C). Per the RN's note, he took over as leader of the emergency response. In N (b)(6); (b)(7)(C) medical record entry, he noted officers were performing chest compressions and manual breaths. During interview of Officer (b)(6); (b)(7)(C), she confirmed she performed two rescue breaths using the CPR mask she brought to the scene. (b)(6); (b)(7)(C) marked to the review team that because officers were performing chest compressions very well, he made the decision to let them continue. On the v (b)(6); (b)(7)(C) en checking TRAN's left wrist for a pulse and according to his note, found none. N (b)(6); (b)(7)(C) note also documents the detainee was not breathing and he had no reaction to a sternal rub.

The video shows NP (b)(6); (b)(7)(C) moved the automated external defibrillator (AED) from the case and attempted to apply the pads under TRAN's shirt. He is heard asking for another provider. RN (b)(6); (b)(7)(C) then seen cutting TRAN's shirt, revealing that the AED pads were placed on the upper abdomen and did not adhere to TRAN's body. PA (b)(6); (b)(7)(C)'s medical record entry (see below) confirms this observation, describing the pads as "partially adhered."

Note: Proper placement of AED pads is one pad on the front of the chest above the right nipple and the other one on the left side of the chest below the breast area. Although the pads were later repositioned, their placement remained imperfect throughout the emergency response.

Note: For an AED to provide accurate analysis and effective shock during a sudden cardiac arrest, AED pads must make proper contact with the patient's skin.

During interview, NP (b)(6); (b)(7)(C) said he did not know whether the pads were expired, which may have caused the gel to be dry and non-adhering. He stated his assumption that the pads did not stick because TRAN was perspiring profusely. NP (b)(6); (b)(7)(C) said it did not occur to him to dry TRAN's skin and if available in the emergency bag, apply new pads.

Note: The reviewer found the emergency bag inventory did not include an extra set of AED pads.

Per NP (b)(6); (b)(7)(C)'s note, "AED analyzed the patient multiple times during resuscitation but without a shockable rhythm." PA (b)(6); (b)(7)(C)'s note cites three as the number of times no shock was advised.

The video shows and NP (b)(6); (b)(7)(C) note documents other rescue efforts, including placement of an ambu bag for administration of oxygen while CPR was performed. The video recording shows the ambu bag did not seal properly until TRAN's head was tilted. Officer (b)(6); (b)(7)(C) informed the review team that she made the suggestion to do so, commenting that the medical responders seemed overwhelmed and nervous. A medical record entry by RN (b)(6); (b)(7)(C) documents she maintained the ambu bag mask in position to ensure it remained sealed until EMS responders

arrived. NP (b)(6); (b)(7)(C) also documented two attempts to establish an intravenous (IV) line²⁶ were unsuccessful, and that nursing staff could not find a blood pressure. A glucometer reading showed blood glucose was significantly elevated at 208²⁷. During CPR, oxygen saturation fluctuated between an abnormally low level of 48 to a near normal level of 93, with peripheral pulse ranging from a low 50 beats per minute to an elevated 115.

As noted previously, NP (b)(6); (b)(7)(C) is heard on the handheld camera video requesting that another provider be called to the scene. The medical record entries of NP (b)(6); (b)(7)(C) both document that they responded to the request. NP (b)(6); (b)(7)(C) wrote that she helped lead the team and coordinated care between security and medical responders to relieve (b)(6); (b)(7)(C) pending arrival of EMS. She assisted with the ambu bag and attempted to insert an IV without success. Her assessment of femoral and brachial pulses²⁸ were without positive result.

PA (b)(6); (b)(7)(C) note documents that he “took a brief medical/psych history to Bravo 600 where patient was housed.” When he arrived, officers were performing chest compressions and NP (b)(6); (b)(7)(C) and RN (b)(6); (b)(7)(C) were managing the airway and giving two breaths every 30 compressions. PA (b)(6); (b)(7)(C) wrote that twice while TRAN was assisted with breathing, he listened for heart sounds or breath sounds and heard breath sounds, only. PA (b)(6); (b)(7)(C) also documented the information discussed above concerning the AED and the fluctuation in pulse oxygen noted by NP (b)(6); (b)(7)(C), adding that there was no reading when the compressions were stopped. Concerning attempts to insert an IV, P (b)(6); (b)(7)(C) wrote that the first attempt was successful for a short time, but not long enough to administer fluids. He made the second attempt and was unsuccessful.

An entry to the Rear Gate Logbook documents the ambulance arrived at **4:30 p.m.** The Eloy Fire District Report corroborates this time. Video from the housing unit camera shows EMS responders entered the east side at **4:33 p.m.**, their arrival having been facilitated by Officer (b)(6); (b)(7)(C). During interview Officer (b)(6); (b)(7)(C) had earlier instructed him to open both entrance gates near Bravo 600 so the ambulance could pull right in.

As reported by Lieutenant (b)(6); (b)(7)(C) and documented by NP (b)(6); (b)(7)(C), EMS responders took over CPR upon arrival. The Eloy Fire District report notes the responders observed “an AED had been placed by medical staff, while ventilations and high quality CPR were being performed”.

Note: CPR by EFCF personnel lasted 17 minutes before the paramedics arrived. Officers rotated performance of chest compressions throughout while medical personnel performed other life-saving efforts.

²⁶ An intravenous line is a portal, established by a hollow-bore needle and connected to plastic tubing, through which fluids and medications can be administered directly into the vein.

²⁷ A normal blood glucose level is roughly 70 to 140.

²⁸ Femoral and brachial pulses are those felt in the inner thigh and inner aspect of the elbow.

Per NP (b)(6); (b)(7)(C) medical record entry, EMS responders started an IV line via interosseous²⁹ route; PA (b)(6); (b)(7)(C) entry specifies access was obtained on the anterior tibial area of the left leg. Both document Narcan³⁰ and one dose of epinephrine³¹ were administered. Asked for his understanding of why Narcan was administered, NP (b)(6); (b)(7)(C) explained it is a routine EMS procedure. (b)(6); (b)(7)(C) documented EMS responders placed their own AED leads on TRAN and were able to obtain a weak pulse. TRAN was placed on a back board and moved to an EMS gurney. NP (b)(6); (b)(7)(C) note also documents that the cardiac monitor showed sinus rhythm³² before the detainee was moved to the ambulance for transport to the Banner Casa Grande Medical Center. The Eloy Fire District Report corroborates the information documented by the EFCF providers.

The housing unit video shows TRAN's placement on the EMS gurney at **4:44 p.m.** and the responders' departure with the gurney from the east side at **4:45 p.m.** Video from the Bravo Entrance Walk shows the gurney was lifted onto the ambulance which at **4:51 p.m.**, moved through the first perimeter gate. Per entry to the Rear Gate Logbook, the ambulance exited the secure compound at **4:53 p.m.** The Eloy Fire District report documents the time of departure was 4:51 p.m.

Officers (b)(6); (b)(7)(C) were assigned to hospital detail, Officer (b)(6); (b)(7)(C) driving the chase vehicle and Officer (b)(6); (b)(7)(C) in the ambulance. Officer (b)(6); (b)(7)(C) recalled on interview that the ambulance drove with both lights and siren activated and arrived at the hospital in approximately 15 minutes. The time of arrival documented in the Hospital Logbook is **5:14 p.m.**; the time of arrival documented in the Eloy Fire District report is 5:11 p.m. Officer (b)(6); (b)(7)(C) stated that upon arrival in the emergency room, TRAN was placed on a respirator and he heard medical staff say he had a low pulse. The detainee was then moved to the intensive care unit (ICU). Officer (b)(6); (b)(7)(C) made appropriate entries to the Hospital Logbook for the remainder of his shift, as did officers assigned to vigil duty during TRAN's hospitalization until the time of his death (see below).

According to the Pertinent Report of the Banner Health Emergency Department, provider care was initiated by (b)(6); (b)(7)(C) at **5:15 p.m.** Following testing, the documented diagnosis was "acute cardiopulmonary arrest with return of spontaneous circulation, suspect anoxic brain injury." The report states TRAN was to be admitted to the ICU.

Chief of Security Chance Leeds notified the Warden that following the emergency, he met with all EFCF responders in his role as a member of the CoreCivic Incident Stress Management Team. He assessed how they were coping and reminded them that the Employee Assistance Program was available.

²⁹ Interosseous refers to marrow within bones.

³⁰ Narcan is used to treat narcotic overdose in an emergency situation.

³¹ Epinephrine is a hormone produced by the adrenal glands which functions to increase cardiac output and to raise glucose levels in the blood.

³² Sinus rhythm refers to a normal heart beat.

Wednesday, June 6, 2018

A hospital update electronically signed at 4:05 a.m. by RN (b)(6); (b)(7)(C) documents TRAN was stable with vital signs within normal limits. He was on a ventilator and receiving hypothermia therapy³³, and his current medication treatment included anodyne³⁴, propofol³⁵, Levophed³⁶, Zosyn³⁷ and normal saline.

Officers' Hospital Logbook entries include the following:

Time	Entry
5:57 a.m.	X-ray taken.
6:45 a.m.	Detainee "being held under observation for 24 hours, being cooled down due to suffering from cardiac arrest per medical staff."
9:00 a.m.	Detainee would be "warmed to regular temp for further evaluation."
10:15 a.m.	Labs being taken. Per the doctor, "did not look promising" but tomorrow "would tell Tran's mental state."
5:26 p.m.	Captain (b)(6); (b)(7)(C) approved visit by detainee's father, (b)(6); (b)(7)(C). In follow up calls, Captain Meiner approved visits by the detainee's sister and mother.
7:57 p.m.	Detainee TRAN's mother and father arrived to visit, leaving at 9:39 p.m.

Thursday, June 7, 2018

A hospital update signed at 2:04 a.m. by RN (b)(6); (b)(7)(C) documents TRAN's condition was unchanged. He remained unresponsive with no reflexes. A rewarming process was initiated the night before and his target temperature was reached at 37 degrees Celsius³⁸. The goal was to maintain that temperature for 72 hours. Paralytic³⁹ medication was discontinued, and his current medications included Versed⁴⁰, Protonix⁴¹, normal saline, Flagyl⁴² and Zosyn via IV and vancomycin⁴³ via oral-gastric tube. He was scheduled to see an intensivist⁴⁴ later that day.

³³ Sinus rhythm refers to a normal heart beat.

³⁴ Anodyne is a drug used to lessen pain by reducing the sensitivity of the brain or nervous system.

³⁵ Propofol is a type of drug which causes relaxation and sleepiness before and during medical procedures.

³⁶ Levophed is the brand name for norepinephrine, a drug used to treat low blood pressure and heart failure.

³⁷ Zosyn is an antibiotic medication used to treat infections.

³⁸ 37 degrees Celsius is 98 degrees Fahrenheit.

³⁹ Paralytics are drugs which cause muscle paralysis.

⁴⁰ Versed is a brand name for midazolam, a sedative medication used to help patients feel relaxed or sleepy before a medical procedure.

⁴¹ Protonix is a brand name for pantoprazole, a drug used to treat gastroesophageal reflux disease and damaged esophagus.

⁴² Flagyl is a brand name for metronidazole, a drug used to treat infections.

⁴³ Vancomycin is a drug used to treat infections.

⁴⁴ An intensivist is a physician who specializes in the care of critically ill patients, most often in the ICU.

A second update was signed by RN (b)(6); (b)(7)(C) at 11:13 a.m. TRAN's condition remained unchanged. He was unresponsive with no pupillary reflex⁴⁵, pain response, or signs of waking. His core body temperature remained steady at 37.1 Celsius⁴⁶. The treatment goal was to continue monitoring his neurological status. Versed was discontinued at 3:00 a.m. Current medications were Flagyl and Zosyn intravenously and vancomycin via oral-gastric tube. The most recent vital signs were elevated pulse of 109, elevated blood pressure of 132/85, and respirations 24 and oxygen saturation 97 percent, both per ventilator settings. There was evidence of kidney injury. The neurologist wanted to wait to perform an electrocardiogram (EEG)⁴⁷ until other medications were discontinued.

Officers' Hospital Logbook entries include the following:

Time	Entry
2:30 a.m.	Per nurses, sedation was reversed at 2:00 a.m.
3:30 a.m.	"Tests from doctors have turned up negative results so far showing no higher brain functions. Dr.'s will be in to see Detainee Tran in the morning for further evaluation."
9:15 a.m.	TRAN's parents visited for one hour. During the visit, the doctor informed them that their son's recovery "did not look good."
12:20 p.m.	The ICU doctor stated TRAN "may not wake up."
1:45 p.m.	A nurse stated there was "some pupil reaction to light very faint but there was some difference from the morning there was none."

Friday, June 8, 2018

A hospital update signed at 1:38 a.m. by RN (b)(6); (b)(7)(C) documents TRAN's condition remained unchanged. He was essentially unresponsive with the exception of some sluggish pupillary reflex to the left eye. There were no signs of waking or pain response. Vitals signs were essentially within normal limits as follows: temperature 37 Celsius, pulse 100, blood pressure 114/65, respirations 24 based on vent setting, and oxygen saturation 94 via ventilator with 30 percent room oxygen. The plan was to perform an EEG that day.

Officers' Hospital Logbook entries include the following:

Time	Entry
10:45 a.m.	The doctor asked who can authorize dialysis. He was referred to ICE.
11:33 a.m.	The doctor arrived to evaluate TRAN and the family arrived for visitation.
12:00 p.m.	The doctor updated the family on TRAN's condition and treatment plan.

⁴⁵ Pupillary reflex refers to the changes in diameter of the pupils when exposed to light.

⁴⁶ 37.1 degrees Celsius is 98.7 degrees Fahrenheit.

⁴⁷ An EEG is a test used to record and monitor electrical activity of the brain.

1:10 p.m.	The family was asked to leave so dialysis ⁴⁸ tubing could be implanted. The tube was planted in detainee TRAN's neck at 1:45 p.m.
7:55 p.m.	TRAN's family returned at 7:55 p.m. and departed at 10:00 p.m.

Saturday, June 9, 2018

RN (b)(6); (b)(7)(C) signed a hospital update at 3:37 a.m. documenting the following vital signs within normal limits: temperature 36.3 Celsius⁴⁹, pulse 96, blood pressure 105/66, respirations 24 per vent setting, and oxygen saturation 95 on ventilator with 30 percent room air. In an addendum timed 3:38 a.m., RN (b)(6); (b)(7)(C) wrote that TRAN's condition was unchanged; he remained unresponsive with no pupillary reflex, no pain response, and no signs of waking. He received dialysis the day before and no fluids were taken out. The current treatment goal was to continue monitoring his neurological status. His medications remained the same. Tube feeding was started late the day before to help stabilize his blood glucose levels. An EEG was to be performed after all medications were discontinued, more improvement was observed, and sedating medication had been discontinued for a minimum of 72 hours.

A second update was signed by RN (b)(6); (b)(7)(C) at 1:06 p.m. TRAN's condition remained unchanged. He was unresponsive with pupils fixed and dilated, had no pain response, and no signs of waking. Dialysis was underway. The treatment goal was to continue monitoring his neurological status. Most recent vital signs were within normal limits. An EEG and brain stem testing were to be done "most likely Monday."

Officers' Hospital Logbook entries include the following:

Time	Entry
9:20 a.m.	Dialysis was started and ended at 6:00 p.m.
10:35 a.m.	Three family members arrived to visit detainee TRAN. A fourth family member joined the group at 1:00 p.m. and two additional family members arrived at 2:55 p.m. The group visited throughout the day. The last visitor left at 7:53 p.m.
8:23 p.m.	TRAN's sister arrived and stayed until 11:00 p.m.

Sunday, June 10, 2018

A hospital update signed at 1:08 a.m. by RN (b)(6); documented TRAN's condition remained unchanged; pupils fixed and dilated, no pain response, and no signs of waking. Vital signs were normal. The treatment goal was to continue monitoring his neurological status.

Officers' Hospital Logbook entries include the following:

⁴⁸ Dialysis is the clinical purification of blood, as a substitute for the normal function of a kidney.

⁴⁹ 36.3 degrees Celsius is 97.3 degrees Fahrenheit.

Time	Entry
12:12 a.m.	TRAN's sister arrived and stayed until 1:33 a.m.
5:00 p.m.	TRAN's parents arrived. His sister returned later. The last visitor left at 10:40 p.m.

Monday, June 11, 2018

A hospital update signed at 6:31 a.m. by RN (b)(6); (b)(7)(C) documents TRAN's condition remained the same. His pulse and blood pressure were abnormally elevated at 103 and 160/106, respectively; respirations at 16 and oxygen saturation at 96 were normal on the ventilator. A CT scan⁵⁰ may be done to determine any brain changes from the baseline scan done on June 5, 2018.

A second update was signed by RN (b)(6); (b)(7)(C) at 10:21 a.m. TRAN's condition remained unchanged. His blood pressure was abnormally elevated at 154/106. Other vital signs were within normal limits. A CT scan was to be completed that day.

Officers' Hospital Logbook entries include the following:

Time	Entry
9:00 a.m.	A test was conducted to determine if TRAN could breathe on his own. "He did not breath [sic] on his own without the machine."
9:25 a.m.	A family member arrived. Others arrived throughout the day
9:55 a.m.	Two doctors informed TRAN's sister "there is little chance Detainee Tran will pull through."
11:55 a.m.	An echo cardiogram was conducted.
1:15 p.m.	A doctor spoke with TRAN's family members about organ donation if there is no brain functioning after testing.
2:55 p.m.	A neuron X-ray ⁵¹ was conducted.
4:42 p.m.	Dialysis was started and continued until 7:08 p.m.

Tuesday, June 12, 2018 – Day of Death

A hospital update signed at 1:42 a.m. by RN (b)(6); (b)(7)(C) documents TRAN's condition remained unchanged. Results of a MRI⁵² were pending. Reported vital signs were within normal limits.

Officer (b)(6); (b)(7)(C) was assigned to hospital vigil duty for the 2:00 a.m. to 2:00 p.m. shift. He reported during interview that hospital staff conducted a test to determine if the detainee had brain waves. Per entry to the hospital logbook, the test began at 8:43 a.m. Officer (b)(6); (b)(7)(C) said that

⁵⁰ A CT scan is an x-ray which produces computerized cross-sectional images of specific areas of the body.

⁵¹ A neuron x-ray refers to a particular kind of brain x-ray used to determine proof of brain death.

⁵² An MRI is a non-invasive test which uses a powerful magnetic field, radio frequency pulses, and a computer to produce detailed picture of specific areas of the body.

after the test, hospital staff left the room and a few hours later, a woman came to inquire about organ donation, asking to speak with an EFCF supervisor. When connected via telephone with a captain, she informed him TRAN had been pronounced dead at 9:20 a.m. Officer (b)(6); (b)(7)(C) said this was the first he heard that death had been pronounced. He remarked that he was confused because the detainee remained on a ventilator throughout his shift, which ended at 2:00 p.m. Officer (b)(6); later completed an incident report documenting these events.

A telephone encounter by RN (b)(6); (b)(7)(C) on 3:55 p.m. documents an EEG conducted early that morning showed no brain activity. Findings were confirmed with apneic testing⁵³ also conducted that morning. Detainee TRAN was declared brain dead at 9:20 a.m. Family members had been notified and were expected to arrive to the hospital that afternoon. The plan was to discontinue the ventilator at that time.

Note: As noted, the time the telephone encounter was entered was 3:55 p.m. The time the information was received from the hospital is not documented but based on the information below, is presumed to be earlier.

Officer (b)(6); (b)(7)(C) was relieved by Officers (b)(6); (b)(7)(C). Both submitted incident reports documenting that at 3:39 p.m. detainee TRAN was removed from life support. At 3:53 p.m. two medical examiners arrived and took photos of TRAN. At 4:06 p.m., Officer (b)(6); was given documentation stating custody of the body was transferred to the Pinal County Medical Examiner's Office. At 4:04 p.m. Officers (b)(6); (b)(7)(C) escorted the medical examiners to their transport van. Officer (b)(6); (b)(7)(C) stated during interview that TRAN's family members were at the hospital when the coroner arrived. He reported a Casa Grande Police Department officer arrived as well.

Note: The incident reports of Officers (b)(6); (b)(7)(C) do not document that the family was present when the medical examiner arrived, nor do they document that a police officer arrived.

Hospital logbook entries document different times for events described in the officers' incident reports. Entries state TRAN was taken off life support at 2:39 p.m., the medical examiner took photos at 3:09 p.m., and the body was moved to the medical examiner's vehicle at 3:59 p.m.

Note: It is unknown whether the incident reports or log book entries document the correct times.

⁵³ (b)(6); is an essential component in the clinical determination of brain death. The main objective of apnea testing is to prove the absence of respiratory control system reflexes in the brainstem when intense physiologic stimulation to breathe takes place.

Post-Death Documentation and Actions

- The hospital discharge summary dated June 12, 2018 documents the following:

“A 47-year-old male with unknown medical history was brought into the emergency department after code arrest. The patient was incarcerated, and two corrections officers saw the patient unresponsive while they were doing room checks, which prompted them to call emergency services. Chest compressions were started prior to EMS arrival. Patient received several rounds of epinephrine along with CPR. Upon arrival to hospital patient was admitted to the ICU. He was found unresponsive and was intubated. Patient remained intubated and unresponsive while work up was completed, no clear evidence of any trauma was found. An extensive discussion was had with parents at bedside, with the sister on phone, and explained about the patient’s critical condition, about comatose state, and told them chances of meaningful neurological recovery would be very low. Family understood. On June 11, brain nuclear study was ordered to prove brain death. There was a technical error with the contrast and the tracer returning incomplete results, and the plan was to repeat the study in 24 hours. On June 12, case discussed with [neurology] and ICU, and instead of repeating imaging, apnea test⁵⁴ was performed and returned positive for brain death. Clinical [neurological] examination was also positive for brain death. Care withdrawal today in coordination with organ donor network”.

- Per the Banner Health Human Remains Release Form, detainee TRAN was pronounced dead by (b)(6); (b)(7)(C) of Banner Casa Grande Medical Center at 9:20 a.m. The listed diagnosis was, “Anoxic encephalopathy, post code, Acute Respiratory Failure, no respiration, Acute Renal Failure.”
- The State of Arizona Certification of Vital Records, Certificate of Death issued June 14, 2018 lists the immediate cause of death as pending.
- A letter from the Consulate General of Vietnam dated June 19, 2018 documents TRAN’s body was turned over to the family for burial.
- The Pinal County Forensic Examination Report, dated July 17, 2018, documents the cause of death as coronary artery disease and the manner of death as natural. There was no evidence of trauma.
- EFCF Investigator (b)(6); (b)(7)(C) conducted a review of events during detainee TRAN’s full period of detention. She reported she was given this assignment by the Warden on the day of TRAN’s death, June 12, 2018. In conducting the review, Investigator (b)(6); (b)(7)(C) interviewed

⁵⁴(b)(6); (b)(7)(C) Testing is a brain death assessment in which all ventilator support is temporarily removed. A positive test is defined by a total absence of respiratory effort under this condition.

security and medical staff and analyzed video footage showing TRAN's movements. In her report, signed June 19, 2018, she concluded the following:

- Information received regarding detainee's placement in Bravo 600 for mental health observation was minimal and provided little insight for security staff to address detainee's needs.
 - **Note:** (b)(6); (b)(7)(C) commented that detainees' health information is not shared with officers.
- Detainee TRAN was not examined by a medical practitioner prior to mental health observation placement as he would have been had he been placed in segregation.
 - **Note:** TRAN was, in fact, assigned to administrative segregation when placed in Bravo 600 for mental health observation. The nurse documented medical clearance based on review of his chart, but failed to see him in person.
- Officer (b)(6); (b)(7)(C) did not complete checks at the required intervals and did not properly document those checks.
- As the reporting party, Officer (b)(6); (b)(7)(C) did not exhibit a sense of urgency given the nature of the emergency.
- Responding female security staff were observed outside of the detainee's cell and did not enter the cell until male staff arrived.
- Officer (b)(6); (b)(7)(C) who was on constant watch at the next cell, did not maintain the required visual observation of his assigned detainee.
- During CPR, airway head tilt and AED pad placement were noted as concerns.
 - **Note:** As discussed above, the concern regarding the airway head tilt related to the fact that medical responders did not take this action until suggested by Officer (b)(6); (b)(7)(C).

Although not discussed in her report, Investigator (b)(6); (b)(7)(C) stated during interview that she "thought it strange" that some medical responders remained in the Bravo 600 dayroom while officers conducted the chest compressions. She also commented that AEDs were previously removed from all housing units and turned in to medical. Investigator (b)(6); (b)(7)(C) noted that despite having multiple AEDs available, medical ironically ended up with one where the pads did not stick. HSA (b)(6); (b)(7)(C) explained that AEDs were removed from housing units because the requirement to inspect them daily and replace them regularly was resource intensive. He said response to medical emergencies was not compromised because medical staff must arrive at the scene within four minutes, with AED.

Note: Failure of the pads to adhere may have been caused by TRAN's perspiration rather than expired or faulty pads. Regardless, as noted, a second set of pads was not available in the emergency bag when the first set did not adhere.

- Lieutenant (b)(6); (b)(7)(C) informed the review team that following the medical emergency, he clarified with the responding officers that a cell may be entered when two officers are present, regardless of the gender of the detainee or responders. He also stated the handheld camera was sent for repair of the slide action that jammed during the emergency.
- On June 20, 2018, TRAN's property and funds were mailed via U.S. Postal Service to his father in Mesa, AZ and signed as received on June 21, 2018.

CONCLUSIONS

Medical

ERO officers ensured detainee TRAN was given priority for medical pre-screening based on their observation that he was sweating profusely upon arrival at EFCF. Video evidence supports that an RN expedited his pre- and full intake screening, although her documentation includes no reference to excessive perspiration. She also did not document any observation of conditions noted by EFCF intake personnel, including that he was very slow to respond and that he drooled and had mucous on his face. Based on his history of schizophrenia and arrival at EFCF with psychiatric medications last taken the day before, the RN referred him for examination by a provider and to the psychiatrist.

NP (b)(6); (b)(7)(C) conducted the initial health appraisal within hours of the intake screening. She documented TRAN's self-reported 17 year history of schizophrenia and anxiety disorder for which he took Haldol and fluoxetine with no side effects. An AIMS test to identify possible side effects of long term use of Haldol resulted in a score of zero. After consulting IHSC psychiatrist Dr. (b)(6); (b)(7)(C) by telephone, NP (b)(6); (b)(7)(C) ordered Haldol and fluoxetine once daily for 14 days in the same dosage as the medications that arrived with TRAN. He received the first doses on May 30, 2018. Assuming he was not given any doses of the intake supply which, if occurred, was not documented, he was without the medications for two days, May 28 and 29, 2018. Ostensibly, the delay in starting the medications was attributable to the timing of (b)(6); (b)(7)(C)'s orders vis-à-vis pharmacy hours.

NP (b)(6); (b)(7)(C) referred TRAN to mental health. She did not specify that the referral was for psychiatric follow up; however, because TRAN was a mental health patient with a long history of taking psychiatric medications, follow up by a psychiatrist was appropriate.

Pursuant to the referrals by RN (b)(6); (b)(7)(C) TRAN was evaluated by (b)(6); (b)(7)(C) six days later, June 4, 2018. An AIMS test pointed to symptoms of EPS, leading to his decision to add Cogentin to the medication regimen to address side effects of Haldol. Although intended, (b)(6); (b)(7)(C) did not order Cogentin. He issued new orders changing the administration times of

fluoxetine and Haldol; however, the orders were not received and processed by the pharmacy until after early morning doses of both medications were given the next day, June 5, 2018. The MAR documents he received a second dose of fluoxetine four hours after the first, constituting a medication error. TRAN was not given a second dose of Haldol, although an entry to the MAR suggests it would have been erroneously offered had he not been taken to the hospital. Based on the fact that the orders changing administration times for fluoxetine and Haldol were not processed until the day after (b)(6); (b)(7)(C) examined TRAN, the reviewer concludes that Cogentin, had it been ordered as intended, would not have been administered to TRAN until sometime on June 5, 2018.

Detainee TRAN was seen by a (b)(6); (b)(7)(C) psychologist, on June 5, 2018 within 24 hours after security staff submitted a referral. In her encounter note, (b)(6); (b)(7)(C) documented physical symptoms that included sweating, muscular rigidity, slow movements, and lethargy. During interviews, CoreCivic intake personnel, the housing unit officer, and TRAN's cellmate also consistently remarked on the detainee's slowness in movement and response. (b)(6); (b)(7)(C) directed TRAN's placement on mental health observation status with follow up in two to three days, but did not refer him to a higher level, prescribing provider based on observed physical symptoms. An RN cleared him for segregation by reviewing his medical record only, without evaluating him in person and taking his vital signs. TRAN's vital signs were last taken during physical examination nine days earlier, on May 28, 2018.

Medically cleared on paper for segregation, TRAN was moved to the mental health observation section of the special management unit. Approximately 75 minutes later, the officer found TRAN unresponsive in his cell and called medical emergency. Security staff responded promptly and initiated CPR, followed quickly by medical responders. Officers rotated performance of chest compressions while medical professionals performed other life-saving efforts, including use of the AED. Video evidence and documentation reflects the AED pads were not properly placed by response team leader NP (b)(6); (b)(7)(C) and did not properly adhere; therefore, proper analysis of heart activity was impeded. At the request of (b)(6); (b)(7)(C), two additional providers responded and participated in life-saving efforts until EMS personnel arrived and took over care. To the credit of EFCF security responders, the EMS report documents quality CPR was being performed when EMS arrived on scene.

For the week following TRAN's admission to the hospital, EFCF nursing staff obtained and documented daily updates on his status until his death on June 12, 2018.

Compliance Findings

The reviewer identified the following deficiencies in the ICE 2011 PBNDS, Medical Care, revised 2016.

Medical Care, section (V)(AA)(4), which states, “Prior to the administration of psychotropic medication, a separate documented informed consent, that includes a description of the medication’s side effects shall be maintained.”

- TRAN did not sign consent for psychotropic medications started May 30, 2018 until June 4, 2018. The signed consent documents side effects were discussed with the detainee but does not list any side effects. Side effects were, however, listed in the psychiatrist’s encounter note.

Creative Corrections notes that beyond the above deficiencies, there may be issues with respect to TRAN’s care that are not within the scope of an RN or this analysis to address because they lie within the province of provider clinical judgment. The following fact-based observations, within scope, are cited.

- TRAN reported during intake that he last received doses of Haldol and fluoxetine the afternoon before he was admitted to EFCF May 27, 2018. Although the medications were received with him and were ordered by (b)(6); (b)(7)(C) the day he arrived, May 28, 2018, medical record documentation indicates he did not receive them until May 30, 2018. This constitutes a break in continuity of care. If TRAN was, in fact, given doses from the intake supply, administration of the medications was not documented. If doses were not given from the intake supply, it is possible that (b)(6); (b)(7)(C) recognized and was not concerned that entry of her orders after pharmacy hours would delay administration of the medications to TRAN until May 30, 2018. Because (b)(6); (b)(7)(C) left employment at EFCF prior to the site visit, reviewers could not determine whether the break in medication treatment was determined acceptable, or was unintended.
- (b)(6); (b)(7)(C) orders changing administration times for fluoxetine and Haldol were not received during pharmacy hours; consequently, they were not processed until the next day, after TRAN received his once-daily doses of the medications. As a result, he received twice the prescribed daily dose of fluoxetine and had he not been taken to the hospital, may have been offered a second dose of Haldol.
- (b)(6); (b)(7)(C) did not order Cogentin to treat EPS symptoms as intended. He stated during interview that his failure to order Cogentin was an oversight. Reviewers note that had he ordered Cogentin, the medication may not have been administered prior to the medical emergency.
- TRAN was observed unresponsive in his SMU cell within approximately four hours after the psychologist ordered his assignment to mental health observation status. The RN who medically cleared TRAN for segregation reviewed his record, only. She did not determine whether his placement in segregation was medically safe and appropriate by taking his vital signs and conducting an in person assessment of his physical condition. Reviewers recommend reinforcement of the expectation to conduct in-person assessments before clearing detainees of placement in segregation (see Security Compliance Findings, below).
- During the medical emergency response, the medical team leader did not place the AED pads in proper position and did not dry TRAN’s skin before attempting placement. The

pads did not adhere, rendering the AED ineffective in analyzing heart activity. The reviewer cannot determine whether the pads did not adhere because they were expired, or because TRAN was perspiring. The emergency bag inventory did not list AED pad expiration dates, nor did it include a second set of pads. The reviewers recommend that inventory of emergency bag contents include review of AED pad expiration dates, and that a second set of pads be included in the bag.

- (b)(6); (b)(7)(C) physical examination entry included documentation that TRAN had no upper or lower teeth. She did not order a special diet to assure adequate nutritional intake.

Security

Starting with the SDDO and DO present when TRAN arrived at EFCF, continuing through every CoreCivic staff person interviewed, observations were shared that point to behaviors and conditions of concern. The ERO personnel appropriately ensured TRAN was seen quickly by a nurse, and the CoreCivic officers in intake and his first housing unit understandably assumed that the medical personnel who cleared him for general population would have directed alternative placement, if necessary. After TRAN was in general population for seven nights, (b)(6); (b)(7)(C) the Unit Manager, saw fit to submit a mental health referral based on her own observations and concerns. The next day, she mentioned TRAN at the weekly multi-disciplinary meeting where detainees with special needs are discussed. Unit Manager (b)(6); (b)(7)(C) actions were appropriate and demonstrated conscientious attention to detainee healthcare issues. Pursuant to her referral, TRAN was seen promptly by a psychologist who directed his placement in segregation for mental health observation with checks every 15 minutes by the officer. As discussed in Medical Conclusions, above, an RN medically cleared TRAN's placement in segregation without assessing him in person.

Officer (b)(6); (b)(7)(C), the officer assigned to the SMU at the time of TRAN's placement, did not make rounds every 15 minutes and falsely documented rounds he did not make. Contrary to the video evidence, the officer documented he checked on TRAN at 3:09 p.m., 3:23 p.m., and 3:38. By contrast, the video evidence shows that after Officer (b)(6); (b)(7)(C) issued linens to TRAN at 3:00 p.m., shortly following the detainee's placement in the SMU, he did not look in the cell again until 3:51 p.m. Video does not allow determination of whether Officer (b)(6); (b)(7)(C) did, in fact, confirm TRAN was alive at that time.

After the 3:51 p.m. check, Officer (b)(6); (b)(7)(C) is next seen looking in TRAN's cell at 4:12 p.m. He removed the food tray from the portal and carried it off the unit, returning to TRAN's cell and immediately opening the door at 4:13 p.m. This action suggests that Officer (b)(6); (b)(7)(C) observed TRAN was not moving when he looked in the cell at 4:12 p.m., yet he took no action until he carried the food tray away. After he opened the cell door, Officer (b)(6); (b)(7)(C) called medical emergency upon the advice of an officer on constant watch duty at the next cell. Officer (b)(6); (b)(7)(C) did not enter the cell again.

The first security responders, all women, arrived within an estimated three minutes after the medical emergency was called. They stood at the cell front and did not enter to render aid. Despite the fact that two officers and one correctional counselor were present, the responding female staff said they did not enter out of concern for their safety. Lieutenant (b)(6); (b)(7)(C) and another male officer arrived on scene a minute later and entered the cell, followed by the female responders.

Lieutenant (b)(6); (b)(7)(C) quickly directed initiation of CPR and instructed Central Control to call EMS. Upon the arrival of medical staff, officers continued to perform chest compressions while medical professionals performed other life-saving efforts pending the arrival of EMS personnel. EMS access to the facility and SMU was efficiently expedited. As noted in Medical Conclusions, the EMS report documents that when the EMS responders arrived, “quality CPR” was being performed. This observation is a credit to the officers and their trainers.

Following the emergency event, all responding staff completed incident reports and employee counseling services were offered to staff. The facility investigator completed a thorough after action review that included interviews of involved staff and review of video appropriately retained for analysis. As a result of the after action review, Officer (b)(6); (b)(7)(C) resigned in lieu of termination and the female staff who did not immediately enter TRAN’s cell when they arrived on scene were counseled.

Compliance Findings

The reviewer identified the following deficiencies in the ICE 2011 PBNDS, revised 2016 governing safety and security.

Custody Classification System, section (V)(A)(4), which states, “Each detainee’s classification shall be reviewed and approved by a first-line supervisor or classification supervisor.”

- A supervisor did not approve the classification rating assigned to detainee TRAN on May 28, 2018.

Special Management Units, section (V)(M), which states, “Close Supervision Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly.”

- Per the psychologist’s order communicated via Special Needs form, officers were to check on TRAN every 15 minutes following placement in the SMU. Video evidence shows TRAN was not observed for 51 minutes after the officer issued linens. Specifically, the officer issued TRAN linens at 3:00 p.m. and is next seen looking in the cell at 3:51. During

the 51 minute period, the officer documented three welfare checks video shows he did not make, at 3:09 p.m., 3:23 p.m., and 3:38 p.m.

Special Management Units, section (V)(P), which states, “Detainees must be evaluated by a medical professional prior to placement in an SMU (or when that is infeasible, as soon as possible and no later than within 24 hours of placement). The assessment should include a review of whether the detainee has been previously diagnosed as having a mental illness.”

- The nurse assigned to evaluate the detainee for placement in the SMU did not conduct a face to face assessment.

This also violates EFDC policy Segregation/Restrictive Housing Unit Management 10-100 which requires screening by a health care professional prior to placement of any detainee in segregation.

INITIAL CUSTODY CLASSIFICATION

CCA Facility: EDC

Initial Classification Date: 05/28/18

I. IDENTIFICATION

Inmate/Resident Name:

Tran

LAST

Admission Date 05/28/18

FIRST

M.I.

CCA/Jurisdiction ID# 037949945

Most Serious Current Charge/Offense:

Legal Status: Pretrial Sentenced Parole Violator Probation Violator Other (list) Detainee

If Sentenced, Is the Offense a Felony Misdemeanor Technical Infraction

II. CUSTODY EVALUATION

A. Severity of Current Offense (Score the most severe current offense or detainer charge.)

SCORE
(b)(7)(E)

Lowest.....1
 Moderate.....3
 High.....5
 Greatest.....7

Agg Assault x3 CONV
 10/25/2000 x2 4/8/09

B. Severity of Prior Criminal Convictions (Score the most severe prior conviction in the past 10 years.)

None.....0
 Lowest.....1
 Moderate.....3
 High.....5
 Greatest.....7

Domestic Violence CONV 8/14/15, 5/10/07
 x2 8/14/15

C. History of Escape or Attempts to Escape

No escapes or attempts to escape.....0
 Escape (or attempt) from low security or community corrections facility
 Over 1 year ago.....1
 Within the past year.....3
 Escape (or attempt) from medium or high security OR any escape with actual or threatened violence
 Over 10 years ago.....5
 Within the past 10 years.....7

D. History of Institutional Violence (Score the most serious documented incident in the past 10 years.)

None.....0
 Behavior NOT involving a weapon or resulting in serious injury.....5
 Behavior involving a weapon or resulting in serious injury.....7

HIGH CUSTODY SCORE (Add items A - D. Enter score at right.)
 (If score is 10 or higher, inmate should be assigned to High Custody.)

SUBTOTAL SCORE (Add Items A

E. Prior Felony Convictions - Adult or Juvenile - (in the past 10 years)

None.....0
 One.....1
 Two or more.....2

Disorderly Conduct x3 11/3/96, 11/24/96, 2/2/00
 7/10/17 5/8/94

F. Drug/Alcohol History (in the past 5 years)

No use.....0
 Occasional or recreational use.....1
 Serious dependence/alcoholic/addict or introduction of drugs or alcohol into a correctional facility.....2

G. Age

24 or younger.....1
 25 to 35.....0
 36 or older.....-2

8/7/70 46

H. Education

No High School Diploma or GED.....0
 High school diploma or GED.....-1

I. Employment

Not Employed.....0
 Employed for at least 1 year at time of arrest.....-1

SUBTOTAL SCORE (ADD ITEMS E - I)

TOTAL CUSTODY SCORE (ADD ITEMS A - I)

III. CUSTODY SCALE AND RECOMMENDATION

Assign Custody Level Indicated by Scale Below

HIGH CUSTODY SCORE (items A – D)	Custody Level
10 or more points	HIGH
TOTAL CUSTODY SCORE (items A – I)	Custody Level
12 or more points.....	HIGH
5 to 11 points.....	MOD
4 or fewer points.....	LOW

Custody Level

Check (✓) All Factors that Apply to this Inmate for Purpose of Over-Riding Scored Custody Level

Non-Discretionary – Low Custody Restrictions

☐ Sex Offender
☐ Hold w/o Bond
☐ High Bail Amount (100K or above)
☐ Time Left to Serve (over 5 years)
☐ Felony detainer or warrant (ICE)
☐ Escape From Secure Facility (W/I 10 yr)

Discretionary Over-Ride – Higher Custody

☐ Known Management Problem
☐ Prison Disturbance/Riot History
☐ Suspected Drug Trafficker inside Institution
☐ Current Escape Threat
☐ Serious Violence Threat
☐ Known Gang Affiliation/Disruptive Group
☐ Threatened Government Official
☐ Other (specify) _____

Discretionary Over-Ride – Lower Custody

☐ Prior Good Institutional Conduct
☐ Isolated Prior Institutional Misconduct

Is Over-Ride of Scored Custody Level Recommended?

☒ Yes

☐ No

If yes, give rationale (required):

Pen Rca Hash

Recommend Population Assignment and Custody Level

Population Assignment
(Select code from the list below)

Code

Custody Level
(Select code from the list below)

Code

General Population GP
Administrative Segregation AS
Disciplinary Segregation DS
Juvenile Unit JU

HIGH
MOD
LOW

Inmate/Resident Signature

Hayden

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

Date 05/28/18

Classification Officer /Case Manager/Counselor Signature

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

Date 05/28/18

IV. ASSISTANT WARDEN/ADMINISTRATOR REVIEW AND COMMENTS OF DISCRETIONARY OVER-RIDE:

Classification Supervisor/Designee Signature

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

Date 05/28/18

Assistant Warden/ Assistant Administrator Review

Assistant Warden/ Assistant Administrator Signature

Date

V. WARDEN/ADMINISTRATOR APPROVAL OF OVER-RIDE

Approve Recommended Population Assignment and Custody Level?

☐ Yes

☐ No

If no, give rationale (required):

Final Population Assignment and Custody Level

Population Assignment
(Select code from the list below)

Code

Custody Level
(Select code from the list below)

Code

General Population GP
Administrative Segregation AS
Disciplinary Segregation DS
Juvenile Unit JU

HIGH
MOD
LOW

Warden/Administrator Signature

Date

5/2018

Month/Year:

Medication Administration Record

Prescriptions

Facility: Eloy

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
AM																															
AM																															
AM																															
AM																															

Order Date: 5-28-18
Exp. Date: 6-11-18
RX #: 1385907

Order Date: 5-28-18
Exp. Date: 6-11-18
RX #: 1385907

Order Date: 5-28-18
Exp. Date: 6-11-18
RX #: 1385907

Order Date: 5-28-18
Exp. Date: 6-11-18
RX #: 1385907

Order Date: 5-28-18
Exp. Date: 6-11-18
RX #: 1385907

Documentation Codes: H - Hold HT: R - Refused WT: DC - Discontinued Order Allergies: NKDA S - Self Administered Diagnosis: NS - No Show O - Other

Registration #: 037949945 Physician: 164

HT: TRAN, May Chi

Exp. Date: 05/29/18

May 10

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

ICE Health Service Corps

Consent for Psychotropic Medications for Adults

Detainee's Name: Tran, Huy Chi

Date: 06/04/2018

Interpreter Provided? ☐ Yes ☒ No Name or INT#: English

Detainee's A#: 216576678

My physician has prescribed the following medication(s) for the treatment of my psychiatric and/or behavioral problems:

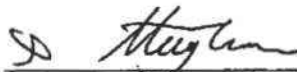
Name of Medication(s):

Haloperidol, fluoxetine, cogenin

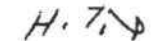
The indications for the use on the above medication(s) have been discussed with me. I have had an opportunity to ask questions about the changes that I might expect to see, and to discuss the possible risks, benefits, and precautions associated with this/these medication(s).

The side effects of this/these medication(s) have also been discussed with me and additional information has been provided about the medication(s). I understand and accept the advantages and disadvantages of this treatment. Based on the information provided, I agree to comply with the instructions provided by my physician for giving the medication.

If I have further questions or concerns after I have started the medication, I will contact the prescribing physician as soon as possible.


Detainee's Signature

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


06/04/2018
Date


06/04/2018
Date

Last Name: Tran	First Name: Huy Chi
A#: <u>216576678</u> <u>037949945</u>	Nationality: Vietnam
Date of Arrival: 05/28/2018	DOB: 08/07/1970
Facility: Eloy CCA Detention Center	Sex: Male

**Pierce County**

Medical Examiner's Office

3619 Pacific Avenue
Tacoma, Washington 98418
(253) 798-6494 • FAX (253) 798-2893

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

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PER RCW 68.50.105**

Medical Examiner Services Manager

POSTMORTEM EXAMINATION REPORT

MEDICAL EXAMINER CASE #: **18-2308**

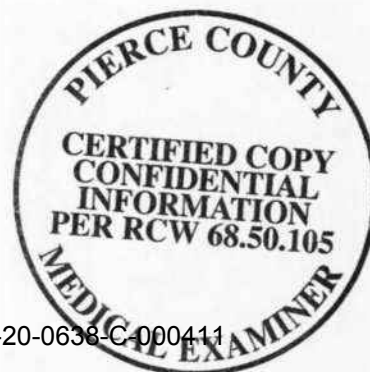
NAME OF DECEASED: **Mergensana Dabaevich Amar**

DATE OF EXAMINATION: **November 26, 2018**

LAW ENFORCEMENT AGENCY AND CASE #: **Tacoma Police Department
18-319-01418**

CAUSE OF DEATH: **Anoxic encephalopathy due to hanging**

MANNER OF DEATH: **Suicide**



FINAL DIAGNOSES:

Abrasion of the neck.
Respirator brain.
Acute bronchopneumonia and bronchitis, widespread.
Fatty change of the liver, severe.

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OPINION:

This 40-year-old man was found hanging in his locked cell at the Northwest Detention Center. He was resuscitated, and regained circulation, but never showed any neurologic response. He was pronounced brain dead on the third hospital day, and extubated.

Autopsy examination shows an abrasion of the neck consistent with the history. Anatomic findings include brain autolysis consistent with prolonging circulation following brain death, fatty change of the liver, and widespread pneumonia, likely the result of aspiration. Toxicology testing is negative for alcohol and other drugs.

Death is due to anoxic encephalopathy secondary to hanging.

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

Medical Examiner

M.D.

Date

22 Feb 2019



EXTERNAL EXAMINATION:

The decedent is received in a body bag clothed only in a hospital gown. He is 66 in. tall and weighs 160 lbs. The hair is brown. The eyes are brown with jaundiced sclera. The teeth are natural. Rigor is not detectable. Livor is purple and posterior. The body is cold.

There is evidence of medical intervention. There is a two-lumen central line in the right arm. A foley catheter is present. There are punctures and bruising in the left antecubital fossa. There is a purple bruise on the posterior left forearm consistent with an attempted vascular access.

There are multiple healing rounded lesions on the anterior abdomen, right side greater than left. There is a scar on the left knee.

Injuries:

There is a band of brown discoloration around the front and both sides of the neck. It is faint, approximately 1/4-in. in average width. It cants upward on both sides of the neck as it proceeds backward. The discoloration is more prominent on the left than the right side of the neck.

There is no internal injury of the neck.

There is faint discoloration of the right periorbital region, possibly representing a bruise.

INTERNAL EXAMINATION:**Body Cavities:**

The serosal surfaces are smooth and glistening. Approximately 600 cc of blood-tinged fluid are present in the right chest cavity. Approximately 100 cc of blood-tinged fluid are present in the left chest cavity. The abdominal cavity contains approximately 50 cc of clear, straw-colored fluid.

Head:

The scalp does not have evidence of injury. The skull is intact. The brain weighs 1640 g. The meninges are thin and delicate, with no evidence of inflammation or hemorrhage. The brain itself is soft and discolored consistent with respirator brain.

Neck:

The hyoid bone is not fused but not fractured. There is no associated hemorrhage. There is no hemorrhage of the strap muscles. The larynx is clear. The thyroid gland is of the usual size and configuration.

Cardiovascular System:

The heart weighs 390 g. The coronary arteries arise in the usual locations. There is a short 10% concentric lesion of the left anterior descending artery and no other significant atherosclerotic disease. Serial sections of myocardium do not show evidence of acute nor old infarction. The valves are normally formed. The descending aorta is intact and does not have significant atherosclerotic disease.

Respiratory System:

The right lung weighs 1120 g, left lung weighs 1290 g. The lungs are firm and noncompliant with diffuse patchy light discoloration. Sections of both lungs sink when placed into formalin.

Liver, Gallbladder, Pancreas:

The liver weighs 1920 g. It is light in color. The gallbladder contains liquid green bile. The pancreas is unremarkable.

Spleen and Lymph Nodes:

The spleen weighs 260 g and is unremarkable. There are no prominent lymph nodes.

Genitourinary System:

The right kidney weighs 200 g, left kidney weighs 220 g. The kidneys are normally formed and do not have focal lesions. The bladder contains 6 cc of urine. The bladder mucosa has multiple punctate hemorrhagic lesions consistent with a foley catheter. The prostate is unremarkable.

Endocrine System:

The adrenal glands are autolyzed.

Digestive System:

The gastrointestinal tract is intact. The stomach contains 70 cc of liquid. An appendix is present and unremarkable.

Musculoskeletal System:

There is a sternal fracture consistent with resuscitative efforts.

Toxicology: Specimens are submitted for toxicologic analysis. A separate report will be issued.

Histopathology: Sections are submitted for microscopic analysis.

Block 1 contains: heart and right lung.

Block 2 contains: left lung and liver.

Block 3 contains: kidney and brain.

MICROSCOPIC EXAMINATION:

Heart: There is no evidence of acute nor old infarction.

Lung: Sections of lung show diffuse alveolar damage with widespread acute bronchitis and bronchopneumonia.

Liver: There is a severe degree of fatty change.

Kidney: No pathologic diagnosis.

Brain: Autolyzed.

TBC: aa

Dictated: 11/26/2018

Transcribed: 11/26/2018

Finalized: 02/20/2019

RETENTION:

Blood, body fluids, tissues, and physical/trace materials that may be collected (the exact samples vary by case) during the examination are routinely held in accordance with our retention policy prior to biohazard disposal, unless transferred to a laboratory or other agency by the Medical Examiner's Office, or otherwise released by special arrangement.



STATE OF WASHINGTON DEPARTMENT OF HEALTH



CERTIFICATE OF DEATH



CERTIFICATE NUMBER: 2018-054225

DATE ISSUED: 02/28/2019

FEE NUMBER: 2715

FIRST AND MIDDLE NAME(S): MERGENSANA DABAEVICH
LAST NAME(S): AMAR

COUNTY OF DEATH: PIERCE
DATE OF DEATH: NOVEMBER 18, 2018
HOUR OF DEATH: 02:45 PM
SEX: MALE AGE: 40 YEARS
SOCIAL SECURITY NUMBER: UNKNOWN

HISPANIC ORIGIN: NO, NOT SPANISH/HISPANIC/LATINO
RACE: MONGOLIAN

BIRTH DATE: OCTOBER 23, 1978
BIRTHPLACE: KHURAMSHA RUSSIA

MARITAL STATUS: SINGLE, NEVER MARRIED
SPOUSE: NOT APPLICABLE

OCCUPATION: ENTREPRENEUR
INDUSTRY: BUSINESS
EDUCATION: BACHELOR'S DEGREE
US ARMED FORCES: NO

INFORMANT: (b)(6); (b)(7)(C)
RELATIONSHIP: FAMILY ACQUAINTANCE
ADDRESS: 3404 19TH AVE S, SEATTLE, WA 98144

CAUSE OF DEATH:
A: ANOXIC ENCEPHALOPATHY

INTERVAL: -

B: HANGING
INTERVAL: -

C:
INTERVAL:

D:
INTERVAL:

OTHER CONDITIONS CONTRIBUTING TO DEATH:

DATE OF INJURY: NOVEMBER 15, 2018
HOUR OF INJURY: 03:06 PM
INJURY AT WORK: NO
PLACE OF INJURY: INSIDE CELL AT ICE NORTHWEST DETENTION
CENTER
LOCATION OF INJURY: 1623 EAST J STREET

CITY, STATE, ZIP: TACOMA, WASHINGTON 98421-1602
COUNTY: PIERCE
DESCRIBE HOW INJURY OCCURRED: HANGED HIMSELF WITH BED SHEET

IF TRANSPORTATION INJURY, SPECIFY: NOT APPLICABLE

PLACE OF DEATH: HOSPITAL
FACILITY OR ADDRESS: ST. JOSEPH MEDICAL CENTER
CITY, STATE, ZIP: TACOMA, WASHINGTON 98405

RESIDENCE STREET: 1123 E J STREET
CITY, STATE, ZIP: TACOMA, WA 98421
INSIDE CITY LIMITS: YES COUNTY: PIERCE
TRIBAL RESERVATION: NOT APPLICABLE
LENGTH OF TIME AT RESIDENCE: 11 YEARS

FATHER/PARENT: SERGEI LUPODOVICH ZHAMSARANOV
MOTHER/PARENT: DULMA DABAEVNA ZHAMSARANOVA

METHOD OF DISPOSITION: CREMATION
PLACE OF DISPOSITION: SOUTH SOUND CREMATORY

CITY, STATE: LACEY, WASHINGTON
DISPOSITION DATE: DECEMBER 11, 2018

FUNERAL FACILITY: FUNERAL ALTERNATIVES OF WASHINGTON -
FEDERAL WAY
ADDRESS: 31919 6TH AVE S, STE 200
CITY, STATE, ZIP: FEDERAL WAY, WASHINGTON 98003
FUNERAL DIRECTOR: (b)(6); (b)(7)(C)

MANNER OF DEATH: SUICIDE
AUTOPSY: YES
WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE
CAUSE OF DEATH: YES
DID TOBACCO USE CONTRIBUTE TO DEATH: NO
PREGNANCY STATUS IF FEMALE: NO RESPONSE

CERTIFIER NAME: (b)(6); (b)(7)(C)
TITLE: CORONER/ME
CERTIFIER ADDRESS: 3619 PACIFIC AVENUE
CITY, STATE, ZIP: TACOMA, WA 984187929
DATE SIGNED: NOVEMBER 26, 2018

CASE REFERRED TO ME/CORONER: NO
FILE NUMBER: 18-2308
ATTENDING PHYSICIAN: NOT APPLICABLE

LOCAL DEPUTY REGISTRAR: (b)(6); (b)(7)(C)
DATE RECEIVED: DECEMBER 11, 2018

DETAINEE DEATH REVIEW: Mergensana AMAR, A216269802
Healthcare and Security Compliance Analysis
Northwest Detention Center
Tacoma, Washington

As requested by the ICE Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU), Creative Corrections participated in a review of the death of detainee Mergensana AMAR while in the custody of the Northwest Detention Center in Tacoma, WA. A site visit was conducted December 11-13 2018, by ERAU staff (b)(6); (b)(7)(C) ERAU Unit Chief, (b)(6); (b)(7)(C) Management and Program Analyst and team leader, and Creative Corrections contract personnel (b)(6); (b)(7)(C) Security Subject Matter Expert and (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert. Contractor participation was requested to assess compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011, revised 2016, governing medical care and security operations.

Included in this report is a case synopsis, description of the facility and its healthcare services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of detainee AMAR's medical record and detention file; tour of the medical clinic, housing units, and intake area; interviews of staff and a detainee; and review of policies, video surveillance footage, police reports and photographs and available incident related documentation. The report was prepared collaboratively by (b)(6); (b)(7)(C), and Creative Corrections ERAU contract Program Manager, (b)(6); (b)(7)(C).

SYNOPSIS

Mergensana AMAR, 39 years old, was admitted to the Northwest Detention Center on December 19, 2017. He reported no medical or mental health issues and none were identified during intake screening and physical examination. He was classified low custody and for the first eight months of his detention, was assigned to general population housing. He had minimal contact with healthcare staff over that period.

In mid-August, 2018, AMAR started refusing meals in protest to what he perceived to be a delay in resolving his immigration status and until notified that he would be allowed to remain in the United States. Hunger strike monitoring in accordance with the applicable ICE detention standard was implemented on August 25, 2018. Because AMAR continued to refuse meals and did not cooperate with medical staff's attempts to monitor his health, a court order was obtained on September 6, 2018 authorizing ICE to take necessary action to save his life. Thereafter, AMAR agreed to health assessments and started eating fruit and drinking nutritional supplements. On October 16, 2018, the Clinical Director discontinued hunger strike monitoring. AMAR did not

resume eating meals until November 12, 2018 but consumed fruit, nutritional supplements, and the contents of snack bags.

When his hunger strike status was discontinued, AMAR was assigned to administrative segregation pursuant to his request for protective custody. On October 26, 2018, he was placed on suicide watch after a rope fabricated from torn linens were found hidden under his mattress. The next day, the psychiatrist discontinued suicide watch and ordered mental health observation. He was on mental health observation status for another nine days, during which AMAR refused to cooperate with healthcare staff's attempts to evaluate him. The status was discontinued on November 5, 2018 when the mental health team decided that there were no evident mental health issues. The team was not told that the day before, an officer found a torn bed sheet hidden beneath AMAR's mattress.

AMAR remained on protective custody following discontinuation of mental health observation. On November 15, 2018, three days after he started eating meals, he informed security personnel that he wished to return to general population. The request was approved but transfer was delayed until ICE personnel notified him his appeal had been denied and that he would be deported. AMAR was found hanging by a rope made of torn bed sheets approximately an hour after he received the notification, and 25 minutes after he was last seen alive. Medical emergency was called and additional security and medical personnel were on scene within two minutes. Cardio pulmonary resuscitation was initiated and continued until Emergency Medical Services responders arrived and took over care, nine minutes after the internal medical emergency was announced. AMAR was transported to the hospital where brain death was determined. He remained in the intensive care unit on life support until November 24, 2018 when, after consultation with his family in Russia, life support was discontinued. Death was pronounced at 6:05 p.m.

According to the Certificate of Death issued by the State of Washington Department of Health, dated February 28, 2019, the date and time of death was November 18, 2018, at ¹, and the cause of death was anoxic encephalopathy² as a result of hanging. An autopsy report from the Pierce County Medical Examiner's Office, signed February 22, 2019, by T (b)(6); (b)(7)(C) MD confirmed the death was due to anoxic encephalopathy, secondary to hanging.

FACILITY DESCRIPTION

Northwest Detention Center (NWDC) is operated by the GEO Group, Inc. (GEO) of Boca Raton, FL. NWDC is a dedicated Intergovernmental Service Agreement facility housing both male and

¹ This date and time denote the when the provider determined there was no brain activity following an imaging brain study.

² Anoxic encephalopathy is a process which begins with the cessation of blood flow to brain tissue, causing changes or absence of brain function.

female ICE detainees. The population on the date of detainee AMAR's death was 1310, including 1121 males and 189 females.

Staff and visitors enter NWDC from the main lobby, first placing their belongings through an X-ray machine, then passing through a metal detector. All persons entering the secure section of the facility must display a staff or visitor identification badge. Video surveillance cameras positioned throughout the facility monitor and record events.

The direct supervision model of detainee supervision is in place in general population housing units. NWDC's control center is located off the main entrance and is staffed at all times by two officers. Officers assigned to the control center handle radio traffic, maintain the logbook, control doors and monitor cameras. During an emergency, they access video from the closest camera in the area.

GEO officers are members of the United Government Security Officers of America (UGSOA) union, Local 883. The union contract permits officers to bid annually for post assignments which are then awarded by seniority. Shifts are 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. Each shift is overseen by a lieutenant as the shift supervisor and a sergeant as the assistant shift supervisor.

NWDC uses the Incident Management System (IMS) for Emergency Responses. Per NWDC Policy 3.2.3, IMS is a three-tiered response system designed to ensure that the right personnel and equipment are present for an emergency response. The goal is to immediately isolate and contain the incident and return the facility to normal operations as soon as possible. For each level, designated staff respond to the emergency. As an incident escalates or de-escalates, the Incident Commander makes the determination whether to raise or lower the level of the incident. Phase I incidents include medical emergencies involving two or less detainees and require a response by NWDC staff only. At this level, all members of the Emergency Response Team may be called to report to the facility. Phase II incidents include escapes, disturbances involving a group of detainees and a possible hostage situation. Phase III incidents include large scale hostage situations, large scale demonstrations or large scale natural disasters such as an earthquake. For Phase III, outside agencies such as local police and fire personnel as well as all available ICE agents may be called to respond. As discussed herein, IMS/Phase I was activated when detainee AMAR's suicide attempt was discovered.

HEALTHCARE SERVICES

NWDC was last accredited by the National Commission on Correctional Health Care in February 2018. Health care is provided 24 hours a day, seven days a week by ICE Health Service Corps (IHSC), supported by contractor STG International. The 2019 staffing plan allocates 25 IHSC positions, including the Health Services Administrator (HSA), two assistant HSAs, five advanced

practice professionals (APP), one nurse manager, eight registered nurses (RN), two pharmacists, one dentist, a health program manager, registered dental hygienist, and three mental health professionals. A full-time IHSC General Schedule (GS) for Federal Pay physician serves as Clinical Director. STG positions include one staff physician, one full time and one part time psychiatrist, three APPs, 18 RNs, seven Licensed Practical Nurses (LPN), a dentist, dental assistant, two pharmacy technicians, radiation technician, five medical records technicians, one administrative assistant and two mental health professionals. Vacancies at the time of AMAR's death included three APPs, eight RNs, one mental health professional, one dental assistant, and one LPN. According to the HSA, most vacancies resulted from a recent contract change which eliminated all sub-contracts.

NWDC's clinic has seven medical examination rooms, an urgent care room, nurses' station, a two-chair dental operator, pharmacy, pill pass room, laboratory, digital radiology room, and various administrative offices. Two holding cells, each with a capacity of eight, serve as waiting rooms. The medical housing unit has four negative pressure rooms for respiratory isolation, one double and three single occupancy cells for medical observation, a padded cell, and a nurses' station. At the time of the site visit the padded cell was being used for storage because structural updates are needed to place it in operation for its intended use. Detainees who are on constant watch receive a suicide smock and blanket, and the metal bed is removed from the cell and replaced with a tear-proof mat. Camera surveillance is present in the four observation cells.

DETENTION SUMMARY

Detainee AMAR was classified low custody throughout his detention. He was housed in general population for eight months following his admission and thereafter, was segregated for hunger strike monitoring, suicide watch, mental health observation, and per his request, for protective custody. No disciplinary charges were filed against him during the detention period. AMAR filed no grievances and 25 facility requests. He had no non-attorney visits and placed 128 calls. His last call was placed five days before his suicide attempt.

SUMMARY OF EVENTS

December 19, 2017

The Booking/Release Report documents detainee AMAR arrived at NWDC at 11:05 a.m. Medical pre-screening was completed by RN (b)(6); (b)(7)(C) who documented she is fluent in the detainee's native language. There were no findings that called for completion of the full intake screening on a priority basis.

Admission processing was completed by Officer (b)(6); (b)(7)(C) who did not document the detainee's primary language or use of interpretation assistance. During interview, Officer (b)(6); (b)(7)(C) acknowledged he completed the intake documents, but stated he had no recollection of AMAR.

Note: The Record of Deportable/Inadmissible Alien form completed by a Customs and Border Protection Officer on December 2, 2017 documents AMAR stated he speaks Russian, Ukrainian, Mongolian, and "a little English." As detailed throughout this report, many healthcare encounters were completed with Russian interpretation assistance. No security personnel used interpretation assistance in interactions with AMAR.

Detainee AMAR's personal property consisted of the following clothing items: one pair of shoes, shoestrings, a pair of boots, three pairs of pants, three pairs of socks, a jacket, coat, one pair of gloves, a belt, underwear, shorts, four hats, and seven shirts. He also had a cell phone and case, charger, a set of headphones, a micro secure digital (SD) card, a suitcase, bag, eyeglasses, miscellaneous toiletries, cotton swabs, nail clipper, miscellaneous paperwork, 21 foreign coins, and a check for \$1533.35.

Note: The foreign coins were not identified and enumerated as required by the PBNDS 2016, Funds and Personal Property.

AMAR was issued linens, clothing, shoes, hygiene supplies, a radio, and the facility and the ICE National Detention Handbooks. He signed for the property and funds inventories and was issued a copy of all receipts. He also signed acknowledgment he was allowed to make a free five-minute phone call.

A rating of low custody was applied by ICE Enforcement and Removal Operations (ERO) prior to AMAR's admission to NWDC and was reapplied during intake using the NWDC Classification Worksheet. The reviewer determined the rating was correctly applied based on the fact the detainee had no criminal history. A supervisor approved the rating the same day. A Prison Rape Elimination Act (PREA) Risk Assessment resulted in determination that AMAR was not at victimization or predatory risk. Facility orientation was completed and documented on the Orientation Checklist form, including instructions on use of the telephone, access to medical care, the grievance system and PREA information. Detainee AMAR signed confirming he had received this orientation.

Note: With the exception of the property receipt and acknowledgment he was given the opportunity to make a free phone call, all forms completed during the intake process, including those signed by detainee AMAR, were in English. The property receipt and phone call acknowledgement were in English and Spanish. The degree to which the detainee understood the information he was given and signed for cannot be determined.

(b)(6); (b)(7)(C) completed the medical and mental health intake screening using the telephonic interpretation service. She noted AMAR said he speaks Russian and some English, and that he was transferred from another detention facility. A transfer summary, medical, dental, and mental health screening, and the initial physical assessment which accompanied him from the San Luis Regional Detention Center (SLRDC) where the detainee had been held since December 7, 2017 identified no healthcare issues. (b)(6); (b)(7)(C) documented detainee AMAR said he felt good and was experiencing no pain, and he denied any current or past medical problems. The mental health screening and suicide risk assessments were negative. His vital signs, entered at 11:32 p.m., were all within normal limits, as follows: temperature 97.9, pulse 88, respirations 16, and blood pressure 124/79. His height was 66.5 inches and he weighed 172 pounds. Tuberculosis symptom screening was negative, and AMAR was cleared for general population housing. Consent for treatment was signed.

Per the Housing History Grid, detainee AMAR was assigned to low custody housing unit B1, cell 117 at 8:57 p.m. His housing assignment remained the same until August 20, 2018.

December 23, 2017

R (b)(6); (b)(7)(C) conducted AMAR's initial physical examination using telephonic interpretation assistance. The vital signs were within normal limits, as follows: temperature 98.1, pulse 62, respirations 16, and blood pressure 120/74. AMAR again denied a history of medical, mental health, and dental problems, and general examination findings were normal. The note was cosigned by Clinical Director (b)(6); (b)(7)(C) the next day.

December 24, 2017 – August 16, 2018

There were no significant medical or security events between these dates. The following summarizes information documented in records provided to reviewers.

- AMAR was seen by healthcare professionals four times. On January 3, 2018 he was assessed by an RN on a routine basis following his "return from borrow out," which reviewers presume refers to return from court. Vital signs and general examination findings were normal, and the detainee was cleared to return to general population. On January 21, 2018, AMAR was seen for complaint of cold symptoms. Per the applicable nursing protocol, RN Guidelines for Upper Respiratory Infection, he was given over-the-counter medications for congestion and pain. On April 24, 2018, AMAR was seen by the dentist for complaint of a broken filling. Upon examination, the dentist recommended extraction of the tooth. The detainee refused the recommended treatment and signed a refusal form. Finally, AMAR was seen by a nurse practitioner (NP) on July 28, 2018 for complaint of pain in his right ear. The NP diagnosed infection and the detainee was given antibiotic ear drops. Vital signs taken during all four encounters were normal. Interpretation assistance was used for all but the first, presumably because it was a routine check involving only rudimentary confirmation of the detainee's wellness.

- AMAR submitted 27 requests over the period, all of which were written and answered in English. As detailed in Appendix 1, they were answered in a timely and responsive manner. Multiple requests were for Russian language books; in many others, the detainee requested access to his property to obtain phone numbers and his credit card number so he could pay his attorney. He also requested release of his cell phone to his attorney. AMAR's requests related to his property and release of his cell phone were honored, and based on available information, facility staff made efforts to provide the detainee with Russian language books.
- AMAR's classification was reviewed on March 8, 2018 and June 14, 2018. His custody level was retained at low.
- A PREA Vulnerability Reassessment completed on April 28, 2018 found AMAR presented no risk.
- The Intelmate Call Detail Report documents AMAR made 128 calls on 69 days over the period. 73 were international, 24 were interstate, and 31 were local. They ranged in duration from one to 25 minutes and averaged 6.4 minutes in length.

August 17, 2018

RN (b)(6); (b)(7)(C) entered an encounter note documenting she conducted a mental health wellness check at 9:52 a.m. She used the telephonic interpretation service. According to the note, AMAR was referred to mental health after he presented to sick call complaining of feeling depressed because there was no one in his dorm who spoke Russian. He claimed he had requested transfer to housing unit G3 on two previous occasions with no success.

Note: The review team was informed G3 housed Russian-speaking detainees. As indicated in Appendix 1, AMAR filed one request for placement in G3 on August 11, 2018. The request was denied on grounds that housing moves are not made based on detainee requests. He was, however, transferred to G3 on August 20, 2018 (see below).

AMAR denied feeling unsafe in his dorm but stated he did not participate in any activities or interactions with other detainees because he had no desire to do so. He denied thoughts of self-harm, suicidal or homicidal ideation, and auditory and visual hallucinations, and reported eating, drinking, and sleeping well. He acknowledged stress related to immigration and legal issues. Vital signs were all within normal limits, as follows: temperature 97.5, pulse 65, respirations 16, and blood pressure 108/66. His weight was 165 pounds, seven pounds less than at intake. The general examination noted he was alert, pleasant, in no acute distress, well hydrated, well nourished, comfortable, calm and relaxed, and cooperative. The psychological examination noted he was oriented with cognitive function intact. He used good eye contact, his judgment and insight were good, mood and affect were full ranged, speech was clear, and his thought process was logical.

and goal directed. The assessment finding was readiness for enhanced resilience³, and AMAR was advised to send a grievance if he did not hear back from custody regarding the housing change. He was advised to continue his daily activities even if he did not feel like it, and was encouraged to engage in a regular exercise program and participate in activities to help with his depression. He was also advised to eat something at every meal, even if just a little bit. Asked if this instruction was based on information that AMAR was not eating, RN (b)(6); (b)(7)(C) stated it was not, explaining that it is a component of the standardized plan called for depression. She said AMAR did not specifically use the words depressed or depression during the encounter, but based on the reason he presented for sick call, she followed the RN Guidelines applicable to stress and depression. The encounter note documents that at the end of the session, AMAR stated he did not need mental health services. Commander (CDR) (b)(6); (b)(7)(C) Doctor of Psychology, documented she reviewed RN (b)(6); (b)(7)(C) note and staffed the case the same day. She concurred with the findings and noted no mental health appointment was indicated at the time.

August 20, 2018

Per the Housing History Grid, detainee AMAR was assigned to general population unit G3 at 8:39 a.m.

August 22, 2018

At 7:25 a.m. CDR (b)(6); (b)(7)(C) nurse practitioner (NP), entered an encounter note, documenting the reason for the appointment was dietary issues. He used the telephonic language interpretation service. NP Vega wrote that AMAR announced he had no intentions of eating from that point on, stating he was protesting the length of time it was taking the immigration system to decide his asylum case. He wanted to be released and allowed to remain in the United States. He denied suicidal and homicidal ideation. His vital signs were all within normal limits, as follows: temperature 97.9, pulse 62, respirations 16, and blood pressure 113/73. His weight was 163 pounds, nine pounds less than at intake. The general examination findings were normal, including general appearance observations that AMAR was in no acute distress, well developed, and well nourished. The treatment plan was to place the detainee in the segregation unit and begin meal count. NP (b)(6); (b)(7)(C) note that he discussed the process for monitoring missed meals, and if prolonged and medically necessary, the possibility a court order may be pursued for involuntary feeding. He explained these steps were not meant to be punitive; rather they were intended to prevent deterioration of the detainee's health. AMAR voiced his understanding and agreement. An unsigned Special Needs Form documents orders for admission to administrative segregation, single cell housing, no commissary food or beverages in his cell, and documentation of all food and beverage intake.

Note: Although not provided with records documenting any communications between security and medical staff that may have led to this encounter, reviewers conclude it

³ This nursing diagnosis refers to a pattern of positive responses to an adverse situation or crisis can be strengthened to optimize human potential.

resulted from notification that AMAR was refusing meals. Beginning this date, August 22, 2018, officers were expected to complete Information Reports noting what, if anything, the detainee consumed. See Appendix 2 for detail.

At 7:30 a.m., RN (b)(6); (b)(7)(C) cleared AMAR for segregation for the purpose of meal monitoring. She used the telephonic language interpretation service to complete the encounter. The detainee's weight was 163 pounds and his vital signs were within normal limits, as follows: temperature 97.9, pulse 62, respirations 16, and blood pressure 113/73. The examination found he had spontaneous speech and answered questions appropriately, he appeared to be within normal limits of behavior, affect, and cognitive functioning, and did not appear to have any acute or unresolved medical conditions which might worsen in segregation. No active psychosis, mania, suicidal ideations or homicidal ideations were noted.

An Administrative Segregation Order was prepared documenting AMAR's placement on the status for medical observation for hunger strike. A copy was provided to AMAR at 8:00 a.m. His property was inventoried and he refused to sign the receipt. Per the Housing History Grid, detainee AMAR was assigned to Unit D3, a Restricted Housing Unit (RHU)⁴ at 8:32 a.m.

Unit D3 is used for general segregation purposes and is the designated RHU for medical housing overflow. It is a two story housing unit with ten double occupancy cells on each tier. Cell 106 on the bottom tier has been decommissioned for housing and is used as a janitor's closet, making the current capacity of the unit 38. There are showers and an enclosed indoor recreation area on each level.

August 23 and 24, 2018

AMAR remained in D3 for meal monitoring. Officers maintained a daily log of his activities documenting he attended recreation on August 24, 2018 but refused other recreation opportunities as well as showers and all meals. RN (b)(6); (b)(7)(C) Sterling made required daily segregation rounds documenting in the notes AMAR's continued refusal of meals. RN (b)(6); (b)(7)(C) did not use interpretation assistance.

August 25, 2018

At 9:19 a.m., RN (b)(6); (b)(7)(C) signed a segregation round encounter note in which she documented custody staff informed her AMAR refused his ninth meal. She documented the detainee spoke English fluently. His speech was spontaneous and he answered questions appropriately. He did not appear to have active psychosis, mania, suicidal or homicidal ideation.

In an encounter note reflecting this date but not signed until the next day, NP (b)(6); (b)(7)(C) documented she saw the detainee "due to declaration of a Hunger strike." The reason for the appointment was Medical Housing Unit (MHU) admission.

⁴ RHUs at NWDC are special management units as defined in the ICE detention standards.

Note: Although not documented by RN (b)(6); (b)(7)(C) reviewers conclude she referred AMAR for provider assessment in accordance with the Hunger Strikes standard which requires referral of any detainee who has not eaten in 72 hours.

N (b)(6); (b)(7)(C) wrote, “He was at meal 9 as of this morning breakfast. He states that the cause of this hunger strike is because he wants to be released. He states that he is experiencing dizziness and lightheadness [*sic*] as a result of his hunger strike.” AMAR stated that the symptoms had been present for two days and were getting worse; also, that the last time he had something to drink was two days prior to the encounter. NP (b)(6); (b)(7)(C) ordered intake and output monitoring every eight hours, daily weights, urinalysis and orthostatic vital signs⁵, laboratory tests, and medications once ordered. She noted detainee AMAR refused examination and refused to have his vital signs taken.

RN (b)(6); (b)(7)(C) entered another encounter note, signed 2:33 p.m., noting the reason for the appointment was, “MHU nursing admit note (hunger strike monitoring)”.

Note: Although RN (b)(6); (b)(7)(C) s note appears before NP (b)(6); (b)(7)(C) in the medical record, reviewers conclude this was the first nursing encounter after (b)(6); (b)(7)(C) evaluated AMAR and admitted him to the MHU. This conclusion is based on the fact that authority to admit detainees to the MHU lies with providers, and (b)(6); (b)(7)(C) s treatment notes, detailed below, reflect (b)(6); (b)(7)(C) orders. (b)(6); (b)(7)(C) kely entered this note before (b)(6); (b)(7)(C) entered hers, out of sequence.

As she had in her earlier note, RN (b)(6); (b)(7)(C) documented AMAR spoke English fluently. She wrote the following in her narrative: “English-speaking male detainee states ‘I refuse (vital signs check), I refuse (to give a urine specimen). Last time I drank was three days ago. Last time I ate food was five days ago. I refuse, take that (plastic urine specimen container) away. I refuse (to sign a Refusal Form). I eat when I go to the outside’. Patient is considered to be on official hunger strike and will be isolated from other detainees for close supervision, observation, and monitoring.” In the treatment section of her note, RN (b)(6); (b)(7)(C) wrote that AMAR was instructed on the potential health problems (dizziness, lightheadedness, possible permanent organ damage and death) he may experience as a result of continued refusal of food and fluids. She also wrote the detainee did not verbalize understanding but non-verbally indicated his agreement. In treatment notes, RN Yamane entered the following:

1. “Continue with vital signs every shift; Intake and Output Monitoring⁶ every shift; Daily weights; Daily orthostatic vital signs.
2. An adequate supply of drinking water and other beverages are available to the patient at all times.
3. Three meals per day are delivered to the patient and delivery of meals is documented.
4. All food not authorized by CD/Physician is removed from the patient’s room.

⁵ Orthostatic vital signs are a series of vital signs of a patient taken while the patient is reclines and then again while standing.

⁶ Intake and output is measurement of fluid a patient takes and how much is lost through urine and other routes.

5. Patient is not allowed to purchase food from commissary/vending machine while on hunger strike.
6. Patient will only be release from hunger strike treatment/monitoring by CD or physician order
7. Patient counseled regarding the medical risks of continuing the hunger strike.
8. Encouraged to terminate the hunger strike and eat/drink as normal.”

Note: The enumerated elements reflect (b)(6); (b)(7)(C) orders and hunger strike protocol requirements.

(b)(6); (b)(7)(C) completed a standardized Care Plan for Weight Loss to address the nursing diagnosis of Alteration in Nutrition: Less than Body Requirements. The expected outcome was maintenance of adequate hydration, as evidenced by good skin turgor⁷, urine output greater than 30 milliliters per hour, and moist mucous membranes; also, that AMAR would resume eating without complications of dehydration or malnutrition. Interventions included obtaining a baseline weight and daily weights; record vital signs once daily; assess hydration status, skin turgor, mucous membranes, intake and output, blood pressure, and heart rate; encourage patient to eat and drink, perform urine dipsticks, as ordered by the medical provider; discuss with patient possible need for enteral or parenteral nutrition; encourage patient to verbalize feelings; and provide psychological, spiritual, or psychosocial assistance, as ordered.

A Special Needs Form documents detainee AMAR was admitted to the MHU for hunger strike monitoring. Property confiscated when he was transferred from general population unit G-3 to the RHU D-3 on August 22, 2018 was returned to him. Again, he refused to sign the receipt.

Per the Housing History Grid, detainee AMAR was assigned to the MHU at 11:12 a.m. The Daily Log for the unit documents detainee AMAR was assigned to cell 4 until August 30, 2018; however, reviewers confirmed with MHU security staff that he was assigned to cell 2. The door to the cell 2 is solid steel and has a window on the upper half. Inside the door is an anteroom with a sink and table and a large window for viewing from the corridor. The cell itself has a bed on wheels, a small moveable table, shower stall, and stainless steel toilet and sink. A call button alerts in the nurse’s station and activates a strobe light outside the cell that remains lit until staff respond.

August 26, 2018 to October 15, 2018

Detainee AMAR’s hunger strike status continued for this period. With the exception of eight hours on September 22, 2018 when moved to D3 for MHU overflow, he was housed in MHU cell 2.

RNs consistently documented attempts to follow the nursing care plan, including taking vital signs and weights, and monitoring input and output every shift. Medical providers, including the

⁷ Skin turgor refers to the skin’s elasticity, which can be tested by pinching the skin to see if it returns to normal.

Clinical Director, saw him almost daily, and a mental health professional saw him on a bi-weekly basis. Use of interpretation assistance was variable. Some healthcare staff used the telephonic interpretation service; some documented an interpreter was not available; and some documented AMAR spoke English fluently or on a limited basis, sufficient to conduct the encounter. On other occasions, (b)(6); (b)(7)(C) who speaks Russian, interpreted. In repeated encounters over the period, AMAR stated his hunger strike was a protest that he would not end until allowed to remain in the United States.

Through September 6, 2018, AMAR declined to cooperate with healthcare staff, often simply stating “refuse” when staff asked to take his vital signs and otherwise assess him. He did, however, periodically answer questions about pain and other symptoms, reporting dizziness, weakness, feeling lightheaded, and pain primarily in his lower body. AMAR refused pain medication and all medications ordered per protocol. As for intake of food and fluids, officers documented he ate nothing (see Appendix 2), also reflected by nurses in encounter notes. Monitoring of fluid intake was not possible because he refused to drink from the pitcher of water provided. He was occasionally observed covertly drinking from the sink while washing his face or brushing his teeth, but output could not be monitored because he refused to use collection cups for measurement, urinating in the commode.

By Order dated September 6, 2018 of the US District Court for the Western District of Washington at Tacoma, ICE was authorized to undertake necessary medical treatment and testing to save AMAR’s life and prevent injury to him. The order specifically authorized involuntary hydration through intravenous (IV) fluids, physical examination with daily weight assessments and frequent vital sign checks, and laboratory testing every 48 to 72 hours. Two days earlier, (b)(6); (b)(7)(C) had entered an encounter note stating, “[Patient] with symptoms of dehydration. We are unable to tell his full condition due to no labs, vital signs or weight. We will request forced monitoring, feeding and/or IV hydration from the court.”

Reviewers were provided with a video-recording showing that on September 7, 2018, (b)(6); (b)(7)(C) Assistant Field Office Director (AFOD) (b)(6); (b)(7)(C) and another ICE official (name unknown), discussed the court order with detainee AMAR. The video shows (b)(6); (b)(7)(C) accessed the telephonic interpretation service for the meeting. Detainee AMAR was laying on his back in his cell covered with a blanket. His eyes were open at all times. During the 40 minute video, (b)(6); (b)(7)(C) explained through the Russian interpreter that being on a hunger strike had been detrimental to the detainee’s health. She explained it was essential for medical staff to obtain his weight, and to check his blood pressure and other vital signs. She also explained why she had asked the Court to allow her to give him hydration and that the Court had granted that permission. When she asked if he would cooperate, he refused until he heard the Court Order. He then refused to sign a refusal form.

The ICE official then read the Court Order, which was translated into Russian by the interpreter. AMAR was then given and appeared to read a copy of the Order. Reviewers do not know if it was

translated into Russian. After the detainee placed the document on the table, AFOD (b)(6); (b)(7)(C) introduced himself as the ICE officer in charge and asked him if he understood the Order. AMAR replied yes. AFOD (b)(6); (b)(7)(C) informed him officers were available to force him to submit to medical testing but asked if he would voluntarily submit. The detainee agreed to do so. Dr. (b)(6); (b)(7)(C) then explained that medical staff would take his blood pressure, heart rate and weight. They would also draw three tubes of blood and ask that the detainee drink a fluid which would replace the need for IV hydration. Detainee AMAR agreed to comply.

In her medical record entry, (b)(6); (b)(7)(C) documented labs were drawn without force and a urine sample, vital signs and weight were taken. The nutritional evaluation studies for phosphorus⁸, creatine kinase⁹, magnesium¹⁰, and prealbumin¹¹ were all within normal limits. She noted there were marked orthostatic changes in the detainee's blood pressure, which was 88/61, as well as a significant weight loss of 21 pounds since the beginning of the hunger strike. Although AMAR reported pain he rated six on the standardized pain scale¹², he declined any pain medication. He drank the oral electrolyte solution so an IV line was not placed. (b)(6); (b)(7)(C) ordered Pedialyte, a beverage which helps prevent dehydration and replace nutrients and electrolytes lost through vomiting and diarrhea.

Detainee AMAR's cooperation with healthcare staff generally improved in the days after the court order was served. He allowed his vital signs to be taken, drank Pedialyte, and was observed drinking water, but continued to refuse meals. **On September 13, 2018**, (b)(6); (b)(7)(C) completed a hunger strike assessment, documenting AMAR's concerns about his heart pain. Vital signs were documented as follows: temperature 97.4, pulse 46, respirations 16, and blood pressure 91/53, all within normal range except for a low pulse rate and low blood pressure, which in some persons can indicate heart disease. (b)(6); (b)(7)(C) documented the normal dipstick urinalysis results and an electrocardiogram were within normal limits, but also noted that while he was in compliance with the court's order for monitoring, his refusal to eat may necessitate court-ordered feeding. She ordered Boost, a liquid nutritional supplement and Thiamine¹³ 100mg twice daily for five days.

AMAR continued to accept Pedialyte and surreptitiously, drink water. He also accepted Boost on most days, but continued to refuse food. Starting September 30, 2018, he ate one to two pieces of fruit per day. On October 9, 2018, (b)(6); (b)(7)(C) documented the detainee was getting about 1800 calories a day and not losing weight, but was eating only fruit off his tray. She offered to return AMAR to general population, but he stated he did not wish to end his hunger strike.

⁸ Phosphorus is a mineral naturally found in the body.

⁹ Creatine kinase is an enzyme expressed by various tissues and cell in the body.

¹⁰ Magnesium is a mineral found in the bones and muscles of the body.

¹¹ Prealbumin is a protein made by the liver.

¹² The standardized pain scale rates the level patient's report of pain from zero to ten, with ten being worst.

¹³ Thiamine is a Vitamin B supplement.

On October 15, 2018, (b)(6); (b)(7)(C) documented AMAR was well-hydrated and his mental health was fine. She noted he continued to refuse meal trays and was eating only whole fruit. She also noted there was no need to compel collection of lab samples, which he had refused since the court ordered studies on September 7, 2018.

October 16, 2018

(b)(6); (b)(7)(C) discontinued AMAR's hunger strike status. Her medical record entry documents his vital signs were within normal limits with the exception of a slightly low blood pressure of 91/55. His weight was 142 pounds. She wrote the following: "[Patient] has continued to drink boost and pedialyte. After refusing lunch tray he then ate complete lunch snack. [Patient] would not admit to giving up his hunger strike but could not explain why he was eating the snack. He is wanting to be able to eat/drink adequate calories and stay on hunger strike. He is told he does not need to be housed in MHU for any medical reason and was asked about his preference in housing after discharge. He has asked to be moved to D3 segregation rather than go to general population for undisclosed reasons." (b)(6); (b)(7)(C) wrote in her treatment notes that GEO was contacted concerning AMAR's request to be housed in D3 and that medication and supplement orders would not change. Her encounter note also documents his refusal to have labs drawn and that given past normal results, there was no need to force them.

During interview, (b)(6); (b)(7)(C) was asked why she did not discontinue AMAR's hunger strike status once he began consuming Pedialyte, Boost, and fruit. She stated it was hoped that as long as he believed his hunger strike was recognized, he would continue to consume the items, gain weight and maintain hydration. Asked about the sack lunch, she explained it was given in an attempt "to try different things to get him to eat." She further stated facility meals are considered unpalatable by some detainees and that a sandwich may be preferred over a meal.

A Special Needs Form documents discontinuation of hunger strike monitoring and discharge from MHU. An Administrative Segregation Order completed by Lieutenant (b)(6); (b)(7)(C) documents the following: "Detainee was released from medical and stated he wanted to [protective custody]. Detainee refused to give any further statement other than he did not want to go to general population." The form notes the detainee did not request a hearing and that a copy of the order was delivered to the detainee at 3:28 p.m.

Per Investigative Report filed by Sergeant (b)(6); (b)(7)(C), AMAR stated upon interview that he wanted protective custody and did not want to go to general population. The detainee stated he did not want to leave medical and he would continue his hunger strike.

RN (b)(6); (b)(7)(C) entered encounter notes documenting AMAR's discharge from MHU at 4:30 p.m. and clearance for segregation. The detainee refused to have his vital signs taken. He was spontaneous in his speech and answered questions appropriately; appeared to be in normal limits of appearance, behavior, affect and cognitive functioning; did not appear to have any acute or unresolved medical conditions that might worsen in segregation; and did not appear to have acute

psychosis, mania, suicide or homicidal ideations. RN (b)(6); (b)(7)(C) electronically signed a Special Needs Form documenting segregation clearance.

Per the Housing History Grid, detainee AMAR was assigned to D3 segregation at 6:47 p.m.

October 17, 2018

RN (b)(6); (b)(7)(C) conducted the first segregation nursing round, noting AMAR was able to express medical needs adequately, in English.

RNs are required to make rounds in segregation on a daily basis to confirm detainee wellness by way of subjective information gathering and examination focused on health factors particularly pertinent in a segregated setting. Taking vital signs is not required during a segregation round. To document their rounds, nurses use the standardized eCW RN Daily Segregation Rounds note which includes a question related to thoughts of self-harm, and an inquiry as to any medical complaints or concerns. The following template language is pre-populated in the Examination section: "Patient has spontaneous speech and answers questions appropriately. In no acute distress, well developed, well nourished. Patient appears to be within normal limits of behavior, affect, and cognitive functioning. Patient does not appear to have any acute or unresolved medical conditions that may worsen in segregation. Patient does not appear to have active psychosis, mania, suicidal ideations or homicidal ideations." The standardized Assessment is, "Health Maintenance Related to Segregation Placement", and when completed, the Preventive Medicine and patient education sections routinely addressed access to medical, mental health, and dental care while in segregation. It could not be determined if nurses were, in fact thorough in their observations and interactive information-gathering to determine accuracy of the standardized findings.

For this and all subsequent segregation rounds while AMAR was on protective custody, RNs entered No in response to the two questions and did not modify the template language for the examination. No segregation rounds were missed. Because the encounter notes were largely redundant, the reviewer did not provide a daily summary of their content in the below chronology. Where individualized, the notes reflected that he continued to refuse meals, periodically ate fruit, and inconsistently drank the prescribed supplements.

Lieutenant (b)(6); (b)(7)(C) conducted a 24-hour review of AMAR's placement on administrative segregation. The staff member noted the detainee was unwilling to live in general population and recommended the status be continued. The recommendation was approved by the Warden Stephen Langford on October 19, 2018.

Per the Housing History Grid, at 12:38 p.m. detainee AMAR was assigned to H Segregation, cell 106 at 12:38 p.m.

Note: As detailed below, he was assigned to this cell until October 26, 2018 when moved to the MHU. He was reassigned to the cell on October 28, 2018, remaining until this death.

A full description of H Segregation and cell 106 is provided in discussion of October 28, 2018 events, below.

October 18, 2018

On an Administrative Detention Review form, Lieutenant (b)(6); (b)(7)(C) documented he interviewed detainee AMAR regarding his placement in protective custody. He did not address use of language interpretation assistance, or whether AMAR's English language proficiency was adequate to complete the interview. The lieutenant wrote, "Detainee stated he would not live in general population and signed for protective custody. Detainee was released from medical holding after eating. Prior to eating detainee was on hunger strike for multiple weeks." Lieutenant (b)(6); (b)(7)(C) recommended retention of the status. The recommendation was approved by the Warden and ICE Officer in Charge (signature illegible) on the same date. A copy of the form was delivered to the detainee.

October 19, 2018

Detainee AMAR was seen by (b)(6); (b)(7)(C) DDS for complaint that his tooth was sensitive to chewing. Interpretation assistance was used. The detainee agreed to have his vital signs taken, all of which were within normal limits. His weight was 147 pounds, representing a five pound weight gain since hunger strike monitoring was discontinued. The assessment finding was secondary canal infection, broken tooth, and an appointment was made for its extraction.

October 22, 2018

(b)(6); (b)(7)(C) saw detainee AMAR in H Segregation after he refused to go to medical for evaluation. She did not use interpretation assistance. She wrote, "He has not been consistent in drinking his Boost and is now refusing to drink it in front of the nurse. [Patient] states he is feeling ok but with some dry mouth." AMAR was told he was in H Segregation for protective custody because D3 was closed. He refused to be weighed and have his blood pressure checked. (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) noted AMAR had been taking fresh fruit off the trays to eat, so it appeared he was following the same pattern of eating and drinking as he did in the MHU. The treatment plan was to continue checking the Medication Administration Record (MAR) for acceptance of Boost and Pedialyte; follow up in three to four days.

Note: As shown in Appendix 2, officers documented that through lunch this date, AMAR had eaten only two apples since the hunger strike was discontinued. If he more regularly ate fruit on trays, as (b)(6); (b)(7)(C) apparently believed to be the case, the information is not documented.

October 24, 2018

(b)(6); (b)(7)(C) again completed the daily segregation round. In addition, RNs documented three shift rounds that did not include standardized segregation template language but included free-form narrative, suggesting AMAR was on medical observation status. The notes document the detainee refused assessment, including vital signs.