

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



U.S. Immigration  
and Customs  
Enforcement

January 8, 2020

Austin Evers  
American Oversight  
1030 15<sup>th</sup> 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  
Third Interim Production**

Dear Mr. Evers:

This letter is the third 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 501 pages of records were reviewed for this interim production. The 501 pages of records were located pursuant to a search of the ICE, Office of Professional Responsibilities (OPR). The 501 pages of records have been marked 2020-ICLI-00057-579 through 2020-ICLI-00057-1079. Upon review, ICE has determined that portions of the 501 pages will be withheld pursuant to FOIA Exemptions, (b)(5), (b)(6), (b)(7)(C) and (b)(7)(E) of the FOIA as described below:

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

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](mailto:michael.tilghman@usdoj.gov)



Sincerely,

Senior Paralegal, ICE FOIA for  
Fernando Pineiro Jr.  
(A)FOIA Officer

Enclosure(s): 501 page(s)

cc:

Michael A. Tilghman II  
Assistant United States Attorney  
Civil Division  
United States Attorney's Office  
for the District of Columbia  
555 Fourth Street, N.W.  
Washington, D.C. 20530  
(202) 252-7113



# County of San Diego

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

CHIEF MEDICAL EXAMINER  
(858) 694-1416

MEDICAL EXAMINER'S DEPARTMENT  
5570 OVERLAND AVE, STE 101, SAN DIEGO, CA 92123-1215  
<http://www.sandiegocounty.gov/me>

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

CHIEF DEPUTY MEDICAL EXAMINER  
(858) 694-1416

|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     |                                                                                               |                                                                                             |                                                                                 |                                      |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|--------------------------------------|
| CALL INFO    | NAME OF DECEASED<br><b>ABIENWI, Nebane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     | AKA                                                                                           | HIO<br><input type="checkbox"/>                                                             | CASE NUMBER<br><b>2019-02553</b>                                                |                                      |
|              | INVESTIGATOR<br>(b)(6); (b)(7)(C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     | REPORTED BY<br>(b)(6); (b)(7)(C)                                                              | REPORTING AGENCY<br><b>Sharp Chula Vista Medical Center</b>                                 |                                                                                 | PREVIOUS WAIVE #                     |
|              | CALL DATE AND TIME<br><b>10/1/2019 1453</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     | ARRIVAL DATE AND TIME<br><b>10/1/2019 1643</b>                                                |                                                                                             | RETURN DATE AND TIME                                                            |                                      |
| DECEDENT     | DATE AND TIME OF DEATH<br><b>10/1/2019 1441</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                     | DATE OF BIRTH<br><b>10/28/1981</b>                                                            | AGE<br><b>37 Years</b>                                                                      | GENDER<br><b>Male</b>                                                           | RACE<br><b>Black</b>                 |
|              | RESIDENCE (STREET, CITY, STATE, ZIP)<br><b>Wangia Street Ngomgham Bamenda, North West Province,</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     |                                                                                               |                                                                                             | COUNTY<br><b>San Diego</b>                                                      |                                      |
|              | COUNTRY OF RESIDENCE<br><b>Cameroon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | OCCUPATION<br><b>Mechanic</b>                                                                 |                                                                                             | PAID AUTOPSY<br><input type="checkbox"/>                                        |                                      |
| DEATH        | LOCATION OF DEATH<br><b>Sharp Chula Vista Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | TYPE OF PLACE<br><b>Hospital</b>                                                              |                                                                                             |                                                                                 |                                      |
|              | ADDRESS (STREET, CITY, STATE, ZIP)<br><b>751 Medical Center Court, Chula Vista, California, 91911</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |                                                                                               |                                                                                             |                                                                                 |                                      |
|              | SUMMARY<br><p>The decedent was a 37-year-old married Black male who was a Cameroon national. At the time of his death, the decedent was in the custody of U.S. Immigration and Customs Enforcement at the Otay Mesa Detention Center. On the morning hours of 09/26/2019, the decedent was found altered in his bunk with left-sided weakness, facial droop, and slurred speech. 911 was called and paramedics transported him from the facility to Sharp Chula Vista Medical Center. Upon arrival, imaging revealed a large intraparenchymal hemorrhage centered on the basal ganglia. He was deemed not to be a surgical candidate and was given a poor prognosis. His health continued to deteriorate and on 10/01/2019, his death was pronounced.</p> <p>Medical Examiner's jurisdiction invoked according to the California Government Code 27491: Deaths in prison or while under sentence.</p> |                     |                                                                                               |                                                                                             |                                                                                 |                                      |
| INCIDENT     | LOCATION OF INCIDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     | INCIDENT PLACE TYPE<br><input type="checkbox"/> AT WORK <input type="checkbox"/> AT RESIDENCE |                                                                                             |                                                                                 |                                      |
|              | ADDRESS (STREET, CITY, STATE, ZIP)<br><b>San Diego</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |                                                                                               |                                                                                             |                                                                                 |                                      |
|              | DATE AND TIME OF INCIDENT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | INVESTIGATING AGENCY<br><b>Immigration and Customs Enforcement</b>                            | OFFICER                                                                                     | BADGE #                                                                         | REPORT #                             |
|              | DECEDENT WAS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | BELTED<br><b>No</b> | HELMETED<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO               | POSITION                                                                                    | ON PRIVATE PROPERTY<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                      |
|              | VEHICLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                     | LICENSE NUMBER                                                                                |                                                                                             | STATE                                                                           |                                      |
| NOTIFICATION | IDENTIFIED BY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     | METHOD<br><b>Visually</b>                                                                     |                                                                                             | DATE AND TIME                                                                   |                                      |
|              | FUNERAL HOME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | PROPERTY<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO               | PUBLIC ADMINISTRATOR<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                                                                 | TYPE OF EXAM<br><b>External Exam</b> |
|              | NAME OF NOK OR OTHER<br>(b)(6); (b)(7)(C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     | RELATIONSHIP<br><b>Wife</b>                                                                   | DATE NOTIFIED<br><b>10/1/2019</b>                                                           |                                                                                 | NOTIFIED BY                          |

DHS-20-0638-C-000001

## INVESTIGATIVE NARRATIVE

**Decedent:** ABIENWI, Nebane

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### Antemortem Events:

On 10/01/2019, the following information was learned through paperwork provided by Otay Mesa Detention Center. The decedent was a 37-year-old married Black male who was a Cameroon national. At the time of his death, the decedent was in the custody of U.S. Immigration and Customs Enforcement at the Otay Mesa Detention Center. The decedent was booked into the facility on 09/18/2019 at 2035 hours.

On 10/01/2019, the following information was learned during a personal interview conducted with nursing staff from Sharp Chula Vista Medical Center and supplemented with medical records. On the early morning hours of 09/26/2019, the decedent was found to have altered mental status, hemiparesis involving the left arm and leg, and facial droop. His bunkmate assisted him down from his bunk to the floor. There was a conflicting record stating that he fell from his bunk. Staff was notified of his condition and he was transferred to the facility medical clinic. 911 was called and paramedics responded and observed the decedent lying supine in a hospital bed, alert, in moderate distress. He had obvious left sided weakness to his upper and lower extremities, facial droop, and slurred speech. His blood sugar was in normal limits and there was no evidence of drug or alcohol intoxication. He was found to have a 1<sup>st</sup> degree atrial valve block and did not have any trauma noted to his body. He was placed in handcuffs by facility staff for transport and he became combative. He was transported via ambulance to Sharp Chula Vista Medical Center. At 0421 hours, he was given 5mg IM of versed midazolam for his combative behavior in attempt for paramedics to gain vascular access while en route to the hospital. He remained combative and paramedics monitored his vitals until arrival to the emergency department. Once he arrived to the emergency department, he had difficulty maintaining his airway and he was intubated. A computed tomography scan of his head revealed a large right-sided acute intraparenchymal hemorrhage measuring 9.1 x 4 x 6.4cm. The hemorrhage was centered on the basal ganglia with intraventricular extension and mass effect. There was a 1.7cm leftward midline shift with effacement of the basilar cisterns, which were concerning for uncal herniation. A toxicology test returned positive for benzodiazepines; however, it was noted that he was administered midazolam while en route to the hospital. Due to the extent of the hemorrhage, he was deemed not to be a surgical candidate and he was given a poor prognosis. His health continued to decline and on 10/01/2019 at 1441 hours, his death was pronounced.

The San Diego County Medical Examiner's Office was notified of the death at 1453 hours, and jurisdiction was invoked.

### Past Medical, Surgical, and Social History:

On 10/01/2019, the following information was learned during a personal interview conducted with nursing staff from Sharp Chula Vista Medical Center and supplemented with medical records. It was reported that the decedent did not have any medical history on file and that he denied any allergies or medications.

### Scene Description:

On 10/01/2019 at approximately 1643 hours, I arrived to the scene which was room 26 in the intensive care unit at Sharp Chula Vista Medical Center, located at 751 Medical Center Court in Chula Vista. The room was a standard medical room, furnished with medical equipment. There was no property located in the room.



**Body Description:**

I further viewed the body of an adult Black male who was lying supine on a hospital gurney covered with a white sheet up to his abdomen. I removed the sheet and observed that he was clad in a hospital gown with his upper and lower extremities extended and in line with his torso. Medical therapy in place included EKG leads, an identification band around his right wrist, intravenous lines in his right arm and right antecubital fossa, a monitor on his left index finger, a band aide on his left wrist, gauze and tape on his left forearm and left antecubital fossa, a blood pressure monitor around his left arm, and a urinary catheter. He was flaccid and cool to the touch. Lividity was unable to be assessed due to his skin tone.

There was no crepitus upon palpation of his head, face, neck, or chest. His ears, nares, and oral cavity was absent of fluids. His oral cavity was absent of trauma. His chest and abdomen were absent of trauma. There appeared to be abrasions on the superior aspect of his right arm. The remainder of his extremities and the posterior aspect of his body appeared unremarkable.

92M Transport personnel (b)(6); (b)(7)(C) arrived and assisted me with the body. A yellow identification band was placed around his right ankle. He was placed into a new white vinyl body pouch and blue tamperproof seal 1419413 was affixed to the outside of the pouch. He was then transported to the San Diego County Medical Examiner's Office for an examination.

**Special Requests:**

There were no special requests.

**Identification:**

The decedent was identified to me by Core Civic Otay Mesa Detention Center security personnel.

**Antemortem Specimens:**

One vial of antemortem specimen was collected.

**Public Administrator:**

This case was referred to the Public Administrator's Office.

**Other Important Factors:**

There were no other important factors.

Signed: \_\_\_\_\_

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

11/22/2019

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

☒ External

☐ Possible SIDS

2019-02553

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

10/2/2019

☒ Not Dictated

☐ Family Paid

ABIENWI, Nebane

☐ Body not coming to office

**CAUSE OF DEATH:** ( ☐ PENDING )

Time interval

Hypertensive basal ganglia hemorrhage

Days

Due To: \_\_\_\_\_

Due To: \_\_\_\_\_

Due To: \_\_\_\_\_

**CONTRIBUTING:** \_\_\_\_\_

**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:**

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

r? ( ) Yes ( ) No ( ) Unknown

nt Supervising Pathologist

10/2/2019  
Date

Rev. 06/15

10/2/19  
DHS-20-0638-C-000004

10/2/19  
(b)(6); (b)(7)(C)

County of San Diego  
OFFICE OF THE MEDICAL EXAMINER

San Diego County Medical Examiner

2019-02553

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

10/2/2019

ABIENWI, Nebane

EXTERNAL EXAMINATION Dictated

**BRIEF HISTORY:** 37-year-old man was in custody of U.S. Immigration and Customs Enforcement at Otay Mesa Detention Center. On the morning of 09/26/2019, he was found altered in his bunk with left sided weakness, facial droop, and slurred speech. He was transported to Sharp Chula Vista. CT showed a large pericardial hematoma centered on the right lateral ganglion, with intraventricular extension, severe mass effect with leftward midline shift. Urine drug screen was positive for benzodiazepines (but no was administered medication). He was given a pain prescription, declined, and died on 10/1/2019. No drug paraphernalia was found at scene. Family requests no autopsy.

**EXTERNAL DESCRIPTION:** ☒ See also diagram

☒ developed ☒ nourished: obese/ thin/ cachectic  
☐ Embalmed ☐ Postmortem artifacts:

Rigor mortis: absent/ mild/ moderate/ full  
Livor mortis: unfixed/ fixed, posterior/ anterior: not apparent  
☐ Decomposition:

**Head:**

(☐ male pattern baldness)  
Hair: gray/ brown/ black/ blond/ mix Length: curly 2"  
Facial hair: shaven; mustache/ beard  
Irides: brown/ hazel/ green/ blue/ undet Pupils: 1 1/2  
Corneas: opaque/ clear/ removed/ arcus senilis sl. cloudy  
Sclerae & conjunctivae: four yellow disc  
Petechia: yes/ no Nose:  
Ears: ☐ pierced ☐ creased  
Mouth and lips:  
Upper Teeth: intact/ partial/ absent/ denture  
Lower Teeth: intact/ partial/ absent/ denture

**Neck:** ☒ symmetrical

**Chest:** ☒ symmetrical  
Breasts: ☐ no masses

**Abdomen:** flat / ☐ distended; soft / firm  
scars:

**Genitalia:** ☒ male / ☒ circumcised

**Arms:**

☐ senile ecchymoses  
Fingernails: short, down

**Legs:** ☒ edema; ☐ deformity  
Toenails:

**Back:** ☒ symmetrical  
Anus:

**Skin:** ☐ jaundiced

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

**EVIDENCE OF MEDICAL THERAPY:**

☐ None ☒ See Diagram  
☐ Endotracheal tube ☐ Oral airway  
☐ Nasogastric tube ☐ EKG pads  
☐ Defib pads/marks  
☐ Needle punctures / IV lines:

**EXTERNAL EVIDENCE OF INJURY:**

☐ See Diagram ☒ No significant / None  
☐ As below:

**SPECIMENS TAKEN:**

☒ None ☐ Urine ☐ CSF  
☐ Vitreous ☐ Blood site:  
☐ OTHER: Antemortem

STAT CO / alcohol:  
Rapid screens:

**HISTOLOGY:** ☒ None / ☐ cassettes

**X-RAYS:** none

**PHOTOGRAPHS:** ☒ ID photo  
☐ External overall ☒ Other:

**CAUSE OF DEATH:**

Due to: See worksheet

Due to:

**CONTRIBUTING:**

**MANNER:** Natural / Accident / Suicide/

Biopsy performed ☐

**SURGERIES:**

Date/Time of injury:  
How injury occurred:

10/2/2019  
DATE

rev. 9/08

DHS-20-0638-C-000005

2020-ICLI-00057 583



EXTERNAL EXAMINATION REPORT

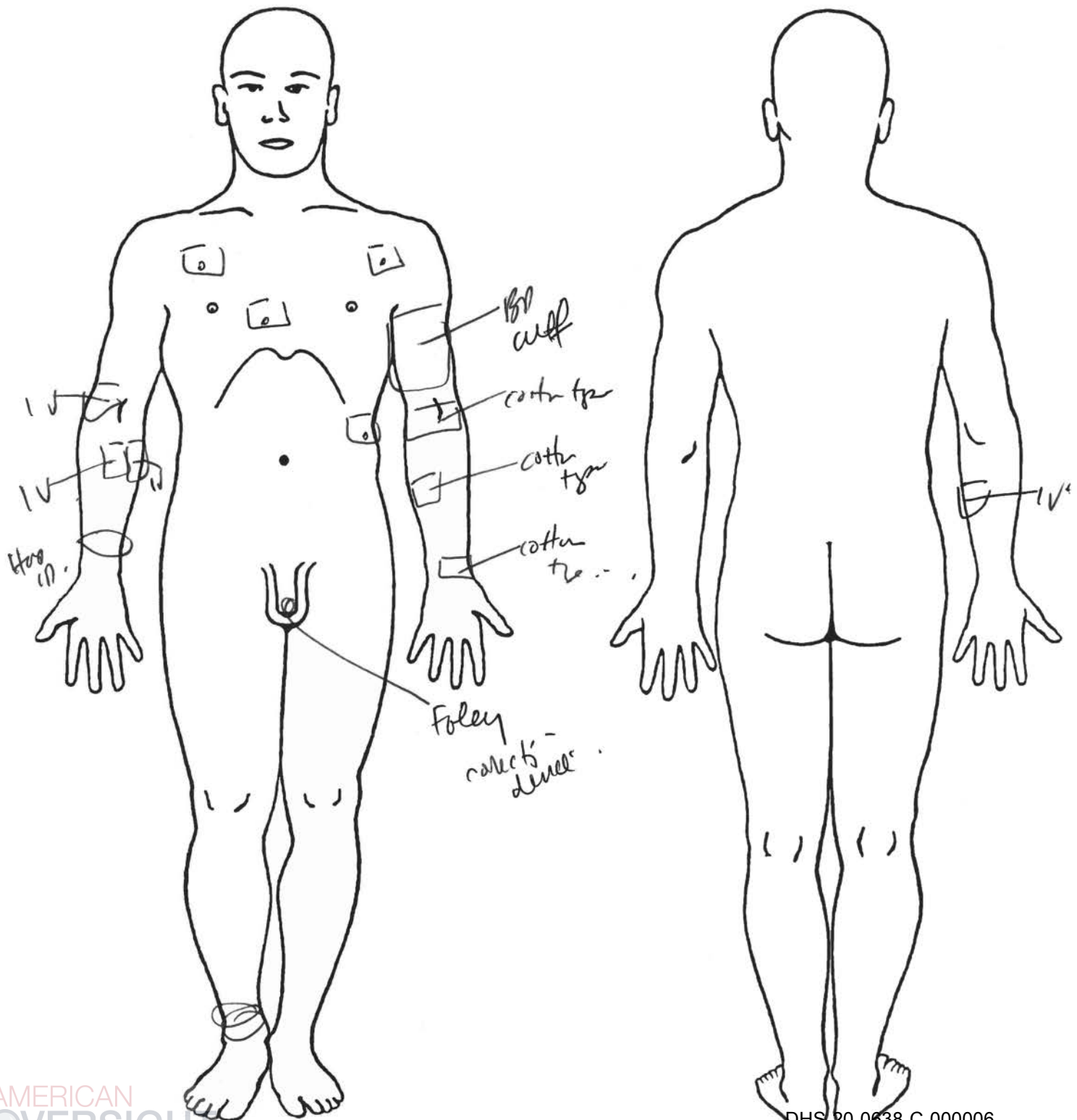
ABIENWI, Nebane

AGE: 37 yrs SEX: Male HEIGHT: 68 in. WEIGHT: 156 lbs. Date & Time of EXAM: 1135

ETHNICITY: ☐ Caucasian ☐ Hispanic ☒ Black ☐ Asian ☐ Filipino ☐ Native American ☐ Other:

CLOTHING: (☒ None/ ☐ Not examined)

IDENTIFICATION: ☒ M.E. ankle band checked







# County of San Diego

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

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>

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

CHIEF DEPUTY MEDICAL EXAMINER  
(858) 694-2895

M.D.

## TOXICOLOGY REPORT

Name: **ABIENWI, Nebane**  
Medical Examiner Number: **2019-02553**  
Date of Death: **10/01/2019**  
Time of Death: **14:41**  
Pathologist: (b)(6); (b)(7)(C)  
Specimens Received: **Antemortem Blood (Serum)**  
Date Specimens Received: **10/02/2019**

| <u>Test Name (Method of Analysis)</u>      | <u>Specimen Tested</u>   | <u>Result</u>               |
|--------------------------------------------|--------------------------|-----------------------------|
| <u>Alcohol Analysis (GC/FID-Headspace)</u> | Antemortem Blood (Serum) |                             |
| Alcohol (Ethanol)                          |                          | Not Detected                |
| Acetone, Isopropanol, Methanol             |                          | Not Detected                |
| <u>Drugs of Abuse Screen (ELISA)</u>       | Antemortem Blood (Serum) |                             |
| Amphetamines                               |                          | Not Detected                |
| <b>Benzodiazepines</b>                     |                          | <b>Presumptive Positive</b> |
| Buprenorphine                              |                          | Not Detected                |
| Cannabinoids                               |                          | Not Detected                |
| Carisoprodol                               |                          | Not Detected                |
| Cocaine metabolites                        |                          | Not Detected                |
| Fentanyl                                   |                          | Not Detected                |
| Methadone                                  |                          | Not Detected                |
| Opiates                                    |                          | Not Detected                |
| Oxycodone                                  |                          | Not Detected                |
| Phencyclidine (PCP)                        |                          | Not Detected                |
| Zolpidem                                   |                          | Not Detected                |
| <u>Benzodiazepines (HPLC/DAD)</u>          | Antemortem Blood (Serum) | Not Detected                |

*Antemortem Blood (Serum) was collected on 09/26/2019 at 04:57 hours*

Unless otherwise requested, all specimens will be destroyed six (6) months after the closure of the case by the Medical Examiner

End Results

Approved and Signed:  
10/29/2019

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

Forensic Toxicology Laboratory Manager

AMERICAN  
OVERSIGHT

2019-02553

An American Board of Forensic Toxicology (ABFT) Accredited Laboratory

2020-1011-00957-585

DHS-20-0638-C-000007

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## STATE OF CALIFORNIA

## CERTIFICATION OF VITAL RECORD

## COUNTY OF SAN DIEGO

## CERTIFICATE OF DEATH

3201937017401

|                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| STATE FILE NUMBER                                                                                                                                                                                                                                                                                                                                                                 |  | LOCAL REGISTRATION NUMBER                                                                                                                                   |  |
| 1. NAME OF DECEDENT - FIRST (Given)<br><b>NEBANE</b>                                                                                                                                                                                                                                                                                                                              |  | 3. LAST (Family)<br><b>ABIENMI</b>                                                                                                                          |  |
| 2. MIDDLE<br>-                                                                                                                                                                                                                                                                                                                                                                    |  | 4. DATE OF BIRTH mm/dd/yyyy<br><b>10/28/1981</b>                                                                                                            |  |
| 5. AGE Yrs.<br><b>37</b>                                                                                                                                                                                                                                                                                                                                                          |  | 6. SEX<br><b>M</b>                                                                                                                                          |  |
| 9. BIRTH STATE/FOREIGN COUNTRY<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                  |  | 10. SOCIAL SECURITY NUMBER<br><b>UNKNOWN</b>                                                                                                                |  |
| 11. EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNK                                                                                                                                                                                                                                                |  | 12. MARITAL STATUS/SFDP* (at Time of Death)<br><b>UNKNOWN</b>                                                                                               |  |
| 13. EDUCATION - Highest Level Degree<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                            |  | 14. DATE OF DEATH mm/dd/yyyy<br><b>10/01/2019</b>                                                                                                           |  |
| 15. WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet or back)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                               |  | 16. DECEDENT'S RACE - Up to 3 races may be listed (see worksheet or back)<br><b>BLACK</b>                                                                   |  |
| 17. USUAL OCCUPATION - Type of work for most of life. DO NOT USE RETIRED.<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                       |  | 18. KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)<br><b>UNKNOWN</b>                                        |  |
| 19. YEARS IN OCCUPATION<br><b>UNK</b>                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                             |  |
| 20. DECEDENT'S RESIDENCE (Street and number, or location)<br><b>UNKNOWN UNKNOWN</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                             |  |
| 21. CITY<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                        |  | 22. COUNTY/PROVINCE<br><b>UNKNOWN</b>                                                                                                                       |  |
| 23. ZIP CODE<br>-                                                                                                                                                                                                                                                                                                                                                                 |  | 24. YEARS IN COUNTY<br><b>UNK</b>                                                                                                                           |  |
| 25. STATE/FOREIGN COUNTRY<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                             |  |
| 26. INFORMANT'S NAME, RELATIONSHIP<br><b>UNDER INVESTIGATION, M.E. OFFICE</b>                                                                                                                                                                                                                                                                                                     |  | 27. INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)<br><b>5570 OVERLAND AVENUE, SAN DIEGO, CA 92123</b> |  |
| 28. NAME OF SURVIVING SPOUSE/SRDP - FIRST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                       |  | 29. MIDDLE<br><b>UNKNOWN</b>                                                                                                                                |  |
| 30. LAST (BIRTH NAME)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                             |  |
| 31. NAME OF FATHER/PARENT - FIRST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                               |  | 32. MIDDLE<br><b>UNKNOWN</b>                                                                                                                                |  |
| 33. LAST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                                        |  | 34. BIRTH STATE<br><b>UNKNOWN</b>                                                                                                                           |  |
| 35. NAME OF MOTHER/PARENT - FIRST<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                               |  | 36. MIDDLE<br><b>UNKNOWN</b>                                                                                                                                |  |
| 37. LAST (BIRTH NAME)<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                                                                                                           |  | 38. BIRTH STATE<br><b>UNKNOWN</b>                                                                                                                           |  |
| 39. DISPOSITION DATE mm/dd/yyyy<br>-                                                                                                                                                                                                                                                                                                                                              |  | 40. PLACE OF FINAL DISPOSITION<br>-                                                                                                                         |  |
| 41. TYPE OF DISPOSITION(S)<br><b>PEND</b>                                                                                                                                                                                                                                                                                                                                         |  | 42. SIGNATURE OF EMBALMER<br><b>NOT EMBALMED</b>                                                                                                            |  |
| 43. LICENSE NUMBER<br>-                                                                                                                                                                                                                                                                                                                                                           |  | 44. NAME OF FUNERAL ESTABLISHMENT<br><b>S.D. COUNTY MEDICAL EXAMINER</b>                                                                                    |  |
| 45. LICENSE NUMBER<br><b>NONE</b>                                                                                                                                                                                                                                                                                                                                                 |  | 46. SIGNATURE OF LOCAL REGISTRAR<br><b>(b)(6); (b)(7)(C)</b>                                                                                                |  |
| 47. DATE mm/dd/yyyy<br><b>10/10/2019</b>                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                             |  |
| 101. PLACE OF DEATH<br><b>SHARP CHULA VISTA MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                    |  | 102. IF HOSPITAL, SPECIFY ONE<br><input checked="" type="checkbox"/> IP <input type="checkbox"/> ER/CP <input type="checkbox"/> DCA                         |  |
| 103. IF OTHER THAN HOSPITAL, SPECIFY ONE<br><input type="checkbox"/> Hospice <input type="checkbox"/> Nursing Home LTC <input type="checkbox"/> Decedent's Home <input type="checkbox"/> Other                                                                                                                                                                                    |  | 104. COUNTY<br><b>SAN DIEGO</b>                                                                                                                             |  |
| 105. FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)<br><b>751 MEDICAL CENTER COURT</b>                                                                                                                                                                                                                                                                 |  | 106. CITY<br><b>CHULA VISTA</b>                                                                                                                             |  |
| 107. CAUSE OF DEATH<br>Enter the chain of events -- diseases, injuries, or complications -- that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.<br><b>(A) HYPERTENSIVE BASAL GANGLIA HEMORRHAGE</b>                                                 |  | 108. DEATH REPORTED TO CORONER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                      |  |
| 109. BICPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                                                                                                                                                                                                                                                     |  | 110. AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                                              |  |
| 111. USED IN DETERMINING CAUSE?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                             |  |
| 112. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107<br><b>NONE</b>                                                                                                                                                                                                                                                     |  |                                                                                                                                                             |  |
| 113. WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? If yes, list type of operation and code.<br><b>NO</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                             |  |
| 114. I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.<br>Decedent Attended Since: (A) mm/dd/yyyy (B) mm/dd/yyyy                                                                                                                                                                                              |  | 115. SIGNATURE AND TITLE OF CERTIFIER<br><b>(b)(6); (b)(7)(C)</b>                                                                                           |  |
| 116. LICENSE NUMBER<br>-                                                                                                                                                                                                                                                                                                                                                          |  | 117. DATE mm/dd/yyyy<br>-                                                                                                                                   |  |
| 118. TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE<br>-                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                             |  |
| 119. I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED.<br>MANNER OF DEATH: <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 120. INJURED AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK                                              |  |
| 121. INJURY DATE mm/dd/yyyy<br>-                                                                                                                                                                                                                                                                                                                                                  |  | 122. HOUR (24 Hours)<br>-                                                                                                                                   |  |
| 123. PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)<br>-                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                             |  |
| 124. DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)<br>-                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                             |  |
| 125. LOCATION OF INJURY (Street and number, or location, and city, and zip)<br>-                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                             |  |
| 126. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 127. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 128. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 129. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 130. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 131. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 132. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 133. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 134. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 135. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 136. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 137. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 138. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 139. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 140. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 141. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 142. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 143. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 144. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 145. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 146. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 147. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 148. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 149. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 150. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 151. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 152. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 153. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 154. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 155. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 156. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 157. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 158. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 159. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 160. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 161. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 162. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 163. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 164. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 165. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 166. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 167. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 168. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 169. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 170. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 171. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 172. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 173. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 174. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 175. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 176. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 177. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 178. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 179. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 180. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 181. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 182. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 183. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 184. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 185. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 186. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 187. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 188. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 189. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 190. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 191. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 192. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 193. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 194. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 195. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 196. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 197. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 198. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 199. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 200. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 201. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 202. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 203. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 204. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 205. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 206. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 207. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 208. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 209. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 210. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 211. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 212. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 213. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 214. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 215. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 216. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 217. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 218. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 219. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 220. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 221. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 222. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 223. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 224. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 225. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 226. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 227. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 228. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 229. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 230. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 231. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 232. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 233. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 234. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 235. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 236. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 237. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 238. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 239. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 240. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 241. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 242. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 243. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 244. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 245. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 246. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 247. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 248. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 249. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 250. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 251. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 252. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 253. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 254. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 255. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 256. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 257. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 258. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 259. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 260. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 261. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 262. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 263. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 264. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 265. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 266. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 267. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 268. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 269. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 270. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 271. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 272. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 273. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 274. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 275. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 276. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 277. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 278. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 279. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 280. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 281. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 282. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 283. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 284. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 285. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 286. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 287. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 288. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 289. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 290. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 291. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 292. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 293. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 294. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 295. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 296. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 297. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 298. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 299. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 300. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 301. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 302. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 303. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 304. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 305. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 306. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 307. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 308. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 309. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 310. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 311. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 312. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 313. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 314. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 315. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 316. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 317. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 318. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 319. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 320. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 321. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 322. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 323. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 324. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 325. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 326. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 327. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 328. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 329. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 330. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 331. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 332. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 333. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 334. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 335. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 336. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 337. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 338. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 339. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 340. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 341. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 342. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 343. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 344. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 345. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 346. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 347. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 348. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 349. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 350. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 351. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 352. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 353. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 354. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 355. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 356. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 357. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 358. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 359. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 360. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 361. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 362. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 363. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 364. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 365. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 366. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 367. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 368. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 369. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 370. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 371. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 372. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 373. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 374. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 375. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 376. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 377. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 378. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 379. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 380. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 381. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 382. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 383. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 384. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 385. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 386. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 387. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 388. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 389. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 390. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 391. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |
| 392. DATE mm/dd/yyyy<br><b>10/09/2019</b>                                                                                                                                                                                                                                                                                                                                         |  | 393. SIGNATURE<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                  |  |



# STATE OF CALIFORNIA

## CERTIFICATION OF VITAL RECORD

### COUNTY OF SAN DIEGO

3052019203091

STATE FILE NUMBER

1.1

#### AFFIDAVIT TO AMEND A RECORD

NO ERASURES, WHITEOUTS, PHOTOCOPIES,  
OR ALTERATIONS

3201937017401

LOCAL REGISTRATION NUMBER

☐ BIRTH ☒ DEATH ☐ FETAL DEATH

TYPE OR PRINT CLEARLY IN BLACK INK ONLY - THIS AMENDMENT BECOMES AN ACTUAL PART OF THE OFFICIAL RECORD

#### PART I INFORMATION TO LOCATE RECORD

|                                                       |                                                                                       |                                           |                                 |                                                                                       |                                 |
|-------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------|---------------------------------|
| INFORMATION<br>AS IT APPEARS<br>ON ORIGINAL<br>RECORD | 1A. NAME—FIRST<br>NEBANE                                                              |                                           | 1B. MIDDLE<br>-                 | 1C. LAST<br>ABIENWI                                                                   |                                 |
|                                                       | 2. SEX<br>M                                                                           | 3. DATE OF EVENT—MM/DD/CCYY<br>10/01/2019 | 4. CITY OF EVENT<br>CHULA VISTA |                                                                                       | 5. COUNTY OF EVENT<br>SAN DIEGO |
|                                                       | 6. FULL NAME OF FATHER/PARENT AS STATED ON ORIGINAL RECORD<br>UNKNOWN UNKNOWN UNKNOWN |                                           |                                 | 7. FULL NAME OF MOTHER/PARENT AS STATED ON ORIGINAL RECORD<br>UNKNOWN UNKNOWN UNKNOWN |                                 |
|                                                       |                                                                                       |                                           |                                 |                                                                                       |                                 |

#### PART II STATEMENT OF CORRECTIONS TO BIRTH, DEATH, OR FETAL DEATH RECORD

| 8. ITEM<br>NUMBER TO BE<br>CORRECTED | 9. INCORRECT INFORMATION THAT APPEARS ON ORIGINAL RECORD | 10. CORRECTED INFORMATION AS IT SHOULD APPEAR                      |
|--------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------|
| 9                                    | UNKNOWN                                                  | CAMEROON                                                           |
| 10                                   | UNKNOWN                                                  | NONE                                                               |
| 11                                   | UNK                                                      | NO                                                                 |
| 12                                   | UNKNOWN                                                  | MARRIED                                                            |
| 13                                   | UNKNOWN                                                  | HIGH SCHOOL DIPLOMA                                                |
| 17                                   | UNKNOWN                                                  | MECHANIC                                                           |
| 18                                   | UNKNOWN                                                  | AUTO REPAIR                                                        |
| 19                                   | UNK                                                      | 22                                                                 |
| 20                                   | UNKNOWN UNKNOWN                                          | - WANGIA STREET<br>NGOMGHAM BAMENDA                                |
| 21                                   | UNKNOWN                                                  | NORTH WEST PROVINCE                                                |
| 24                                   | UNK                                                      | 0                                                                  |
| 25                                   | UNKNOWN                                                  | CAMEROON                                                           |
| 26                                   | UNDER INVESTIGATION,<br>M.E. OFFICE                      | NYOU AMBE AKOROGNWI<br>ELVIS, BROTHER                              |
| 27                                   | 5570 OVERLAND AVENUE,<br>SAN DIEGO, CA 92123             | WANGIA STREET NGOMGHAM<br>BAMENDA, NORTH WEST<br>PROVINCE CAMEROON |
| 28                                   | UNKNOWN                                                  | SUSAN                                                              |
| 29                                   | UNKNOWN                                                  | -                                                                  |
| 30                                   | UNKNOWN                                                  | MANJEIA                                                            |
| 31                                   | UNKNOWN                                                  | SAMUEL                                                             |

|                          |                                     |
|--------------------------|-------------------------------------|
| REASON FOR<br>CORRECTION | 11. TO TAKE OUT OF TEMP ENVAULTMENT |
|--------------------------|-------------------------------------|

|                                                                                                          |                                                                                                                                                                           |                                                               |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|
| AFFIDAVITS<br>AND<br>SIGNATURES                                                                          | We, the undersigned, hereby certify under penalty of perjury that we have personal knowledge of the above facts and that the information given above is true and correct. |                                                               |
|                                                                                                          | (b)(6); (b)(7)(C)                                                                                                                                                         | 12C. TITLE/RELATIONSHIP TO PERSON IN PART I<br>MORTUARY STAFF |
|                                                                                                          | 12D. ADDRESS (STREET and NUMBER, CITY, STATE, ZIP)<br>5880 EL CAJON BLVD, SAN DIEGO, CA 92115                                                                             | 12E. DATE SIGNED—MM/DD/CCYY<br>11/07/2019                     |
|                                                                                                          | 13A. SIGNATURE OF SECOND PERSON<br>(b)(6); (b)(7)(C)                                                                                                                      | 13C. TITLE/RELATIONSHIP TO PERSON IN PART I<br>MORTUARY       |
| TWO<br>PERSONS<br>MUST SIGN<br>THIS FORM TO<br>CORRECT A<br>BIRTH, DEATH,<br>OR FETAL<br>DEATH<br>RECORD | 13D. ADDRESS (STREET and NUMBER, CITY, STATE, ZIP)<br>5880 EL CAJON BLVD, SAN DIEGO, CA 92115                                                                             | 13E. DATE SIGNED—MM/DD/CCYY<br>11/07/2019                     |
|                                                                                                          | 14. OFFICE OF VITAL RECORDS OR LOCAL REGISTRAR<br>STATE REGISTRAR - OFFICE OF VITAL RECORDS                                                                               | 15. DATE ACCEPTED FOR REGISTRATION<br>11/07/2019              |

STATE OF CALIFORNIA, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF VITAL RECORDS



FORM VS 24e (REV. 1/08)

1.1

County of San Diego - Health & Human Services Agency - 3851 Rosecrans Street. This is to certify that, if bearing the OFFICIAL SEAL OF THE STATE OF CALIFORNIA, the OFFICIAL SEAL OF SAN DIEGO COUNTY AND THEIR DEPARTMENT OF HEALTH SERVICES EMBOSSED SEAL, this is a true copy of the ORIGINAL DOCUMENT FILED. This copy not valid unless prepared on engraved border displaying seal and signature of Registrar

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

DATE ISSUED: 1/31/2020 WILMA J. WOOTEN, M.D., M.P.H.  
REGISTRAR OF VITAL RECORDS  
County of San Diego



A003608136

DHS-20-0638-C-000009

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

CASANDIEO1



2020-10-11-00057 588  
ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE



# STATE OF CALIFORNIA

## CERTIFICATION OF VITAL RECORD

### COUNTY OF SAN DIEGO

3052019203091

STATE FILE NUMBER

2.1

#### AFFIDAVIT TO AMEND A RECORD

NO ERASURES, WHITEOUTS, PHOTOCOPIES,  
OR ALTERATIONS

3201937017401

LOCAL REGISTRATION NUMBER

☐ BIRTH ☒ DEATH ☐ FETAL DEATH

TYPE OR PRINT CLEARLY IN BLACK INK ONLY - THIS AMENDMENT BECOMES AN ACTUAL PART OF THE OFFICIAL RECORD

#### PART I INFORMATION TO LOCATE RECORD

|                                                       |                                                                                   |                                           |                                 |                                                                              |                                 |  |
|-------------------------------------------------------|-----------------------------------------------------------------------------------|-------------------------------------------|---------------------------------|------------------------------------------------------------------------------|---------------------------------|--|
| INFORMATION<br>AS IT APPEARS<br>ON ORIGINAL<br>RECORD | 1A. NAME—FIRST<br>NEBANE                                                          |                                           | 1B. MIDDLE<br>-                 |                                                                              | 1C. LAST<br>ABIENWI             |  |
|                                                       | 2. SEX<br>M                                                                       | 3. DATE OF EVENT—MM/DD/CCYY<br>10/01/2019 | 4. CITY OF EVENT<br>CHULA VISTA |                                                                              | 5. COUNTY OF EVENT<br>SAN DIEGO |  |
|                                                       | 6. FULL NAME OF FATHER/PARENT AS STATED ON ORIGINAL RECORD<br>SAMUEL AFUME NUMFOR |                                           |                                 | 7. FULL NAME OF MOTHER/PARENT AS STATED ON ORIGINAL RECORD<br>BIH PHERE NIBA |                                 |  |
|                                                       |                                                                                   |                                           |                                 |                                                                              |                                 |  |

#### PART II STATEMENT OF CORRECTIONS TO BIRTH, DEATH, OR FETAL DEATH RECORD

| 8. ITEM<br>NUMBER TO BE<br>CORRECTED | 9. INCORRECT INFORMATION THAT APPEARS ON ORIGINAL RECORD | 10. CORRECTED INFORMATION AS IT SHOULD APPEAR |
|--------------------------------------|----------------------------------------------------------|-----------------------------------------------|
| 42                                   | NOT EMBALMED                                             | (b)(6); (b)(7)(C)                             |
| 43                                   | -                                                        | EMB9570                                       |
| LIST ONE<br>ITEM PER<br>LINE         |                                                          |                                               |
|                                      |                                                          |                                               |
|                                      |                                                          |                                               |
|                                      |                                                          |                                               |

|                          |                         |
|--------------------------|-------------------------|
| REASON FOR<br>CORRECTION | 11. TO CHANGE EMBALMING |
|--------------------------|-------------------------|

|                                                                                                          |                                                                                                                                                                           |                                                         |
|----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| AFFIDAVITS<br>AND<br>SIGNATURES                                                                          | We, the undersigned, hereby certify under penalty of perjury that we have personal knowledge of the above facts and that the information given above is true and correct. |                                                         |
|                                                                                                          | 12A. SIGNATURE OF FIRST PERSON<br>(b)(6); (b)(7)(C)                                                                                                                       | 12B. PRINTED NAME<br>MORTUARY STAFF                     |
|                                                                                                          | 12D. ADDRESS (STREET and NUMBER, CITY, STATE, ZIP)<br>5880 EL CAJON BLVD, SAN DIEGO, CA 92115                                                                             |                                                         |
|                                                                                                          | 12E. DATE SIGNED—MM/DD/CCYY<br>11/08/2019                                                                                                                                 | 12C. TITLE/RELATIONSHIP TO PERSON IN PART I<br>MORTUARY |
| TWO<br>PERSONS<br>MUST SIGN<br>THIS FORM TO<br>CORRECT A<br>BIRTH, DEATH,<br>OR FETAL<br>DEATH<br>RECORD | 13A. SIGNATURE OF SECOND PERSON<br>(b)(6); (b)(7)(C)                                                                                                                      | 13B. PRINTED NAME<br>MORTUARY                           |
|                                                                                                          | 13D. ADDRESS (STREET and NUMBER, CITY, STATE, ZIP)<br>5880 EL CAJON BLVD, SAN DIEGO, CA 92115                                                                             |                                                         |
|                                                                                                          | 13E. DATE SIGNED—MM/DD/CCYY<br>11/08/2019                                                                                                                                 |                                                         |
|                                                                                                          | 13C. TITLE/RELATIONSHIP TO PERSON IN PART I<br>MORTUARY                                                                                                                   |                                                         |
| STATE/LOCAL<br>REGISTRAR<br>USE ONLY                                                                     | 14. OFFICE OF VITAL RECORDS OR LOCAL REGISTRAR<br>STATE REGISTRAR - OFFICE OF VITAL RECORDS                                                                               |                                                         |
|                                                                                                          | 15. DATE ACCEPTED FOR REGISTRATION<br>11/08/2019                                                                                                                          |                                                         |

STATE OF CALIFORNIA, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF VITAL RECORDS



020201004359455

FORM VS 24e (REV. 1/08)

2.1

County of San Diego - Health & Human Services Agency - 3851 Rosecrans Street. This is to certify that, if bearing the OFFICIAL SEAL OF THE STATE OF CALIFORNIA, the OFFICIAL SEAL OF SAN DIEGO COUNTY AND THEIR DEPARTMENT OF HEALTH SERVICES EMBOSSED SEAL, this is a true copy of the ORIGINAL DOCUMENT FILED. This copy not valid unless prepared on engraved border displaying seal and signature of Registrar

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

DATE ISSUED: 1/31/2020 WILMA J. WOOTEN, M.D., M.P.H.  
REGISTRAR OF VITAL RECORDS  
County of San Diego



A003608138

DHS-20-0638-C-0000142

ANY ALTERATION OR ERASURE VOIDS THIS CERTIFICATE

CASANDIEO1



SECRET

**Detainee Death Review: ABIENWI, Nebane A 213 187 584**  
**Medical and Security Compliance Analysis**  
**Otay Mesa Detention Center, San Diego, CA**

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 Nebane ABIENWI while in the custody of the Otay Mesa Detention Center (OMDC), San Diego, California. A team consisting of ERAU personnel (b)(6); (b)(7)(C) Inspection and Compliance Specialist and (b)(6); (b)(7)(C) Unit Chief, and contract subject matter experts in correctional healthcare and security (b)(6); (b)(7)(C) conducted a site visit November 12 – 14, 2019. ERAU requested contractor participation to determine compliance with the ICE Performance Based National Detention Standards (PBNDS) 2011, revised 2016, governing healthcare and security operations.

This report is a collaborative effort on the part of (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) Creative Corrections' program manager for the OPR/ERAU contract. Included is a case synopsis, overview of the facility's healthcare services, detention summary, a narrative description of events, and conclusions. The information and findings herein are based on analysis of ABIENWI'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**

Nebane ABIENWI, a 37 year old citizen of Cameroon, was admitted to OMDC on September 19, 2019. He reported his only current medical condition was a rash and that he had recently been hospitalized for high blood pressure, but was not on anti-hypertensive medication. His blood pressure at the time of intake was within normal limits at 104/67.

On September 26, 2019, ABIENWI rolled off his top bunk, landing on a chair. In response to a medical emergency call, nurses arrived and observed no injuries, but ABIENWI was unable to follow verbal commands or answer questions. His speech was slurred and the nurses observed jerky movements to his upper and lower extremities. He was moved by wheelchair to the medical clinic where his disorientation continued and his blood pressure was found to be 180/100. A nurse called for emergency medical services, and ABIENWI was transported by ambulance to the local hospital.

At the hospital, a computed tomography (CT) scan showed a brain hemorrhage. He was admitted and placed in the intensive care unit where his condition continued to decline. On October 1, 2019 at 12:05 p.m., hospital staff pronounced ABIENWI brain dead. A death certificate and autopsy were not available as of the date of this report.



## HEALTHCARE SERVICES

OMDC earned accreditation by the National Commission on Correctional Health Care in 2017. The health services department is staffed 24 hours a day, seven days a week by ICE Health Services Corp (IHSC) and contractor STG International (STGi) headquartered in Alexandria, Virginia. The staffing plan authorizes 103 positions, including 21 designated for commissioned officers of the US Public Health Service (USPHS) and 70 contract, plus 12 recently approved General Schedule for Federal Pay (GS) positions. USPHS officers include the Clinical Director<sup>1</sup>, Health Services Administrator (HSA), and Assistant HSA. The blended complement of other positions consists of staff physicians, advance practice providers<sup>2</sup>, registered nurses (RN), licensed vocational nurses, mental health professionals, dental professionals, pharmacy personnel, radiology technicians, and administrative assistants. According to Assistant HSA (b)(6); (b)(7)(C) STGi has had difficulty meeting the minimal RN coverage requirements, necessitating use of temporary duty RNs. On September 26, 2019, the night of ABIENWI's medical emergency, staffing levels were above the minimum.

ERAU's review of the credential files for the six medical staff involved in ABIENWI's care found the following:

- The license of (b)(6); (b)(7)(C) radiology technician, was not primary source verified.
- The license for (b)(6); (b)(7)(C) RN, was issued on December 28, 2017, but not primary source verified until November 5, 2019.
- (b)(6); (b)(7)(C)'s credential files did not contain documentation of training on emergency first aid. (b)(6); (b)(7)(C), RN, last received first aid training on April 28, 2018, and (b)(6); (b)(7)(C) RN, last received the training on March 14, 2018.
- Documentation of nurse competency training and initial orientation is missing in RN (b)(6); (b)(7)(C) file. RN (b)(6); (b)(7)(C) last received competency training on April 28, 2018, and (b)(6); (b)(7)(C) last received the training on March 14, 2018.

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 healthcare professionals conduct patient encounters, and they 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.

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<sup>1</sup> The Clinical Director during ABIENWI's detention (b)(6); (b)(7)(C) coincidentally transferred to another duty station the day of his death. An IHSC Regional Clinical Director based in the state of Washington was named acting Clinical Director upon her departure (b)(6); (b)(7)(C) STGi staff physician, served as local Clinical Director at the time of ERAU's site visit.

<sup>2</sup> Advanced Practice Providers include nurse practitioners and physician assistants.

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## DETENTION SUMMARY

ABIENWI was classified low custody and was assigned to a general population housing unit during his detention. He had no social visits and made five telephone calls.

## NARRATIVE

On September 18, 2019, US Customs and Border Patrol transferred custody of ABIENWI and ten other detainees to ICE Enforcement and Removal Operations (ERO) for detention at OMDC.<sup>3</sup> Upon his arrival (b)(6); (b)(7)(C) RN, conducted ABIENWI's medical prescreening assessment.<sup>4</sup> The findings were as follows<sup>5</sup>:

- ABIENWI's primary language was English.
- ABIENWI reported a current illness or health problem and that he was taking medication.
- ABIENWI denied having pain.
- ABIENWI denied wanting to hurt himself or fear that someone would hurt him.
- ABIENWI displayed no evidence of behavioral problems, reduced state of consciousness, or difficulty moving or breathing.

RN (b)(6); (b)(7)(C) designated ABIENWI for Priority-1 (PRI-1) intake screening.<sup>6</sup>

Officer (b)(6); (b)(7)(C) initiated the OMDC booking process at 8:35 p.m.<sup>7</sup> The process extended into the early morning hours of September 19, 2019 and was supported by Officer (b)(6); (b)(7)(C)

ABIENWI signed all required admission documents, including the property inventory listing clothing, jewelry items, and identity documents; a transaction receipt for \$5.00 in cash; and acknowledgement that he received facility issued items, the detainee handbook, and orientation by way of video.<sup>8</sup> ABIENWI made a three-minute phone call to a friend, Christopher Funebe, whom he named as his emergency contact.<sup>9</sup>

<sup>3</sup> See Form I-216, Record of Persons Transferred, dated September 18, 2019. See also, Form I-203, Order to Detain Alien, dated September 18, 2019.

<sup>4</sup> Prescreening involves nurses meeting individually with detainees after they exit the transport vehicle before they enter the facility for the purpose of asking simple triage questions to assess for emergencies or communicable diseases. (b)(6); (b)(7)(C) was not available for interview because she left employment prior to ERAU's site visit. ERAU interview with Commander (CDR (b)(6); (b)(7)(C) HSA dated November 14, 2019.

<sup>5</sup> See Pre-Screen medical encounter note, dated September 18, 2019.

<sup>6</sup> Nurses assign PRI-1 status if detainees report information requiring expedited review. ERAU interview with Lieutenant Commander (b)(6); (b)(7)(C) Assistant HSA, dated November 13, 2019.

<sup>7</sup> See Inmate/Detainee Commitment Summary, dated September 18, 2019.

<sup>8</sup> See property inventory (untitled) dated September 18, 2019; Transaction Receipt dated September 19, 2019; Clothing Issued Receipt dated September 19, 2019; and Acknowledgement of Inmate/Detainee Orientation dated September 18, 2019.

<sup>9</sup> See Detainee Free Admission Telephone Call, dated September 19, 2019 and Inmate/Detainee Commitment Summary, dated September 18, 2019.



On the ICE Custody Classification Worksheet, Officer (b)(6); (b)(7)(C) documented ABIENWI's primary language was English.<sup>10</sup> He classified ABIENWI low custody on the basis he had no criminal history or security threat group involvement. Supervisors approved the rating on September 19 and 20, 2019. In the Special Vulnerabilities and Management Concerns section, Officer (b)(6); (b)(7)(C) documented ABIENWI was the victim of assault and sexual abuse while detained by the military in November 2017. That information was also noted on the Assessment Questionnaire Information form used to screen detainees for sexual assault victimization and predatory risk<sup>11</sup>, and the Booking Observation Report. The Booking Observation Report clarifies that ABIENWI reported the assault and sexual abuse occurred during a ten-month detention by the Cameroon military.<sup>12</sup> By email timed 10:57 p.m., Officer (b)(6); (b)(7)(C) notified multiple recipients of ABIENWI's report of past sexual assault.<sup>13</sup>

At 7:26 p.m. (b)(6); (b)(7)(C) radiology technician, completed a chest x-ray.<sup>14</sup> The finding was negative for active tuberculosis.

**On September 19, 2019** at approximately 1:38 a.m., (b)(6); (b)(7)(C) RN, conducted ABIENWI's medical and mental health intake screening.<sup>15</sup> She documented the following:

- ABIENWI spoke English fluently.
- ABIENWI's vital signs were within normal limits, as follows: blood pressure 104/67, heart rate 67, respiratory rate 17, temperature 97.7, and pulse oxygen<sup>16</sup> 98. He weighed 156 pounds.
- ABIENWI reported that he was hospitalized for three days starting August 23, 2019 following a diagnosis of high blood pressure. He reported that he took medication for two weeks, after which it was discontinued because a doctor determined his blood pressure was normal.<sup>17</sup>

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<sup>10</sup> See ICE Custody Classification Worksheet, dated September 18, 2019.

<sup>11</sup> See Assessment Questionnaire Information, dated September 18, 2019.

<sup>12</sup> See Booking Observation Report, dated September 19, 2019.

<sup>13</sup> See email from Officer (b)(6); (b)(7)(C) dated September 18, 2019. The titles and agencies of the recipients are not reflected; however, one was (b)(6); (b)(7)(C) Acting Assistant Field Officer Director (Acting AFOD). Officer (b)(6); (b)(7)(C) documented on the Custody Classification Worksheet that Acting AFOD (b)(6); (b)(7)(C) was notified.

<sup>14</sup> See Radiology Report, dated October 9, 2019.

<sup>15</sup> See Intake medical encounter note, dated September 19, 2019.

<sup>16</sup> Oxygen saturation, or pulse oxygen, is the percentage of oxygen in the blood. Normal pulse oxygen levels are 95 percent to 100 percent for adults.

<sup>17</sup> As detailed below, record of a visit to a clinic in Tijuana, Mexico on August 30, 2019 and prescription for an anti-hypertensive medication was found among documents in his cell after his hospitalization. No record of a three-day hospitalization starting August 23, 2019 was found.

- ABIENWI reported he never used drugs and rarely drank alcohol, stating he last drank on September 4, 2019. As documented by RN (b)(6); (b)(7)(C) he stated he drank 4 4 cans of beer when drinking.<sup>18</sup>
- ABIENWI reported he was a victim of sexual abuse in December 2017 but did not feel in any danger of being sexually or physically assaulted.<sup>19</sup>
- ABIENWI reported no mental health concerns or medical issues other than a rash on his lower abdomen and thighs. He stated he was using cortisone<sup>20</sup> and Calmoseptine<sup>21</sup> creams, both of which were in his property.

Regarding ABIENWI's report of hospitalization for high blood pressure, RN (b)(6); (b)(7)(C) informed ERAU she does not recall asking for any further details, to include the name of the medication or who took him off the medication two weeks later.<sup>22</sup> Regarding the rash, RN (b)(6); (b)(7)(C) noted it was on his lower abdomen, describing it in her incident statement as dry and lichenified.<sup>23</sup> She informed ERAU that ABIENWI asked for ointment, but was not allowed to keep the creams he possessed upon intake because they were not labeled properly.<sup>24</sup> She explained to him that he would have to sign up for sick call, and educated him on the process by showing him the sick call sign-up form.<sup>25</sup>

RN (b)(6); (b)(7)(C) concluded the intake screening by coding it normal, clearing ABIENWI for custody and scheduling him for a physical examination simple (PE-S).<sup>26</sup> RN (b)(6); (b)(7)(C) stated to ERAU that she scheduled ABIENWI for a PE-S rather than a physical examination complex (PE-C) because she did not believe he needed priority attention.<sup>27</sup> She emphasized that his blood

<sup>18</sup> RN (b)(6); (b)(7)(C) clarified during interview on November 14, 2019 that ABIENWI reported drinking four cans of beer at a sitting, not 44.

<sup>19</sup> RN (b)(6); (b)(7)(C) did not refer ABIENWI for follow up by a mental health professional.

<sup>20</sup> Cortisone cream is used to treat inflammation and dry, itchy skin.

<sup>21</sup> Calmoseptine cream is used to protect skin irritations from moisture or perspiration.

<sup>22</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>23</sup> See incident statement dated October 11, 2019. Lichenified skin is dry and leathery in appearance due to excessive itching or rubbing.

<sup>24</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>25</sup> Assistant HSA (b)(6); (b)(7)(C) explained during interview on November 13, 2019 that rather than submitting request forms, detainees access healthcare by signing up for sick call between 5:00 a.m. and 6:00 a.m. daily. Nursing staff collect sign-up forms at 6:00 a.m. and RNs triage detainees the same day. Medical staff provided ERAU with sick call sign up logs for five of the eight days ABIENWI was detained, none of which included his name. Because logs were not available for three days, ERAU cannot positively determine whether ABIENWI signed up for sick call. See P Pod sick call logs, dated September 18, 19, 21, 22 and 23, 2019.

<sup>26</sup> A PE-S is the initial physical examination of patients without chronic conditions, conducted by a provider within 14 days of arrival.

<sup>27</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 14, 2019. A PE-C is for patients who arrive on medications for a chronic medical condition or are having medical symptoms needing to be addressed. (b)(6); (b)(7)(C) stated during interview the same day that based on the intake assessment and the information available to RN (b)(6); (b)(7)(C) a PE-S versus PE-C was appropriate.



pressure was within normal limits, he was asymptomatic, and he was not on blood pressure medication.

ABIENWI signed consent for medical and mental health treatment.<sup>28</sup>

At approximately 5:52 a.m., security personnel escorted ABIENWI to P Pod<sup>29</sup>, a two level, direct supervision, low security housing unit with a capacity of 128.<sup>30</sup> There are 12 bay-style sleeping quarters, with walls at the rear and on the sides and open in the front. Each bay has four to five bunk bed sets accommodating a total of eight to ten detainees. The bays on the lower level open onto the dayroom; bays on the upper level open onto the catwalk. Stationary cameras are positioned throughout the unit to capture events and activities in common areas. ABIENWI was assigned to bay 101 on the lower level of P Pod for the duration of his detention.<sup>31</sup> Bay 101 is the first to the right of the officer's station, allowing direct visibility.

**On September 26, 2019** at 3:26 a.m., P Pod Officer (b)(6); (b)(7)(C) called a medical emergency after observing ABIENWI fall from the top bunk onto a chair.<sup>32</sup> During interview, Officer (b)(6); (b)(7)(C) stated ABIENWI was assigned to the top bunk of the bunk bed set on the far left of the bay.<sup>33</sup> He further stated that before the fall, he observed ABIENWI lying on his back, repeatedly stretching his left leg outward over the side of the bunk, then retracting it. ABIENWI rolled over onto his left side as if adjusting his sleeping position, but then rolled off the bed, his upper body landing on a plastic chair next to the bunk. In his incident statement, Officer (b)(6); (b)(7)(C) described the fall as a belly flop onto the chair.<sup>34</sup> As described by detainee (b)(6); (b)(7)(C) ABIENWI fell from the top of the bunk onto the chair, his head and body on the floor.<sup>35</sup> According to Detention Supervisor (b)(6); (b)(7)(C) stated ABIENWI looked dizzy or like something was wrong, then rolled to his side and fell off the bunk, hitting a plastic chair, then slowly moved to the floor.<sup>36</sup>

After observing the fall, Officer (b)(6); (b)(7)(C) immediately responded to the bay and observed ABIENWI turned his upper body from the seat of the chair, sliding to a seated position on the floor.<sup>37</sup> Officer (b)(6); (b)(7)(C) asked ABIENWI if he was okay and if he could stand, but did not

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<sup>28</sup> See IHCS Medical Consent Form, dated September 18, 2019.

<sup>29</sup> See Inmate Housing History report.

<sup>30</sup> ERAU tour, November 13, 2019.

<sup>31</sup> See OMD C Inmate Housing History report.

<sup>32</sup> See Control Center logbook entry, dated September 26, 2019 and Officer (b)(6); (b)(7)(C) Incident Statement, dated October 1, 2019.

<sup>33</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated November 13, 2019.

<sup>34</sup> See Officer (b)(6); (b)(7)(C) Incident Statement, dated October 1, 2019.

<sup>35</sup> See (b)(6); (b)(7)(C) Incident Statement, dated October 1, 2019. Written statements from eight other detainees in the bay document they did not witness the fall.

<sup>36</sup> See email from (b)(6); (b)(7)(C) to Warden (b)(6); (b)(7)(C) dated September 26, 2019. Although consistent with Officer (b)(6); (b)(7)(C)'s account of the incident, ERAU cannot explain Shift Supervisor (b)(6); (b)(7)(C) extrapolation of (b)(6); (b)(7)(C) observations as documented in his Incident Statement.

<sup>37</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated November 13, 2019.

understand ABIENWI's response. He did not observe any visible injuries. Although ABIENWI tried to stand, Officer (b)(6); (b)(7)(C) instructed him to stay seated and stepped away to call the Control Center while another detainee assisted with keeping ABIENWI in a seated position. Per instructions from the Control Center, Officer (b)(6); (b)(7)(C) announced the medical emergency over the radio, followed up by the Control officer.<sup>38</sup> Officer (b)(6); (b)(7)(C) returned to ABIENWI and waited for medical staff to arrive.<sup>39</sup>

Video surveillance footage shows nurses, identified as (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) RN, responded to the unit with wheelchair and emergency bag at 3:27 a.m.,

approximately one minute after the medical emergency call.<sup>40</sup> Unidentified officers and (b)(6); (b)(7)(C)

(b)(6); (b)(7)(C) Shift Supervisor arrived as well. RN (b)(6); (b)(7)(C) reported that when she and RN (b)(6); (b)(7)(C)

arrived, ABIENWI was sitting on the floor.<sup>41</sup> RN (b)(6); (b)(7)(C) stated that he was unable to follow

verbal commands or answer questions, and he had jerky movements to his upper and lower

extremities. RN (b)(6); (b)(7)(C) corroborated that ABIENWI was sitting on the floor when they

arrived, and noted he was oriented to person only and had slurred speech.<sup>42</sup> ABIENWI had no

visible injuries and denied pain or shortness of breath. RN (b)(6); (b)(7)(C) recalled they got a pulse

oximeter reading in the pod to make sure he was stable and did not need supplemental oxygen,

commenting that she wanted to get him to the clinic quickly.<sup>43</sup> At 3:33 a.m., the RNs and

officers transferred ABIENWI from the housing unit to the clinic in a wheelchair.<sup>44</sup> RN

(b)(6); (b)(7)(C) noted they did not place a cervical collar on ABIENWI for the transfer because he was

moving his head and denied hitting his head or neck.<sup>45</sup>

(b)(6); (b)(7)(C) recalled that once ABIENWI was in the clinic's urgent care room, RN (b)(6); (b)(7)(C) and

an officer moved him from the wheelchair to the bed.<sup>46</sup> She said ABIENWI stood with their

help; however, he could not pivot on his own, suggesting he may not have been able to bear his

full weight. She checked ABIENWI's medical record and noted he had no medical history other

than a reported past high blood pressure. She attempted to reach the on-call provider but

<sup>38</sup> As noted, the Control Center logbook documents the medical emergency call at 6:26 a.m.

<sup>39</sup> See Office (b)(6); (b)(7)(C) Incident Statement, dated October 1, 2019. See also, video surveillance footage, dated September 26, 2019.

<sup>40</sup> Video surveillance footage, dated September 26, 2019.

<sup>41</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 22, 2019. See also, RN (b)(6); (b)(7)(C) written incident statement, dated October 14, 2019.

<sup>42</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 14, 2019. See also, (b)(6); (b)(7)(C) emailed written incident statement, dated September 28, 2019.

<sup>43</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 22, 2019.

<sup>44</sup> Video surveillance footage, dated September 26, 2019.

<sup>45</sup> See RN (b)(6); (b)(7)(C) mailed written incident statement, dated September 28, 2019.

<sup>46</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 22, 2019. List



received no response.<sup>47</sup> Due to the critical needs of the patient, she called for emergency medical services (EMS) at approximately 3:45 a.m.<sup>48</sup>

RN (b)(6); (b)(7)(C) medical record encounter note documents the following<sup>49</sup>:

- ABIENWI's vital signs entered at 3:52 a.m. included a significantly elevated blood pressure of 180/100.<sup>50</sup> Vital signs within normal limits were heart rate 72 beats per minute, respiratory rate 18, temperature 98.1 degrees, pulse oxygen 98 percent, and fingerstick blood glucose 115.<sup>51</sup>
- While still in the housing unit, ABIENWI was initially confused and unable to speak or respond to questions or commands. While in route to medical, he was able to state his name, only. After approximately 15 minutes, ABIENWI spoke and responded to questions. He said he was attempting to get out of bed and missed a step.
- ABIENWI was diaphoretic<sup>52</sup> but could not communicate why. He complained of thirst.
- ABIENWI tried continually to get off the bed and did not respond when asked to lie back down.
- ABIENWI's movements continued to be jerky.

(b)(6); (b)(7)(C) reported to ERAU that in addition to observations documented in her medical record entry, she noted ABIENWI was beginning to show signs of facial paralysis on the left side.<sup>53</sup>

(b)(6); (b)(7)(C) corroborated this observation in his incident statement, documenting that while RN (b)(6); (b)(7)(C) checked ABIENWI's medical record and attempted to contact a provider, he noted that when ABIENWI smiled, only the right side of his face moved.<sup>54</sup> When asked to squeeze his fingers, ABIENWI was only able to squeeze with his right hand. When asked to wiggle and elevate his legs, he moved only his right leg.

<sup>47</sup> Assistant HSA (b)(6); (b)(7)(C) stated they were unaware RN (b)(6); (b)(7)(C) was unable to reach the on-call provider. RN (b)(6); (b)(7)(C) offered that it is unusual not to reach the on-call provider. She said that after the incident, the provider offered her personal mobile phone number because the phone issued to on-call providers does not get reliable service. ERAU interviews on November 13 and 14, 2019.

<sup>48</sup> See RN (b)(6); (b)(7)(C)'s written incident statement, dated October 14, 2019. (b)(6); (b)(7)(C) stated she fully supports RN (b)(6); (b)(7)(C)'s decision to call for EMS without provider authorization due to the emergent situation. ERAU interview with (b)(6); (b)(7)(C) dated October 14, 2019.

<sup>49</sup> See eCW Clinical Encounter dated September 26, 2019.

<sup>50</sup> ABIENWI's blood pressure was approaching hypertensive crisis level. According to the American Heart Association, hypertensive crisis parameters are a systolic (upper number) reading greater than 180 and/or a diastolic (lower number) greater than 120.

<sup>51</sup> Although eCW shows the reading to be high, those set parameters are generally based off of a patient who has fasted for the past eight to twelve hours. A normal random blood glucose reading between 79 – 140 mg/dl is considered normal.

<sup>52</sup> Diaphoretic is a medical term for perspiring profusely.

<sup>53</sup> ERAU interview with R (b)(6); (b)(7)(C) dated November 22, 2019.

<sup>54</sup> See RN (b)(6); (b)(7)(C)'s emailed written incident statement, dated September 28, 2019.

According to the Mercy Medical Transportation Patient Care Report,<sup>55</sup> a unit was dispatched at 3:50 a.m., in route at 4:04 a.m., at the scene at 4:06 a.m., and at the patient's side at 4:13 a.m.<sup>56</sup> In her incident statement, (b)(6); (b)(7)(C) noted the EMS responders' arrival was delayed.<sup>57</sup> She explained to ERAU that one of the responders commented he was frustrated by the delay in reaching the patient, which he attributed to the fact it was count time.<sup>58</sup> She remarked she did not believe any delay was more than a couple minutes.

The EMS report documents the following:<sup>59</sup>

- ABIENWI's blood pressure was 180/120. Other vital signs were within normal limits, as follows: heart rate was 90 beats per minute, respiratory rate 18, temperature 37.2 Celsius<sup>60</sup>, pulse oxygen 98 percent, and blood glucose 111.
- An electrocardiogram (EKG) showed a sinus rhythm.<sup>61</sup>
- ABIENWI's smile was asymmetrical.<sup>62</sup>
- ABIENWI's motor function to his left upper arm and left lower leg were absent.
- ABIENWI's Glasgow Coma Scale (GCS) was 15 out of 15.<sup>63</sup>
- ABIENWI was alert and oriented to person, place and time. There were no signs of trauma and no other physical findings. He was becoming agitated.

The ambulance departed the facility at 4:20 a.m. in emergency mode in route to Sharp Chula Vista Medical Center (SCVMC).<sup>64</sup> EMS responders noted ABIENWI was jerking his body violently and displaying extreme combative behavior. ABIENWI was given Versed intramuscularly<sup>65</sup> but remained combative and uncooperative.

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<sup>55</sup> See Mercy Medical Transportation Patient Care Report dated September 9, 2019.

<sup>56</sup> An entry to the Control Center logbook documents the ambulance arrived at OMDC at 4:12 a.m. ERAU cannot explain the discrepancy.

<sup>57</sup> See written incident statement by (b)(6); (b)(7)(C) dated October 14, 2019.

<sup>58</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 22, 2019.

<sup>59</sup> See Mercy Medical Transportation Patient Care Report dated 9/26/19.

<sup>60</sup> A temperature of 37.2 Celsius is approximately 98.8 Fahrenheit.

<sup>61</sup> An EKG records electrical activity of the heart. Sinus rhythm is a reading that means the heart rate and rhythm are normal.

<sup>62</sup> An asymmetrical smile is when one side of the mouth isn't turning upward, but rather tends to droop down. This can be an early symptom in someone having a stroke.

<sup>63</sup> Glasgow Coma Scale is an assessment tool used in critical care settings. It scores assessment findings to determine how critically ill a patient is. The best score on this scale is 15; however, a score of 15 does not mean a patient is not critically ill. The patient still needs close monitoring.

<sup>64</sup> See Mercy Medical Transportation Patient Care Report dated 9/26/19. The time of departure documented in the Rear Gate Logbook is 4:30 a.m. ERAU cannot explain the discrepancy.

<sup>65</sup> Versed is a sedative used to help calm patients or help with sedation prior to a procedure.

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Officers (b)(6); (b)(7)(C) were assigned to the transport detail, Officer (b)(6); (b)(7)(C) in the chase vehicle and Officer Sandoval in the ambulance.<sup>66</sup> Officer (b)(6); (b)(7)(C) stated that before ABIENWI was moved to the ambulance, he was somewhat resistant to having restraints applied.<sup>67</sup> During the transport, ABIENWI appeared to go in and out of consciousness and consistent with the EMS report, Officer (b)(6); (b)(7)(C) noted he was combative.

The ambulance arrived at the SCVMC emergency department at 5:04 a.m. where EMS turned over care to hospital personnel.<sup>68</sup> (b)(6); (b)(7)(C) MD, triaged ABIENWI, noting he presented as a stroke code needing immediate intervention.<sup>69</sup> Abnormal findings included right pupil size of four millimeters and nonreactive left pupil of two millimeters.<sup>70</sup> A computed tomography (CT) scan<sup>71</sup> showed large, right side intraparenchymal<sup>72</sup> acute hemorrhage centered on the basal ganglia<sup>73</sup> with intraventricular extension<sup>74</sup>, and a leftward midline shift with effacement of the basilar cisterns<sup>75</sup> concerning for uncal herniation<sup>76</sup>. A neurological examination revealed ABIENWI did not open his eyes or follow commands, was nonverbal, and attempted to move his right arm in response to painful stimuli. ABIENWI was intubated<sup>77</sup> for airway protection, an oral gastric tube<sup>78</sup> was placed in his stomach, and he was started on nicardipine<sup>79</sup> drip for blood pressure control. (b)(6); (b)(7)(C) consulted with a neurosurgeon and an intensivist,<sup>80</sup> and admitted ABIENWI to the intensive care unit (ICU).

At approximately 2:27 p.m., ERO San Diego obtained ABIENWI's emergency contact information from his from detention file, and contacted (b)(6); (b)(7)(C) in an attempt to locate ABIENWI's family.<sup>81</sup>

<sup>66</sup> See Transportation Trip Ticket and ERAU interview with Officer (b)(6); (b)(7)(C) dated November 13, 2019.

<sup>67</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated November 13, 2019.

<sup>68</sup> See Mercy Medical Transportation Patient Care Report, dated 9/26/19.

<sup>69</sup> See SCVMC Emergency Documentation, dated September 26, 2019.

<sup>70</sup> Nonreactive pupils are when the pupil does not react to light being shined on it. It can be a sign of brain injury.

<sup>71</sup> A CT scan is an x-ray image taken from different angles, followed by computer processing to create cross-sectional images. See SCVMC Computed Tomography report, dated September 26, 2019.

<sup>72</sup> Intraparenchymal refers to functional tissue of the brain. Damage to this area often results in loss of cognitive ability or even death.

<sup>73</sup> Basal ganglia hemorrhage is bleeding that has occurred in the basal ganglia area of the brain. The bleeding is caused by a ruptured artery.

<sup>74</sup> Intraventricular extension means the bleeding has spread into the four cavities (ventricles) of the brain.

<sup>75</sup> Effacement of the basilar cisterns refers to the narrowing of anatomical spaces in the brain.

<sup>76</sup> Uncal herniation occurs when pressure inside the skull (from swelling or bleeding) causes the brain to move.

<sup>77</sup> Intubated is when a tube is inserted into the trachea to assist with mechanical breathing.

<sup>78</sup> Oral gastric tube is a tube placed through the mouth into the stomach to be used for feeding, medication administration or suctioning out contents in the stomach.

<sup>79</sup> Nicardipine is a medication used to relax the blood vessels, making it easier for the heart to pump. It is used to treat high blood pressure.

<sup>80</sup> Intensivist is a physician who specializes in the care of critically ill patients.

<sup>81</sup> See ICE Significant Incident Report, October 2, 2019. Primary source documentation is not available.

Starting on this date and continuing through ABIENWI's death on October 1, 2019, OMDC healthcare staff obtained updates from SVCMC.<sup>82</sup> The updates were communicated by way of email, including to and from Captain (CAPT) (b)(6); (b)(7)(C) ID, IHSC Deputy Medical Director, and (b)(6); (b)(7)(C) outgoing OMDC Clinical Director. As summarized below, two of the updates were obtained by (b)(6); (b)(7)(C)

OMDC did not provide the hospital logbook documenting ABIENWI's arrival and admission to the hospital this date, through September 29, 2019. Acting AFOD (b)(6); (b)(7)(C) informed ERAU that the logbooks for these dates were taken to an off-site file storage location for archiving and could not be located.<sup>83</sup>

**On September 27, 2019** at 9:45 a.m., (b)(6); (b)(7)(C) spoke with (b)(6); (b)(7)(C) at SCVMC.<sup>84</sup> (b)(6); (b)(7)(C) reported ABIENWI was unresponsive and his right pupil was dilated.<sup>85</sup> Vital signs were stable. Treatment included intubation, ventilation, feeding tubes and medical management in the ICU. (b)(6); (b)(7)(C) stated serial CT scans showed hemorrhaging had stopped, but examination found expansion from the hemorrhage was persistent and worsening with signs of herniation<sup>86</sup>. ABIENWI's prognosis was poor and he was not expected to survive either surgical intervention or the management plan.

At approximately 10:44 a.m., ERO attempted to contact the Cameroon Consulate to request assistance with contacting ABIENWI's next of kin.<sup>87</sup> At approximately 12:42 a.m., the consulate replied that they would assist.

Also on this date, HSA (b)(6); (b)(7)(C) sent email communications to various ICE personnel requesting information regarding ABIENWI's reported hospitalization for hypertension prior to his arrival at OMDC.<sup>88</sup> At approximately 3:00 p.m., ERO staff located records documenting two separate medical encounters for care provided prior to ICE custody.<sup>89</sup> A couple hours later, HSA (b)(6); (b)(7)(C) was provided documentation from a medical facility in Tijuana, Mexico and from a physical examination while ABIENWI was in the custody of CBP. They document the following:

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<sup>82</sup> See IHSC email communications, dated September 26, 2019 to October 1, 2019.

<sup>83</sup> ERAU interview with Acting AFOD (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>84</sup> See email communication from (b)(6); (b)(7)(C) dated September 27, 2019.

<sup>85</sup> Pupil dilation can be a result of uncal herniation, compressing a cranial nerve.

<sup>86</sup> Herniation occurs when pressure inside the skull (from swelling or bleeding) causes the brain to move. It is considered a very serious brain injury that can lead to death or permanent and significant injury.

<sup>87</sup> See ICE Significant Incident Report, October 2, 2019. Primary source documentation is not available.

<sup>88</sup> See e-mails between HSA (b)(6); (b)(7)(C), Acting AFOD (b)(6); (b)(7)(C) and Supervisory Detention and Deportation Officers (SDD) (b)(6); (b)(7)(C) dated September 27, 2019.

<sup>89</sup> See email communication from (b)(6); (b)(7)(C), Acting Assistant Field Officer Director, dated September 27, 2019. (b)(6); (b)(7)(C) Assistant HSA (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) informed ERAU that documents in a detainee's possession upon admission not flagged for medical are given to custody staff for disposition in accordance with security procedures.



- On August 30, 2019, ABIENWI received treatment for essential hypertension<sup>90</sup> at the Centro De Salud Tijuana in Tijuana, Mexico.<sup>91</sup> A provider prescribed medications captopril<sup>92</sup> 25 milligrams (mg), one tablet twice daily for 30 days, and ranitidine<sup>93</sup> 150 mg, one tablet twice daily for 30 days.<sup>94</sup> The section on the prescription for patient signature upon receiving the medications is blank. For this reason, and because ABIENWI retained possession of the prescription, (b)(6); (b)(7)(C) surmises he did not fill it before his apprehension by CBP on September 5, 2019.<sup>95</sup>
- On September 11, 2019, ABIENWI was evaluated by an advanced practice provider from Mission Medical Support.<sup>96</sup> The provider noted ABIENWI had no current medications and no past medical history. His examination was unremarkable except for a complaint of constipation and signs of a rash. ABIENWI's vital signs were within normal limits, as follows: blood pressure 118/74, heart rate 67, respiratory rate 16, temperature 98.2, and pulse oxygen 99. He was given one-time doses of MiraLAX<sup>97</sup>, lactulose<sup>98</sup>, and docusate<sup>99</sup>; Benadryl<sup>100</sup> 25 mg to be taken every four to six hours; and Calmoseptine and hydrocortisone creams to be applied twice daily for rash for ten days.<sup>101</sup> The provider cleared ABIENWI for transport and detention.

**On September 28 and 29, 2019,** there were no changes or improvements to ABIENWI's condition.<sup>102</sup>

<sup>90</sup> Essential hypertension is high blood pressure that doesn't have an underlying cause. It tends to develop gradually over years. Most people with essential hypertension have no signs or symptoms.

<sup>91</sup> See Certificado Medico, Centro De Salud Tijuana and Hospital General de Tijuana, dated August 30, 2019. The documentation does not reflect admission for in-patient care; therefore, ERAU concludes ABIENWI's reported three-day hospitalization on August 23, 2019, if it occurred, was a different encounter.

<sup>92</sup> Captopril is a medication used to treat high blood pressure.

<sup>93</sup> Ranitidine is an antacid used to treat heartburn, stomach ulcers or other conditions that produce too much stomach acid.

<sup>94</sup> See Receta Medica, dated August 30, 2019.

<sup>95</sup> Per ERAU interview with (b)(6); (b)(7)(C) November 14, 2019.

<sup>96</sup> See Mission Medical Support, New Patient Comprehensive Exam, dated September 11, 2019. September 11, 2019 was six days after CBP took ABIENWI into custody.

<sup>97</sup> MiraLAX is a medication used to treat constipation.

<sup>98</sup> Lactulose is a medication used to treat constipation.

<sup>99</sup> Docusate is a medication used to soften stools.

<sup>100</sup> Benadryl is a medication used to allergy symptoms to include itching from a rash.

<sup>101</sup> The documentation does not reflect the number of doses of Benadryl Mission Medical Support supplied. ERAU speculates the Benadryl ran its course before ABIENWI's transfer to ICE. As noted, the topical creams arrived with him upon admission to OMD.

<sup>102</sup> See IHSC email communications, dated September 28 and 29, 2019 to October 1, 2019.

**On September 30, 2019** at 10:30 a.m., (b)(6); (b)(7)(C) spoke with (b)(6); (b)(7)(C) at SCVMC.<sup>103</sup> He reported a diagnosis of persistent vegetative state with brain activity at approximately five percent secondary to brain herniation, and that IV hypertonic saline<sup>104</sup> was discontinued because the patient's sodium level reached an unacceptably high level. Respiratory and nutritional support continued. (b)(6); (b)(7)(C) shared that the risks of a surgical intervention far outweighed the benefits. The prognosis was grim with the best case scenario of coma or persistent vegetative state. In bold font, (b)(6); (b)(7)(C) wrote that family input was imperative.

At approximately 2:13 p.m., ERO and IHSC spoke by phone to ABIENWI's wife (b)(6); (b)(7)(C) in Cameroon and provided her with information on how to contact the treating hospital physician.<sup>105</sup>

**On October 1, 2019 at 8:35 a.m.**, Officer (b)(6); (b)(7)(C) notified the captain at OMDC that ABIENWI's family attempted to call him.<sup>106</sup> Officer (b)(6); (b)(7)(C) who was assigned to hospital detail with Officer (b)(6); (b)(7)(C) explained to ERAU that hospital personnel staff informed them a caller identifying themselves as a family member had called the hospital directly.<sup>107</sup>

At 8:55 a.m., Officer (b)(6); (b)(7)(C) notified Lieutenant (b)(6); (b)(7)(C) that hospital staff stated ABIENWI would be removed from life support.<sup>108</sup> The lieutenant stated he would contact ICE.

At 11:20 a.m., the Assistant Warden notified Officer (b)(6); (b)(7)(C) and Acting AFOD (b)(6); (b)(7)(C) would be contacting SCVMC regarding ABIENWI's condition.<sup>109</sup>

At 12:00 p.m., Officer (b)(6); (b)(7)(C) informed Captain (b)(6); (b)(7)(C) that hospital staff asked permission to notify ABIENWI's family of his condition.<sup>110</sup> Captain (b)(6); (b)(7)(C) stated the hospital must coordinate OMDC medical staff.

At 12:05 p.m., hospital physicians pronounced ABIENWI's death.<sup>111</sup> Prior to the pronouncement, the clinical examination was consistent with brain death, confirmed by an apnea test<sup>112</sup> and verified by two physicians. The discharge diagnoses were as follows: large right

<sup>103</sup> See email communication from (b)(6); (b)(7)(C) dated September 30, 2019.

<sup>104</sup> Hypertonic saline is fluid containing electrolytes used in patients with brain injury to help pull fluid away from the brain tissue to help decrease the pressure on the brain.

<sup>105</sup> See ICE Significant Incident Report, October 2, 2019. Primary source documentation is not available.

<sup>106</sup> See hospital log book entry, dated October 1, 2019. Officer Campos's first name is unknown.

<sup>107</sup> ERAU interview with DO (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>108</sup> See hospital logbook entry dated October 1, 2019.

<sup>109</sup> See ICE Significant Incident Report, October 2, 2019. Primary source documentation is not available.

<sup>110</sup> See hospital log book entry dated October 1, 2019. Officer (b)(6); (b)(7)(C) first name unknown, served as relief officer during breaks.

<sup>111</sup> See SCVMC Discharge Summary, dated October 1, 2019

<sup>112</sup> An apnea test proves the absence of respiratory reflexes in the brainstem when physiologic stimulation to breathe takes place. It is an essential component in determining brain death.



basal ganglia hemorrhage with intraventricular extension, uncal herniation, acute respiratory failure<sup>113</sup>, acute hypotension<sup>114</sup>, and hypernatremia<sup>115</sup>, iatrogenic<sup>116</sup>.

At 12:38 p.m., ERO informed ABIENWI's wife of the passing of her husband and at 3:05 p.m., notified the Consulate General of Cameroon.<sup>117</sup>

By email timed 5:07 p.m., Assistant HSA (b)(6); (b)(7)(C) authorized the release of ABIENWI's body to the coroner.<sup>118</sup> Officer Iremedia and the medical examiner signed the Transfer of Custody form.<sup>119</sup> At 5:25 p.m., the medical examiner took custody of the body.<sup>120</sup>

**On October 4, 2019** (b)(6); (b)(7)(C), Chief of Security, completed an Incident Investigation Report compiling staff and detainee incident statements and reports, logbooks, and the hospital discharge summary.<sup>121</sup> The Investigative Conclusions section of the report summarized basic facts. An After-Action Review was not completed because ABIENWI's death occurred as a result of natural causes.<sup>122</sup>

According to Chief of Security (b)(6); (b)(7)(C) CoreCivic offers employee assistance to staff involved in critical incidents.<sup>123</sup> No staff interviewed reported participating in this service.

ERO San Diego sent ABIENWI's personal property via Fed Ex to ABIENWI's brother (b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

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<sup>113</sup> Acute respiratory failure occurs when gas exchange between oxygen and carbon dioxide fails. Tissues in the body don't receive oxygen and it quickly leads to death.

<sup>114</sup> Hypotension means low pressure where the first number in a blood pressure reading is less than 90 and/or the second number in the reading is < 60.

<sup>115</sup> Hypernatremia is an electrolyte imbalance in the body where the sodium levels are too high.

<sup>116</sup> Iatrogenic means caused by the medical treatments.

<sup>117</sup> See ICE Significant Incident Report, October 2, 2019. Primary source documentation is not available.

<sup>118</sup> See email from Assistant HS (b)(6); (b)(7)(C) dated October 1, 2019.

<sup>119</sup> See Transfer of Custody Receipt, dated October 1, 2019.

<sup>120</sup> See hospital log book entry dated October 1, 2019.

<sup>121</sup> See OMDC Incident Investigation Report, dated October 4, 2019.

<sup>122</sup> See Core Civic policy 5-1, Incident Reporting.

<sup>123</sup> ERAU interview with Chief of Security (b)(6); (b)(7)(C) dated November 13, 2019.

<sup>124</sup> See Fed Ex mailing label.

## CONCLUSIONS

### Medical

#### Compliance Findings

ERAU identified the following deficiencies in the ICE PBNDS 2011, revised 2016.

1. Medical Care, Section (V)(I), which states, “All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements.”

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

2. Medical Care, Section (V)(P), which states, “If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow up as appropriate. When a referral for medical follow up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment.

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

3. Medical Care, Section (V)(T)(1)(d), which states, “Each facility shall have a written emergency services plan for delivery of 24-hour emergency health care. This plan shall be prepared in consultation with the facility’s [Clinical Medical Authority] or the HSA, and must include the following: (d) all detention and medical staff shall receive cardio pulmonary resuscitation (CPR, AED) and emergency first aid training annually.”

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

Record of first aid training.

In addition, ERAU notes the following policy violation:

1. IHSC Operations memorandum, OM 17-004, Nursing Competencies, November 9, 2017, Section (4-1.2), which states, “The nurse manager arranges orientation for all new nursing staff and ensure and maintains documentation that each RN and LVN or LPN is



trained and has completed their discipline specific competencies within 2 months of their hire date and annually thereafter.”

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

#### **Area of Concern**

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

#### **Security**

##### **Compliance Findings**

ERAU identified no deficiencies in the ICE PBNDS 2011, revised 2016, governing safety and security.

#### **Area of Concern**

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



## Detainee Death Review Report

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# Nebane ABIENWI

Date of Death: October 1, 2019

Alien File Number: 213 187 584

Joint Integrity Case Management System (JICMS) Number: 202000048

August 14, 2020

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



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## **DETAILS OF REVIEW**

From November 13 to 14, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Otay Mesa Detention Center (OMDC) to review the circumstances surrounding Nebane ABIENWI'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 consulting firm.<sup>1</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to ABIENWI, in addition to conducting in-person interviews of individuals employed by CoreCivic, ICE Health Service Corps (IHSC) staff assigned to OMDC, contractors employed with STG International (STGi), and the San Diego Field Office of ICE Enforcement and Removal Operations (ERO San Diego). ABIENWI was detained at OMDC from September 18, 2019 through September 26, 2019, when he was transferred to the Sharp Chula Vista Medical Center (SCVMC), where he remained until his death on October 1, 2019. The County of San Diego Medical Examiner's Office documented ABIENWI's official cause of death as hypertensive basal ganglia hemorrhage.<sup>2</sup>

## **FACILITY PROFILE**

OMDC is owned and operated by CoreCivic as a Contract Detention Facility, which authorizes ICE to utilize the facility for detainee bed space. OMDC is authorized by ICE to house male and female detainees for periods in excess of 72 hours and has bed capacity for 1,142 detainees.<sup>3</sup> OMDC is contractually obligated to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. Medical care at OMDC is provided by IHSC, with contracted support from STGi. CoreCivic is responsible for custody and security services at OMDC. At the time of ABIENWI's death, OMDC's average ICE detainee daily population was 966, and the facility housed 828 male and 174 female ICE detainees.<sup>4</sup>

## **IMMIGRATION AND CRIMINAL HISTORY**

On September 5, 2019, ABIENWI applied for admission into the United States from Mexico at the San Ysidro Port of Entry, via the pedestrian primary inspection lane, (b)(6); (b)(7)(C) (b)(5); (b)(6); (b)(7)(C) At that time, he was referred for further inspection and was subsequently processed and taken into CBP custody.<sup>5</sup>

On September 8, 2019, ABIENWI was served with a Notice to Alien Ordered Removed/Departure Verification (DHS Form I-296).<sup>6</sup>

<sup>1</sup> See Exhibit 1: Creative Corrections Medical and Security Compliance Analysis.

<sup>2</sup> See Exhibit 2: County of San Diego Medical Examiner's Office, dated November 22, 2019.

<sup>3</sup> See ERO Facility List Report, dated October 7, 2019.

<sup>4</sup> *Id.*; see also ERO Records Request, dated October 9, 2019.

<sup>5</sup> See CBP Appendix D – SYS P.O.E. form, dated September 5, 2019; see also Multiple Inspection Referral (CBP Form I-443), dated September 5, 2019.

<sup>6</sup> See DHS Form I-296, dated September 8, 2019.



On September 9, 2019, CBP interviewed ABIENWI and he reported a fear of being removed from the United States and returned to his home country. He was served with a Notice and Order of Expedited Removal (DHS Form I-860), charging him as inadmissible under section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act, as an immigrant without a valid visa.<sup>7</sup>

On September 11, 2019, a CBP Physician Assistant (PA)-Certified conducted ABIENWI's new patient comprehensive exam and identified, among other things, that he had no chronic conditions, was not on any medications, had no past medical or surgical history and that his vital signs were within normal limits.<sup>8</sup> As a result, the PA gave him over-the-counter medications and creams and cleared him for transport and detention.

On September 18, 2019, CBP released ABIENWI into ERO San Diego's custody at OMDC.<sup>9</sup>

On September 20, 2019, ERO San Diego referred ABIENWI to U.S. Citizenship and Immigration Services (USCIS) for a credible fear interview.<sup>10</sup>

## **CHRONOLOGY OF EVENTS**

### **September 18, 2019**

CBP released ABIENWI into ERO San Diego's custody at OMDC.

At 7:26 p.m., radiology technician (b)(6); (b)(7)(C) completed ABIENWI's chest X-ray screening for tuberculosis (TB), which came back negative for active TB that evening.<sup>11</sup>

At approximately 8:35 p.m., Detention Officer (Officer (b)(6); (b)(7)(C)) booked ABIENWI into OMDC and Registered Nurse (RN) (b)(6); (b)(7)(C) conducted ABIENWI's medical pre-screening assessment. (b)(6); (b)(7)(C) documented ABIENWI spoke English fluently and that his appearance, behavior, ease of movement, and breathing were normal.<sup>12</sup> Through a standard set of pre-screening questions that medical staff ask detainees, ABIENWI reported to the nurse that he had a current (but unspecified) illness or health problem and was taking medications. (b)(6); (b)(7)(C) triaged ABIENWI as a Priority-1 (PRI-1)<sup>13</sup> pre-screening.

<sup>7</sup> See DHS Form I-860, dated September 9, 2019.

<sup>8</sup> See New Patient Comprehensive Exam form, dated September 11, 2019.

<sup>9</sup> See Record of Persons Transferred (DHS Form I-216), dated September 18, 2019.

<sup>10</sup> ENFORCE Alien Removals Module (EARM) database, Case Actions & Decisions, dated September 20, 2019.

<sup>11</sup> See untitled OMDC TB screening results, dated September 18, 2019.

<sup>12</sup> See Inmate/Detainee Commitment Summary, dated September 18, 2019; see also Pre-Screen medical encounter note, dated September 18, 2019. During her interview with ERAU on November 13, 2019, Lt. (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) the facility's Assistant Health Services Administrator (AHSA), stated she was unsure why (b)(6); (b)(7)(C) triaged ABIENWI as Priority-1 but opined that it may have been because of a prior hospitalization. ERAU was unable to interview (b)(6); (b)(7)(C) as, at the time of its site visit, RN (b)(6); (b)(7)(C) had separated from service with OMDC.

<sup>13</sup> IHSC Directive 03-08, *Pre-Screening*, dated January 19, 2015, states Priority-1 detainees are those "with identified 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."

During ABIENWI's admission process, officers inventoried ABIENWI's personal property, issued him facility clothing and toiletries and provided him orientation.<sup>14</sup> ABIENWI told Officer Solis he had been a victim of sexual abuse and assault while the Cameroonian military detained him in November or December of 2017.<sup>15</sup> Shortly thereafter, Officer (b)(6); (b)(7)(C) notified various OMDC security staff and supervisors via email about ABIENWI's alleged sexual abuse history.<sup>16</sup>

At an unknown time, Officer (b)(6); (b)(7)(C) completed ABIENWI's classification rating using the ICE Custody Classification Worksheet and appropriately classified ABIENWI with a "low" custody level.<sup>17</sup>

## September 19, 2019

At 12:40 a.m., ABIENWI signed a consent form for medical and mental health treatment.<sup>18</sup> At approximately 1:38 a.m., RN (b)(6); (b)(7)(C) conducted ABIENWI's medical and mental health intake assessment and documented<sup>19</sup> the following:

- ABIENWI spoke English fluently.
- In August 2019, ABIENWI was hospitalized<sup>20</sup> for three days as a result of high blood pressure. ABIENWI took blood pressure medication for two weeks thereafter, until a doctor discontinued his medication because his blood pressure returned to normal.
- ABIENWI reported using cortisone and Calmoseptine<sup>21</sup> creams for a rash on his lower abdomen and thighs.<sup>22</sup>
- ABIENWI reported no mental health problems or medical issues other than his rash.
- ABIENWI reported being a victim of sexual abuse in December 2017.
- ABIENWI denied using tobacco and admitted to rarely drinking alcohol.
- ABIENWI's vital signs were all within normal limits.<sup>23</sup>

<sup>14</sup> See Property Inventory (untitled), dated September 18, 2019; *see also* Clothing Issued Receipt dated September 19, 2019; *see also* Acknowledgement of Inmate/Detainee Orientation, dated September 18, 2019.

<sup>15</sup> See Assessment Questionnaire Information, dated September 18, 2019.

<sup>16</sup> See Officer (b)(6); (b)(7)(C) email, "Special Vulnerabilities," dated September 18, 2019.

<sup>17</sup> See ICE Custody Classification Worksheet, dated September 18, 2019. Two unknown supervisors (illegible signatures) approved the classification rating on September 19 and September 20, 2019.

<sup>18</sup> See IHSC Medical Consent Form, dated September 18, 2019. Although the form is dated September 18, 2019, it is clear based on the time stamp (0040) and other actions the RN documented in eClinicalWorks (eCW), that these actions occurred in the early morning hours of September 19, 2019.

<sup>19</sup> See eCW Intake encounter, dated September 19, 2019.

<sup>20</sup> During his intake screening, ABIENWI reported a previous hospitalization for hypertension but did not provide documentation of that stay to OMDC medical during his detention. As such, HSA (b)(6); (b)(7)(C) requested the assistance of ERO in obtaining this information the day after his fall at OMDC. Additionally, interviews with OMDC medical staff provided that, unless records are marked for medical, custody determines their disposition. As noted later in the report, OMDC discovered the referenced hospital documents in ABIENWI's inventoried property.

<sup>21</sup> Calmoseptine cream is a medication used to temporarily relieve itching and discomfort due to skin irritation.

<sup>22</sup> In RN (b)(6); (b)(7)(C) incident statement, dated October 11, 2019, she documented that after ABIENWI's death, his rash was dry and lichenified. Lichenified skin is dry and leathery in appearance due to excessive itching or rubbing.

<sup>23</sup> Normal limits can vary depending on factors such as an individual's activity and age; however, generally speaking, a normal temperature is considered around 98.6 degrees Fahrenheit; 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; a normal blood pressure is less than 120/80; and a normal pulse oximeter reading range is from 95% to 100%.



ABIENWI arrived at OMDC with creams prescribed by the CBP PA-C to treat his rash but was not allowed to keep the creams in his possession because they were not labeled properly. RN (b)(6); (b)(7)(C) stated that she explained to ABIENWI that in order for a provider to prescribe cream he would have to sign up for sick call.<sup>24</sup> She educated ABIENWI on the sick call process by showing him the sick call sign-up form.<sup>25</sup>

(b)(6); (b)(7)(C) classified ABIENWI's intake screening as normal and cleared him for general population housing. She scheduled ABIENWI for a physical examination simple (PE-S),<sup>26</sup> rather than a physical examination complex (PE-C), on September 29, 2019 because she did not believe he needed priority attention given that his blood pressure was within normal limits, he was asymptomatic, and he was not on blood pressure medication.<sup>27</sup>

At 5:52 a.m., security personnel escorted ABIENWI to OMDC housing, P Pod, bay 101.<sup>28</sup>

### September 26, 2019

At approximately 3:26 a.m., P Pod Officer (b)(6); (b)(7)(C) called Central Control to alert them of a medical emergency after observing ABIENWI fall from the top bunk bed onto a chair.<sup>29</sup> Prior to ABIENWI's fall, Officer (b)(6); (b)(7)(C) had observed ABIENWI lying on his back, repeatedly stretching his left leg outward over the side of the bunk, then retracting it. The officer noted this as he was worried ABIENWI was going to kick the detainee on the bunk bed beside him in the head. ABIENWI then rolled over onto his left side, as if adjusting his sleeping position but rolled off the bed onto the plastic chair next to the bunk, eventually sliding to a seated position on the floor.<sup>30</sup> After the fall, Officer (b)(6); (b)(7)(C) immediately ran over to bay 101 to check on ABIENWI but did not observe any visible injuries. Officer (b)(6); (b)(7)(C) stated ABIENWI looked very confused and

<sup>24</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>25</sup> During her interview with ERAU on November 13, 2019, AHSA (b)(6); (b)(7)(C) explained that rather than submitting request forms, detainees access healthcare by signing up for sick call between 5:00 a.m. and 6:00 a.m. daily. Nursing staff collect sign-up forms at 6:00 a.m., and RNs triage detainees the same day. Medical staff provided ERAU with sick call sign-up logs for five of the eight days ABIENWI was detained, none of which included his name. Because logs were not available for three days, ERAU cannot determine whether or not ABIENWI signed up for sick call. See P Pod sick call logs, dated September 18, 19, 21, 22 and 23, 2019.

<sup>26</sup> See eCW Intake encounter, dated September 19, 2019; see also eCW PE-Initial appointment schedule slip, dated September 29, 2019. A PE-S is the initial physical examination of patients without chronic conditions, required to be conducted by a provider within 14 days of arrival.

<sup>27</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 14, 2019. A PE-C is for patients who arrive on medication for a chronic medical condition or are having medical symptoms needing to be addressed. During her interview with ERAU the same day, (b)(6); (b)(7)(C) stated that based on the intake assessment and the information available to (b)(6); (b)(7)(C) a PE-S was appropriate.

<sup>28</sup> See OMDC Inmate Housing History report, entry dated September 19, 2019.

<sup>29</sup> See untitled logbook marked "257," entry dated September 26, 2019; see also ERAU interview with Officer (b)(6); (b)(7)(C) dated November 13, 2019.

<sup>30</sup> During her telephone interview with ERAU on November 22, 2019, RN (b)(6); (b)(7)(C) stated that the original emergency call over the radio advised that ABIENWI had fallen from his bunk; however, when medical arrived, the officer told them ABIENWI was getting off the last step of his bunk bed and fell. R (b)(6); (b)(7)(C) added that ABIENWI was only able to verbalize his name and that he slipped off the bottom step of his bunk bed.



was not responding to his questions. ABIENWI tried to stand but Officer (b)(6); (b)(7)(C) instructed ABIENWI to remain seated.<sup>31</sup>

Officer (b)(6); (b)(7)(C) stepped out of bay 101 to the P Pod office to call the Control Center while another detainee assisted with keeping ABIENWI seated. Per instructions from the Control Center, Officer (b)(6); (b)(7)(C) announced the medical emergency over his radio, twice, then the Control Center called a medical emergency over the radio for a third time. Officer (b)(6); (b)(7)(C) returned to ABIENWI and waited for medical staff to arrive.<sup>32</sup>

At 3:28 a.m., approximately two minutes after the medical emergency call, (b)(6); (b)(7)(C) and RN (b)(6); (b)(7)(C) responded to the unit with a wheelchair and an emergency go-bag.<sup>33</sup> RN (b)(6); (b)(7)(C) reported that when she and (b)(6); (b)(7)(C) arrived, ABIENWI was sitting on the floor with another detainee sitting behind him.<sup>34</sup> She added that ABIENWI was unable to follow verbal commands or answer questions and exhibited “jerky movements” to his upper and lower extremities. RN (b)(6); (b)(7)(C) documented that ABIENWI was oriented to person only and was not aware of his location or time and had slurred speech.<sup>35</sup> ABIENWI had no visible injuries and denied pain or shortness of breath.<sup>36</sup>

At 3:33 a.m., the RNs and officers transported ABIENWI in a wheelchair from the housing unit to the medical clinic.<sup>37</sup> RN (b)(6); (b)(7)(C) documented that he did not feel it was necessary to place a cervical collar<sup>38</sup> around ABIENWI’s neck for the transfer because he was moving his head around and denied hitting either his head or neck.<sup>39</sup>

At 3:36 a.m., medical staff entered the OMDC urgent care room.<sup>40</sup> (b)(6); (b)(7)(C) also documented that once ABIENWI was in the urgent care room, he and an officer moved ABIENWI from the wheelchair to the bed.<sup>41</sup> (b)(6); (b)(7)(C) stated that ABIENWI stood with their help; however, he could not pivot on his own, suggesting he may not have been able to bear his full weight. She checked ABIENWI’s medical record and noted he had no medical history other than reporting a past issue with high blood pressure. RN (b)(6); (b)(7)(C) documented an unsuccessful attempt to reach the on-call provider, (b)(6); (b)(7)(C) Nurse Practitioner (NP); therefore, she determined that EMS should be contacted.<sup>42</sup>

<sup>31</sup> See Officer (b)(6); (b)(7)(C) Incident Statement, dated October 1, 2019.

<sup>32</sup> *Id.*; see also P-Unit 2 Video Surveillance Footage, dated September 26, 2019.

<sup>33</sup> See P-Unit 2 Video Surveillance Footage, dated September 26, 2019.

<sup>34</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 22, 2019; see also eCW Fell from Bunk assessment, dated September 26, 2019.

<sup>35</sup> See RN Domingo email, “RE: Need Written Statements,” dated September 28, 2019.

<sup>36</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 22, 2019.

<sup>37</sup> See P-Unit 2 Video Surveillance Footage, dated September 26, 2019.

<sup>38</sup> A cervical collar is a medical device used to support a person’s neck.

<sup>39</sup> See RN (b)(6); (b)(7)(C) email, “RE: Need Written Statements,” dated September 28, 2019.

<sup>40</sup> See Medical to Mental H Video Surveillance Footage, dated September 26, 2019.

<sup>41</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 22, 2019.

<sup>42</sup> During their interviews with ERAU on November 13 and 14, 2019, HSA (b)(6); (b)(7)(C) and HSA (b)(6); (b)(7)(C) stated they were unaware RN (b)(6); (b)(7)(C) was unable to reach the on-call provider. RN (b)(6); (b)(7)(C) clarified during her interview that it is unusual for staff not to be able to reach the on-call provider. She said that after the incident, the provider offered her personal mobile phone number because the phone issued to on-call providers does not get reliable



At approximately 3:50 a.m., Central Control Officer (b)(6); (b)(7)(C) called EMS due to the critical needs of the patient.<sup>43</sup>

At approximately 3:52 a.m., RN (b)(6); (b)(7)(C) assessed ABIENWI and documented<sup>44</sup> the following:

- ABIENWI's vital signs<sup>45</sup> were within normal limits<sup>46</sup> except for an elevated blood pressure of 180/100.<sup>47</sup>
- While in the housing unit, ABIENWI was initially confused and unable to speak or respond to questions or commands. While en route to medical, he was only able to state his name. After approximately 15 minutes, ABIENWI was able to speak and respond to questions.
- ABIENWI said he was attempting to get out of bed and missed a step.
- ABIENWI was diaphoretic<sup>48</sup> but could not explain why; he also complained of thirst.<sup>49</sup>
- ABIENWI continued attempting to remove himself from the examination bed and would not respond when asked to lie back down.
- Although ABIENWI was unable to move his left side extremities and no visible injuries were located, he continued exhibiting "jerky movements" in all extremities.

RN (b)(6); (b)(7)(C) noted that when he was conducting a neuro-check assessment, ABIENWI smiled but only the right side of his face moved.<sup>50</sup> When RN (b)(6); (b)(7)(C) asked ABIENWI to squeeze his fingers, ABIENWI was only able to squeeze with his right hand. When asked to wiggle and elevate his legs, he could only move his right leg.

At 4:02 a.m., the EMS dispatch notified the responding EMS unit of the call, and by 4:04 a.m., they were en route to OMD.<sup>51</sup>

service (b)(6); (b)(7)(C) also stated during her interview with ERAU that RNs contact the on-call Advanced Practice Providers (APP) first, and if the APP needs to elevate the issue, they call her. She stated she did not receive a phone call that morning.

<sup>43</sup> See untitled logbook marked "257," dated September 26, 2019; *see also* Mercy Medical Transportation Patient Care Report dated September 9, 2019.

<sup>44</sup> See eCW clinical encounter, dated September 26, 2019.

<sup>45</sup> Although the eCW vitals show that RN (b)(6); (b)(7)(C) entered ABIENWI's vital signs, (b)(6); (b)(7)(C) clarified in his incident statement email that he was the one who took ABIENWI's vitals while (b)(6); (b)(7)(C) was looking up ABIENWI's medical history and attempting to reach the on-call provider.

<sup>46</sup> Although eCW shows ABIENWI's fingerstick glucose reading to be high at 115 milligrams per deciliter (mg/dL), those parameters are generally based off of a patient who has fasted for the past eight to twelve hours. It is unknown if ABIENWI was fasting or if the high reading was recorded in error. Per the Mayo Clinic, a fasting blood glucose level below 100 mg/dl is considered normal and a random blood glucose reading below 200 mg/dl is considered normal.

<sup>47</sup> According to the American Heart Association (AHA), this blood pressure reading indicates stage two hypertension, which is characterized by a systolic reading of at least 140 or a diastolic reading of at least 90. ABIENWI's blood pressure was approaching hypertensive crisis, which the AHA characterizes as a systolic reading higher than 180 and/or a diastolic reading higher than 120.

<sup>48</sup> Diaphoretic is a medical term for perspiring profusely.

<sup>49</sup> RN (b)(6); (b)(7)(C) provided ABIENWI approximately three cups of water and staff assisted him with the cups as he was unable to drink on his own. *See* RN (b)(6); (b)(7)(C) email, "RE: Need Written Statements," dated September 28, 2019.

<sup>50</sup> *Id.*; *see also* eCW clinical encounter, dated September 26, 2019.

<sup>51</sup> *See* Mercy Medical Transportation Patient Care Report, dated September 26, 2019.

At 4:05 a.m., the local fire department arrived at OMDC, and by 4:08 a.m., three fire rescue responders entered the OMDC urgent care room.<sup>52</sup>

At 4:12 a.m., EMS arrived at OMDC and by 4:18 a.m., were at ABIENWI's side with a gurney.<sup>53</sup> During her interview with ERAU, (b)(6); (b)(7)(C) stated that the ambulance had to wait at the gate for approximately 10 minutes prior to being allowed in.<sup>54</sup> She explained that one of the EMS responders commented he was frustrated by the delay in reaching the patient as they were told it was count time.<sup>55</sup>

At approximately 4:18 a.m., EMS assessed ABIENWI and documented<sup>56</sup> the following:

- ABIENWI had left-sided weakness to his upper and lower extremities, was positive for facial droop on the right side of his face and had slurred speech.
- The paramedics' primary impression was that ABIENWI had a stroke, cerebrovascular accident (CVA),<sup>57</sup> or transient ischemic attack (TIA).<sup>58</sup>
- ABIENWI's vital signs were all within normal limits, except for an elevated blood pressure of 180/120.
- An electrocardiogram (EKG) showed ABIENWI had a sinus rhythm.<sup>59</sup>
- ABIENWI's smile was asymmetrical.<sup>60</sup>
- Motor function to ABIENWI's left upper arm and left lower leg was absent.
- ABIENWI's Glasgow Coma Scale (GCS) score was a 15 out of 15.<sup>61</sup>
- ABIENWI was alert and oriented to person, place, and time. There were no signs of trauma or other physical findings.

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<sup>52</sup> See untitled logbook marked "257," dated September 26, 2019; *see also* Medical to Mental H Video Surveillance Footage, dated September 26, 2019.

<sup>53</sup> See untitled logbook marked "258," dated September 26, 2019; *see also* Medical to Mental H Video Surveillance Footage, dated September 26, 2019. Although the Mercy Medical Transportation Patient Care Report stated EMS arrived at OMDC at 4:06 a.m. and were at ABIENWI's side by 4:13 a.m., OMDC video surveillance footage shows EMS responders entering the OMDC urgent care room at 4:18 a.m. As ERAU cannot verify the timeline of events in the EMS report, ERAU is providing times from OMDC's time-stamped video surveillance footage, which supports most of the times documented in OMDC's logbooks.

<sup>54</sup> ERAU telephonic interview with (b)(6); (b)(7)(C) dated November 22, 2019.

<sup>55</sup> See untitled incident statement by (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>56</sup> See Mercy Medical Transportation Patient Care Report, dated September 26, 2019.

<sup>57</sup> CVA is another term for a stroke.

<sup>58</sup> According to the Mayo Clinic, a TIA (a.k.a. ministroke) is a temporary period of symptoms similar to those of a stroke. A TIA usually lasts only a few minutes and does not cause permanent damage.

<sup>59</sup> An EKG records electrical activity of the heart. A sinus rhythm is a reading that means the heart rate and rhythm are normal.

<sup>60</sup> An asymmetrical smile is when one side of the mouth does not turn upward, rather tends to droop downward. This can be an early symptom of someone who experienced a stroke.

<sup>61</sup> GCS is an assessment tool used in critical care settings. The scale scores assessment findings to determine how critically ill a patient is. The best score on this scale is 15; however, a score of 15 does not mean a patient is not critically ill. The patient still needs close monitoring.



At 4:25 a.m., EMS transported ABIENWI out of the OMDC urgent care room and lifted him into the ambulance at 4:27 a.m.<sup>62</sup> Surveillance footage showed ABIENWI lifting his head up and bending his right leg in and out several times while en route to the ambulance through the facility.<sup>63</sup>

At 4:34 a.m., the ambulance departed OMDC for SCVMC.<sup>64</sup> EMS responders noted ABIENWI displayed extremely combative behavior while in the ambulance, jerking his body violently and pulling “his cables off.” A paramedic gave ABIENWI Versed<sup>65</sup> (5 mg) by intramuscular injection so they could gain vascular access while en route to the hospital; however, ABIENWI remained combative and uncooperative, and the paramedics were unable to establish an intravenous (IV) line.<sup>66</sup>

OMDC Assistant Chief of Security (ACOS) (b)(6); (b)(7)(C) assigned Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) to transport duty.<sup>67</sup> Officer (b)(6); (b)(7)(C) followed the ambulance in the chase vehicle, and Officer (b)(6); (b)(7)(C) accompanied ABIENWI in the ambulance.<sup>68</sup> Officer (b)(6); (b)(7)(C) stated that before they moved ABIENWI to the ambulance, he was somewhat resistant to having restraints applied. He also mentioned that during transport, ABIENWI appeared to go in and out of consciousness.<sup>69</sup>

At 4:50 a.m., the ambulance arrived at the SCVMC emergency department.<sup>70</sup>

At 4:54 a.m., SCVMC Medical Doctor (b)(6); (b)(7)(C) triaged ABIENWI, noting that he presented as having an acute hemorrhagic stroke<sup>71</sup> and needed immediate intervention but that they were unable to obtain medical history from ABIENWI as he was nonverbal with snoring respirations.<sup>72</sup> Abnormal findings included right pupil size of four millimeters and nonreactive left pupil of two millimeters.<sup>73</sup> Upon arrival to the hospital, medical staff transported ABIENWI to receive a computed tomography (CT) scan,<sup>74</sup> which showed a large area of blood in the brain and damage to some of the structures inside the skull caused by pressure of added fluid. A

<sup>62</sup> See Inner Bus Sally Port NW Video Surveillance Footage, dated September 26, 2019.

<sup>63</sup> See Medical to Mental H Video Surveillance Footage, dated September 26, 2019.

<sup>64</sup> See Vehicle Gate log, entry dated September 26, 2019; see also Inner Bus Sally Port East video surveillance footage, dated September 26, 2019. Although the Mercy Medical Transportation Patient Care Report documents the ambulance left the facility at 4:20 a.m., the time of departure documented on several OMDC logs and shown in OMDC video surveillance footage does not corroborate this time, including the time of arrival at SCVMC. Google Maps shows the distance between OMDC and SCVMC is approximately 14-16 minutes. ERAU is unable to explain the discrepancy in the EMS record as compared to OMDC surveillance footage and recorded log times.

<sup>65</sup> Versed, generic name midazolam, is a sedative used to help calm patients or help with sedation prior to a procedure.

<sup>66</sup> See SCVMC Emergency Documentation, dated September 26, 2019.

<sup>67</sup> See OMDC Transportation Trip Ticket, dated September 26, 2019.

<sup>68</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated November 13, 2019.

<sup>69</sup> ERAU notes the Mercy Medical Transportation Patient Care Report, dated September 26, 2019, makes no mention of ABIENWI losing consciousness during his transport to the hospital.

<sup>70</sup> See Mercy Medical Transportation Patient Care Report, dated September 26, 2019.

<sup>71</sup> A hemorrhagic stroke is caused by a weakened vessel that ruptures and bleeds into the surrounding brain. The blood accumulates, compressing the surrounding brain tissue.

<sup>72</sup> See SCVMC Emergency Documentation, dated September 26, 2019.

<sup>73</sup> A nonreactive pupil is when the pupil does not react to light being shined on it. It can be a sign of brain injury.

<sup>74</sup> A CT scan is an X-ray image taken from different angles, followed by computer processing to create cross-sectional images. See SCVMC Computed Tomography report, dated September 26, 2019.



neurological examination revealed ABIENWI did not open his eyes or follow commands, was nonverbal, and that he responded to painful stimuli by attempting to move his right arm. Medical staff intubated<sup>75</sup> ABIENWI for airway protection, placed an oral gastric tube<sup>76</sup> in his stomach, and started him on an IV nicardipine<sup>77</sup> drip for blood pressure control. (b)(6); (b)(7)(C) consulted with neurosurgeon (b)(6); (b)(7)(C) and an unidentified intensivist<sup>78</sup> and admitted ABIENWI to the intensive care unit (ICU).

At approximately 9:55 a.m., Office (b)(6); (b)(7)(C) notified Shift Supervisor (b)(6); (b)(7)(C) over the phone that (b)(6); (b)(7)(C) from SCVMC had requested contact information for ABIENWI's family.<sup>79</sup> The physician stated ABIENWI had a brain hemorrhage and could succumb to his injuries within 24 hours. In her email recalling the details of Officer (b)(6); (b)(7)(C) Hall, Shift Supervisor Apablaza noted that someone (unidentified) notified Officer in Charge (OIC) (b)(6); (b)(7)(C), Acting Assistant OIC ((A)AOIC) (b)(6); (b)(7)(C) and ERO Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) and that they would reach out to the family.

At approximately 2:27 p.m., ERO San Diego obtained ABIENWI's emergency contact, (b)(6); (b)(7)(C) from his detention file. (A)AOIC (b)(6); (b)(7)(C) attempted to call (b)(6); (b)(7)(C) to locate contact information for ABIENWI's family.<sup>80</sup> (A)AOIC (b)(6); (b)(7)(C) left a voicemail asking (b)(6); (b)(7)(C) to call him back.<sup>81</sup>

From this date until the date of ABIENWI's death, OMDC healthcare staff obtained multiple daily updates from SCVMC by telephone regarding ABIENWI's condition.<sup>82</sup>

## September 27, 2019

At 2:01 a.m., Shift Supervisor (b)(6); (b)(7)(C) notified the Senior Warden, (b)(6); (b)(7)(C), and other OMDC management that he had spoken with SCVMC medical staff who reported that ABIENWI's brain function was declining, his pupils were dilating further, and that they had scheduled a CT scan for 5:00 a.m.<sup>83</sup> At 6:34 a.m., after Senior Warden (b)(6); (b)(7)(C) forwarded this information to AHSA (b)(6); (b)(7)(C), she sent an email to the OMDC Clinical Director, (b)(6); (b)(7)(C), and (b)(6); (b)(7)(C) stating she believed a doctor-to-doctor conversation would be necessary, as her nursing staff did not get the aforementioned information directly from the hospital.<sup>84</sup>

<sup>75</sup> Intubated is when a tube is inserted into the trachea to assist with mechanical breathing.

<sup>76</sup> An oral gastric tube is a tube placed through the mouth into the stomach to be used for feeding, medication administration, or suctioning out contents in the stomach.

<sup>77</sup> Nicardipine is a medication used to relax the blood vessels, making it easier for the heart to pump. It is used to treat high blood pressure.

<sup>78</sup> An intensivist is a physician who specializes in the care of critically ill patients.

<sup>79</sup> See Shift Supervisor Apablaza email, "RE: Unscheduled Offsite Medical Transport," dated September 26, 2019.

<sup>80</sup> See EARM Comments, entry dated September 26, 2019.

<sup>81</sup> *Id.*

<sup>82</sup> See IHSC email communications, dated September 26, 2019, through October 1, 2019. The hospital updates were communicated by email to the appropriate OMDC medical and facility management.

<sup>83</sup> See Shift Supervisor (b)(6); (b)(7)(C) email, "RE: Unscheduled Offsite Medical Transport," dated September 27, 2019.

<sup>84</sup> See AHSA (b)(6); (b)(7)(C) email, "FW: Unscheduled Offsite Medical Transport," dated September 27, 2019.



At 9:45 a.m., (b)(6); (b)(7)(C) spoke with SCVMC (b)(6); (b)(7)(C) <sup>85</sup> (b)(6); (b)(7)(C) reported ABIENWI was unresponsive, and his right pupil was dilated.<sup>86</sup> ABIENWI's vital signs were stable and his treatment included intubation, ventilation, feeding tubes, and medical management in the ICU. (b)(6); (b)(7)(C) stated serial CT scans showed the hemorrhaging had stopped but an examination found expansion from the hemorrhage was persistent and worsening with signs of herniation.<sup>87</sup> ABIENWI's prognosis was poor, and he was not expected to survive either surgical intervention or the daily management plan for his persistent vegetative state. At approximately 10:00 a.m., (b)(6); (b)(7)(C) notified (A)AOIC (b)(6); (b)(7)(C) her conversation with the SCVMC physician.

At approximately 10:16 a.m., Acting SDDO (b)(6); (b)(7)(C) attempted to contact (b)(6); (b)(7)(C) and left a voice message to call him or (A)AOIC (b)(6); (b)(7)(C).

At approximately 10:44 a.m., Acting SDDO (b)(6); (b)(7)(C) at the Consulate of Cameroon and left a message requesting assistance with notifying ABIENWI's next of kin and a return call.<sup>89</sup>

At 10:56 a.m., Acting SDDO (b)(6); (b)(7)(C) spoke with (b)(6); (b)(7)(C) who was unable to provide any contact information for family members ABIENWI may have had in the United States or Cameroon and claimed he was the main point of contact for ABIENWI.

At 11:13 a.m., Acting SDDO (b)(6); (b)(7)(C) emailed the Consulate of Cameroon with ABIENWI's alien number, date of birth, and copies of his Cameroon ID card and birth certificate.<sup>90</sup> Shortly thereafter, Acting SDDO (b)(6); (b)(7)(C) spoke (b)(6); (b)(7)(C) again.<sup>91</sup>

At 12:40 p.m., HSA (b)(6); (b)(7)(C) sent an email to other regional IHSC management with a summary of (b)(6); (b)(7)(C) conversation with SCVMC (b)(6); (b)(7)(C). The summary concluded that ABIENWI was not expected to survive either surgical intervention or management plan. Furthermore, if he should survive, ABIENWI would not be expected to regain consciousness or have any meaningful interaction with others or his environment. (b)(6); (b)(7)(C) expressed that family input was imperative in determining ABIENWI's ultimate plan of care should he survive.

At approximately 12:42 p.m., Acting SDDO (b)(6); (b)(7)(C) spoke with (b)(6); (b)(7)(C) and informed him of ABIENWI's medical status. Acting SDDO (b)(6); (b)(7)(C) requested assistance in locating contact information for ABIENWI's next of kin and (b)(6); (b)(7)(C) stated his office would attempt to locate that information.<sup>93</sup>

<sup>85</sup> See (b)(6); (b)(7)(C) email, "FW: ICU Update: ABIENWI 213 187 584," dated September 27, 2019.

<sup>86</sup> Pupil dilation can be a result of increased pressure in the skull that compresses on the cranial nerve.

<sup>87</sup> Herniation occurs when pressure inside the skull (from swelling or bleeding) causes the brain to move. It is considered a very serious brain injury that can lead to death or permanent and significant injury.

<sup>88</sup> See EARM Comments, entry dated September 27, 2019.

<sup>89</sup> *Id.*

<sup>90</sup> See ICE Significant Incident Report (SIR), dated October 2, 2019.

<sup>91</sup> See EARM Comments, entry dated September 27, 2019.

<sup>92</sup> See HSA Canada email, "FW: ICU Update: ABIENWI 213 187 584," dated September 27, 2019.

<sup>93</sup> See ICE SIR, dated October 2, 2019.

At 1:53 p.m., HSA (b)(6); (b)(7)(C) requested information from various ICE personnel regarding ABIENWI's reported hospitalization for hypertension prior to his arrival at OMDC.<sup>94</sup> In response, Acting SDDC (b)(6); (b)(7)(C) provided a copy of the documentation from ABIENWI's physical exam that occurred while he was in CBP custody.<sup>95</sup> Additionally, (A)AOIC (b)(6); (b)(7)(C) indicated that OMDC Compliance staff pulled ABIENWI's property and found medical records from a hospital in Tijuana, Mexico.<sup>96</sup> The Centro De Salud Tijuana (CST) (Tijuana Health Center) had documented<sup>97</sup> the following:

- On August 30, 2019, a CST physician diagnosed ABIENWI with essential hypertension.<sup>98</sup>
- CST medical staff prescribed captopril<sup>99</sup> (25 mg), one tablet twice daily for 30 days, and ranitidine<sup>100</sup> (150 mg), one tablet twice daily for 30 days.<sup>101</sup>

On a separate form from the Hospital General de Tijuana (HGT) (Tijuana General Hospital), the doctor's orders note documented<sup>102</sup> the following without additional context or reference dates:

- Normal diet
- Saline solution .9% (500 cubic centimeters (cc))
- Medicine: Omeprazole<sup>103</sup> 40 (mg) every 24 hours; Captopril 50 (mg) orally
- Vital signs per shift and general nursing care:
  - Monitor neurological and hemodynamic status, as well as his respiratory pattern

At an unknown time on this date, due to his poor prognosis and the lack of available surrogate decision makers, the SCVMC medical team decided to classify ABIENWI as a do not resuscitate (DNR) patient.<sup>104</sup>

## September 28 and 29, 2019

<sup>94</sup> See HSA (b)(6); (b)(7)(C) email, "RE: ICU Update: ABIENWI 213187 584," dated September 27, 2019.

<sup>95</sup> See Acting SDDC (b)(6); (b)(7)(C) email, "RE: ICU Update: ABIENWI 213187 584," dated September 27, 2019.

<sup>96</sup> See (A)AOIC (b)(6); (b)(7)(C) email, "RE: ICU Update: ABIENWI 213187 584," dated September 27, 2019. During their interviews with ERAU, (b)(6); (b)(7)(C) noted that documents in a detainee's possession not flagged for medical upon admission are provided to custody staff for appropriate disposition.

<sup>97</sup> See CST Certificado Médico, dated August 30, 2019.

<sup>98</sup> Essential hypertension is high blood pressure that does not have an underlying cause. It tends to develop gradually over years. Most people with essential hypertension have no signs or symptoms.

<sup>99</sup> Captopril is a medication used to treat high blood pressure.

<sup>100</sup> Ranitidine is an antacid used to treat heartburn, stomach ulcers, or other conditions that produce too much stomach acid.

<sup>101</sup> See Receta Médica, dated August 30, 2019. ERAU is unable to determine if ABIENWI filled his prescriptions before being apprehended by CBP because the section on the bottom of the prescription slip, intended to be signed by the patient upon receiving the medications, is blank.

<sup>102</sup> See HGT Nota Médica, undated.

<sup>103</sup> According to the Mayo Clinic, Omeprazole is used to treat certain conditions where there is too much acid in the stomach. It is used to treat gastric and duodenal ulcers, erosive esophagitis, and gastroesophageal reflux disease (GERD).

<sup>104</sup> See SCVMC Discharge Summary, dated October 1, 2019. During her interview with ERAU on November 13, 2019, AHSA (b)(6); (b)(7)(C) stated she was not aware of the DNR until October 25, 2019, during an IHSC review of ABIENWI's death.



There were no changes or improvements to ABIENWI's condition.<sup>105</sup>

### September 30, 2019

At 10:30 a.m. (b)(6); (b)(7)(C) poke with SCVMC (b)(6); (b)(7)(C) who reported a diagnosis of a persistent vegetative state with approximately five percent brain activity secondary to extensive damage to the brain caused by a hemorrhagic stroke.<sup>106</sup> (b)(6); (b)(7)(C) also reported that they discontinued the primary method they were using to manage ABIENWI's brain swelling and herniation, IV hypertonic saline,<sup>107</sup> because his sodium reached an unacceptably high level of 163.<sup>108</sup> SCVMC continued ABIENWI's respiratory support via intubation and ventilation and his nutritional support via a nasogastric tube and (b)(6); (b)(7)(C) stated that the risks of a surgical intervention far outweighed the benefits. ABIENWI's prognosis was grim and the anticipated scenario was brain death from complete herniation, consistent with tests the hospital had conducted; if ABIENWI did not completely herniate his brainstem, the best-case scenario based on his current condition, would be a coma or persistent vegetative state with 100% dependence on artificial ventilation and nutrition. (b)(6); (b)(7)(C) wrote that family input was imperative should ABIENWI survive herniation.

At approximately 11:25 a.m., (A)AOIC (b)(6); (b)(7)(C) emailed the Consulate of Cameroon for an update on the status of locating ABIENWI's next of kin.<sup>109</sup>

At approximately 12:22 p.m., Acting SDDO (b)(6); (b)(7)(C) who was able to provide a number for ABIENWI's brother, (b)(6); (b)(7)(C), who resided in South Africa.<sup>110</sup> ERO contacted (b)(6); (b)(7)(C) and relayed information about ABIENWI's current condition; (b)(6); (b)(7)(C) was on the call to answer any questions the brother had. (b)(6); (b)(7)(C) provided them with the name of ABIENWI's wife, who was in Cameroon, and ERO with her telephone number. At approximately 2:13 p.m., ERO and (b)(6); (b)(7)(C) poke by telephone to ABIENWI's wife and provided her with information on how to contact SCVMC so she could speak directly to the physician for an update on ABIENWI's medical condition.<sup>111</sup> AHS (b)(6); (b)(7)(C) further documented notifying SCVMC about contact with ABIENWI's wife and sharing the ICU contact information with her.

At 3:25 p.m., an SCVMC nurse received a second call from ABIENWI's brother about the status of ABIENWI.<sup>112</sup> Officer (b)(6); (b)(7)(C) assigned to hospital detail at SCVMC, documented that

<sup>105</sup> See IHSC email communications, dated September 28 and 29, 2019.

<sup>106</sup> See (b)(6); (b)(7)(C) mail, "Hospital update 213 187 584," dated September 30, 2019.

<sup>107</sup> Hypertonic saline is fluid containing electrolytes used in patients with brain injury to help pull fluid away from the brain tissue to help decrease the pressure on the brain.

<sup>108</sup> The normal upper limit for sodium is 145.

<sup>109</sup> See EARM Comments, entry dated September 30, 2019.

<sup>110</sup> *Id.*; see also AHS (b)(6); (b)(7)(C) mail, "RE: Hospital update 213 187 584," dated September 30, 2019.

<sup>111</sup> *Id.*

<sup>112</sup> See hospital logbook, entry dated September 30, 2019. As mentioned in the Area of Concern below, OMDC could not locate the hospital logbook from September 26, 2019, through the afternoon of September 30, 2019. OMDC stated that the logbook had been taken for archiving at an off-site location, and efforts to retrieve the logbook from the offsite location were unsuccessful.

she directed the SCVMC nurse to call OMDC regarding ABIENWI's brother obtaining additional information.

### Day of Death – October 1, 2019

At 8:35 a.m., Officer (b)(6); (b)(7)(C) assigned to hospital detail, notified OMDC Shift Supervisor (b)(6); (b)(7)(C) that someone claiming to be ABIENWI's family called the hospital to speak with ABIENWI.<sup>113</sup> Officer (b)(6); (b)(7)(C) who was assigned to hospital detail with Officer (b)(6); (b)(7)(C) explained to ERAU that hospital personnel staff informed them a caller identifying themselves as a family member had called the hospital directly.<sup>114</sup> Officer (b)(6); (b)(7)(C) told the hospital to wait for ICE to verify the number was actually ABIENWI's family before giving out any information on ABIENWI's status.

At 8:55 a.m., Officer (b)(6); (b)(7)(C) notified Assistant Shift Supervisor (b)(6); (b)(7)(C) that hospital staff stated they would be removing ABIENWI from life support and needed to know what the next step would be.<sup>115</sup> Assistant Shift Supervisor (b)(6); (b)(7)(C) stated he would contact ICE. The SCVMC doctor notified Officer (b)(6); (b)(7)(C) that they would perform two additional tests on ABIENWI before officially declaring him brain dead.

At 11:20 a.m., one of the facility's two Assistant Wardens notified Officer (b)(6); (b)(7)(C) that HSA Canada and (b)(6); (b)(7)(C) could be contacting SCVMC regarding ABIENWI's condition.<sup>116</sup> Officer (b)(6); (b)(7)(C) further documented notifying ABIENWI's attending nurse.

At approximately 11:46 a.m., SCVMC conducted a clinical examination and documented findings consistent with brain death, which SCVMC confirmed through an apnea test<sup>117</sup> verified by two physicians, (b)(6); (b)(7)(C).<sup>118</sup> AHSA (b)(6); (b)(7)(C) also noted ICE and IHSC were making contact with the family.

At 12:00 p.m., Officer (b)(6); (b)(7)(C) who took over for Officer (b)(6); (b)(7)(C) while she was on her break, documented that he called Shift Supervisor (b)(6); (b)(7)(C) as SCVMC medical staff were asking for permission to notify ABIENWI's family members about his current status.<sup>119</sup> He documented that Shift Supervisor (b)(6); (b)(7)(C) responded, "everybody here already knows" and advised him to inform SCVMC they should be going to OMDC medical staff for that type of request.

<sup>113</sup> See hospital logbook, entry dated October 1, 2019.

<sup>114</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated November 14, 2019.

<sup>115</sup> See hospital logbook, entry dated October 1, 2019.

<sup>116</sup> *Id.* Because at the time of ABIENWI's hospitalization the facility had two Assistant Wardens and the Officer did not document the individual's name, ERAU is unable to confirm to which Assistant Warden the officer was referring.

<sup>117</sup> An apnea test proves the absence of respiratory reflexes in the brainstem when physiologic stimulation to breath takes place. It is an essential component in determining brain death.

<sup>118</sup> See AHSA Ramsburg email, "RE: Hospital update 213 187 584," dated October 1, 2019; *see also* SCVMC Discharge Summary, dated October 1, 2019.

<sup>119</sup> See hospital logbook, entry dated October 1, 2019.



At 12:05 p.m., (b)(6); (b)(7)(C) pronounced ABIENWI's brain death.<sup>120</sup> Office (b)(6); (b)(7)(C) notified OMDC Senior Detention Officer (b)(6); (b)(7)(C) of the death.<sup>121</sup> (b)(6); (b)(7)(C) documented<sup>122</sup> ABIENWI's discharge diagnoses as a large right basal ganglia hemorrhage with intraventricular extension, uncal herniation, acute respiratory failure (secondary to the aforementioned),<sup>123</sup> acute hypotension,<sup>124</sup> and iatrogenic<sup>125</sup> hypernatremia.<sup>126</sup>

At 12:38 p.m., ERO informed ABIENWI's wife of the passing of her husband and at 3:05 p.m., notified the Consulate of Cameroon.<sup>127</sup> At 5:07 p.m., AHSA (b)(6); (b)(7)(C) emailed OMDC ACOS (b)(6); (b)(7)(C) authorizing the release of ABIENWI's body.<sup>128</sup> At 5:25 p.m., the Medical Examiner took custody of ABIENWI.<sup>129</sup>

## Post-Death Actions

On October 1, 2019, at 6:36 p.m., ACO (b)(6); (b)(7)(C) completed an incident report, including the names of the detainees who were witness to ABIENWI's fall and other relevant OMDC staff who were either involved in the initial emergency response or who were on hospital watch with ABIENWI.<sup>130</sup>

On October 4, 2019, CO (b)(6); (b)(7)(C) completed an Incident Investigation Report, compiling staff and detainee incident statements and reports, logbooks, and the hospital discharge summary.<sup>131</sup> Per OMDC policy, OMDC did not complete an after-action review because ABIENWI's death occurred as a result of natural causes.<sup>132</sup> Also on this date, OMDC Detention

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<sup>120</sup> See SCVMC Emergency Documentation, dated October 1, 2019. Although IHSC emails from the day of death, OMDC security logs from the hospital, and the SCVMC Discharge Summary all state ABIENWI died at 12:05 p.m., the County of San Diego Medical Examiner's Office and the County of San Diego Certificate of Death both list the official time of death as 2:41 p.m. ERAU notes SCVMC recorded ABIENWI's last vital signs at 2:41 p.m., documenting his pulse as "0," and the SCVMC Discharge Summary continued, "ICE officials helped facilitate communication with family (wife and brother), who were notified of his brain death and declined organ donation. He was therefore extubated."

<sup>121</sup> See hospital logbook, entry dated October 1, 2019.

<sup>122</sup> See SCVMC Discharge Summary, dated October 1, 2019.

<sup>123</sup> Acute respiratory failure occurs when gas exchange between oxygen and carbon dioxide fails. Tissues in the body do not receive oxygen and it quickly leads to death.

<sup>124</sup> According to the Mayo Clinic, hypotension is generally characterized as a blood pressure reading lower than 90 millimeters of mercury (mm Hg) for the top number (systolic) or 60 mm Hg for the bottom number (diastolic).

<sup>125</sup> Iatrogenic means caused by a medical treatment.

<sup>126</sup> Hypernatremia is an electrolyte imbalance in the body where the sodium levels are too high.

<sup>127</sup> See ICE SIR, dated October 2, 2019.

<sup>128</sup> See AHSA Ramsburg email, "Release of deceased to Coroner," dated October 1, 2019.

<sup>129</sup> See hospital logbook entry dated October 1, 2019; *see also* CoreCivic Transfer of Custody Receipt, dated October 1, 2019.

<sup>130</sup> See OMDC Incident Report, dated October 1, 2019. The report did not provide additional context about the incident outside of the individuals involved in the response or care of ABIENWI and three sentences explaining what transpired.

<sup>131</sup> See OMDC Incident Investigation Report, dated October 4, 2019. The two-paragraph report did not provide additional context about the incident, apart from the cause of death.

<sup>132</sup> See Core Civic policy 5-1, Incident Reporting.

Office (b)(6); (b)(7)(C) mailed ABIENWI's stored property to ABIENWI's brother in Johannesburg, South Africa.<sup>133</sup>

COS (b)(6); (b)(7)(C) stated that CoreCivic offered employee assistance to staff involved in the care and handling of ABIENWI; however, during her interview with ERAU, Office (b)(6); (b)(7)(C) stated that she was not offered employee assistance.<sup>134</sup>

On November 22, 2019, the County of San Diego Medical Examiner's Office documented ABIENWI's official cause of death as hypertensive basal ganglia hemorrhage.<sup>135</sup>

On January 31, 2020, the County of San Diego issued ABIENWI's Certificate of Death.<sup>136</sup>

## **FINDINGS**

ERAU reviewed the medical care OMDC provided ABIENWI, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found OMDC failed to comply with three of the requirements of ICE PBNDS 2011. In this report, ERAU has included other areas of concern that are not covered by ICE PBNDS 2011. 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 (V)(I)(3):** "All health care staff must be verifiably licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements. Copies of the documents must be maintained on site and readily available for review. A restricted license does not meet this requirement."
  - ERAU reviewed the credential files for the medical staff involved in ABIENWI's care. Radiology Technician Sioson's license was unverified by the facility from its original source from her hire date of June 1, 2017, to the time of ERAU's site visit. RN (b)(6); (b)(7)(C) license was issued on December 28, 2017 but was not verified by the facility until November 5, 2019.
2. **Medical Care, Section (V)(P):** "If any security or medical intake screening or classification assessment indicates that a detainee has experienced prior sexual victimization or perpetrated sexual abuse, staff shall, as appropriate, ensure that the detainee is immediately referred to a qualified medical or mental health practitioner for medical and/or mental health follow up as appropriate. When a referral for medical follow up is initiated, the detainee shall receive a health evaluation no later than two working days from the date of assessment. When a referral for mental health follow-up is initiated, the detainee shall receive a mental health evaluation no later than 72 hours after the referral."

<sup>133</sup> See FedEx 776494256577 Ship Date Information, dated October 4, 2019.

<sup>134</sup> ERAU interviews with COS (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) dated November 13, 2019, and November 14, 2019, respectively.

<sup>135</sup> See Exhibit 2: County of San Diego Medical Examiner's Office, dated November 22, 2019.

<sup>136</sup> See Exhibit 3: County of San Diego Certificate of Death, dated January 31, 2020.



- On September 18, 2019, during the admission process, ABIENWI reported being a victim of sexual abuse in December 2017. Although the booking officer properly notified her chain of command, OMDC supervisory staff did not refer ABIENWI to a qualified medical or mental health professional. Moreover, the following day, during ABIENWI's initial medical and mental health assessment, although he once again reported being a victim of sexual abuse, RN (b)(6); (b)(7)(C) did not refer ABIENWI for a follow-up appointment with a qualified medical or mental health practitioner. Although ERAU notes the IHSC assessment screening template prompts medical staff to focus on sexual abuse within the past six months, the detention standard requirement does not impose a time limitation.
3. **Medical Care, Section (V)(T)(1)(d):** "Each facility shall have a written emergency services plan for delivery of 24-hour emergency health care. This plan shall be prepared in consultation with the facility's CMA [Clinical Medical Authority] or HSA, and must include the following: ... (d) all detention and medical staff shall receive cardiopulmonary resuscitation (CPR, AED), and emergency first aid training annually."
- During its site visit, ERAU reviewed the records of the medical professionals involved in ABIENWI's care and discovered four records did not include emergency first aid training within the past year, as required. Specifically, (b)(6); (b)(7)(C) last received first aid training on April 28, 2018; (b)(6); (b)(7)(C) last received training on March 14, 2018; and (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) had no record of first aid training.

## AREAS OF CONCERN

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

- IHSC Operations memorandum, OM 17-004, *Nursing Competencies*, Section (4-1.2): "The nurse manager arranges orientation for all new nursing staff and ensure and maintains documentation that each RN and LVN or LPN is trained and has completed their discipline specific competencies within 2 months of their hire date and annually thereafter."
  - Of the OMDC medical staff credentials ERAU reviewed, (b)(6); (b)(7)(C) credential file was missing documentation of initial orientation and nurse competency training. RN (b)(6); (b)(7)(C) last received competency training on April 28, 2018 and (b)(6); (b)(7)(C) last received the training on March 4, 2018.
- On September 26, 2019, RN (b)(6); (b)(7)(C) documented she was unable to reach the on-call provider after ABIENWI was brought to the medical unit for assessment pursuant to his fall; as a result, she made the determination EMS should be contacted. Although (b)(6); (b)(7)(C) acknowledged to ERAU that the inability to reach the on-call provider was a problem, she did not notify health services leadership. Notification to the OMDC medical management team would have allowed a review of the reasons the RN was unable to reach the provider and an opportunity to place immediate corrective actions in place to mitigate the possibility of this issue from reoccurring. In fact, health services leadership was not aware of the issue until ERAU discussed it with them during the on-site visit.

3. OMDC could not locate the hospital logbook from September 26 through the afternoon of September 30, 2019, stating that the logbook had been taken for archiving at an off-site location. As such, ERAU was unable to review entries made on these dates for additional facts or compliance with facility policy.
4. ABIENWI's detention file was inclusive of multiple illegible signatures. Staff seldomly used name stamps or ID numbers, or printed their names, which made identifying who conducted an action difficult for both the facility and ERAU.
5. Due to a lack of coordination between OMDC medical and security staff, officers assigned to vigil duties were unaware that ICE and OMDC management had advised ABIENWI's family to communicate directly with hospital staff. As such, security officers communicated conflicting information to the hospital staff; it is unknown if this matter adversely effected the hospital from ultimately sharing information regarding ABIENWI's condition with his family.

## **EXHIBITS**

1. Creative Corrections Medical and Security Compliance Analysis
2. County of San Diego Medical Examiner's Office, dated November 22, 2019
3. County of San Diego Certificate of Death, dated January 31, 2020





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)  
Associate Director

FROM: (b)(6); (b)(7)(C)  
Acting Assistant Director  
Inspections and Detention Oversight

SUBJECT: Detainee Death Review Findings – Nebane ABIENWI  
(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 Nebane ABIENWI, a 37-year-old who died on October 1, 2019, while in the custody of ICE at the Otay Mesa Detention Center (OMDC) in San Diego, California (CA). The County of San Diego Medical Examiner's Office documented ABIENWI's official cause of death as hypertensive basal ganglia hemorrhage.<sup>1</sup>

### Abbreviated Chronology<sup>2</sup>

On September 5, 2019, ABIENWI applied for admission into the United States from Mexico at the San Ysidro Port of Entry, via the pedestrian primary inspection lane, (b)(6); (b)(7)(C) At that time, U.S. Customs and Border Protection (CBP) took ABIENWI into its custody.

On September 9, 2019, a CBP Officer completed a Notice and Order of Expedited Removal (DHS Form I-860), charging him as inadmissible under section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act, as an immigrant without a valid visa.

On September 11, 2019, a CBP provider assessed ABIENWI, prescribed him medications for constipation and a skin rash, and medically cleared him for transport and detention.

<sup>1</sup> See County of San Diego Medical Examiner's Office, dated November 22, 2019.

<sup>2</sup> See Detainee Death Review for complete chronology.

On September 18, 2019, CBP released ABIENWI into ICE custody at OMDC. On September 19, 2019, ABIENWI received a timely intake screening, and all his vital signs were within normal limits. During his screening, ABIENWI reported being hospitalized in Mexico for three days in August 2019 due to high blood pressure. ABIENWI stated he took blood pressure medication the physician prescribed him for approximately two weeks until the physician discontinued it because his blood pressure returned to normal. ABIENWI also reported being a prior victim of sexual abuse to both security and medical staff, but neither referred him to mental health.

On September 26, 2019, at approximately 3:26 a.m., the officer in ABIENWI's housing unit called a medical emergency after observing ABIENWI fall from his top bunk. An OMDC registered nurse (RN) evaluated ABIENWI once they arrived at the medical department, documenting that although he did not have any visible injuries, he was initially confused and not able to respond to questions, except for his name. ABIENWI also had paralysis to the left side of his body, including his face, was exhibiting jerky movements in all extremities, and had an elevated blood pressure of 180/100. After being unable to reach the on-call provider, an RN determined EMS should be contacted. At 3:50 a.m., a central control officer contacted emergency medical services (EMS) to transport ABIENWI to the hospital. At 4:18 a.m., EMS arrived at ABIENWI's side and left OMDC at 4:34 a.m.

At 4:50 a.m., EMS arrived to Sharp Chula Vista Medical Center (SCVMC) hospital. Upon arrival to SCVMC, a SCVMC physician triaged ABIENWI, noting that he presented as having an acute hemorrhagic stroke.<sup>3</sup> SCVMC medical staff conducted a computed tomography (CT) scan and neurological examination. The results of the CT scan showed ABIENWI suffered from a large area of blood in the brain and damage to some of the structures inside the skull caused by pressure of added fluid. A separate neurological examination revealed ABIENWI was nonverbal, did not open his eyes or follow commands, and that he attempted to move his right arm in response to painful stimuli. SCVMC medical staff intubated ABIENWI, placed an oral gastric tube<sup>4</sup> in his stomach, and started him on an intravenous nicardipine<sup>5</sup> drip for blood pressure control. After consultation with a neurosurgeon and intensivist, SCVMC decided to admit ABIENWI to the Intensive Care Unit. By the next morning, ABIENWI's condition had deteriorated significantly, and SCVMC physicians notified OMDC that he was not expected to survive either surgical intervention or the daily management plan for his persistent vegetative state. Over the next few days, ERO attempted to locate information for ABIENWI's next of kin several times but was unsuccessful until September 30, 2019.

On September 30, 2019, ERO and OMDC management communicated via telephone with ABIENWI's brother and wife, informed them of ABIENWI's declining state, and shared contact information for SCVMC, so they could speak with the attending physician

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<sup>3</sup> A hemorrhagic stroke is caused by a weakened vessel that ruptures and bleeds into the surrounding brain. The blood accumulates, compressing the surrounding brain tissue.

<sup>4</sup> An oral gastric tube is a tube placed through the mouth into the stomach to be used for feeding, medication administration, or suctioning out contents in the stomach.

<sup>5</sup> Nicardipine is a medication used to relax the blood vessels, making it easier for the heart to pump. It is used to treat high blood pressure.



directly.

On October 1, 2019, at 12:05 p.m., after completing a test to confirm clinical exam findings of ABIENWI's brain death, SCVMC medical staff declared him brain dead.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care OMDC provided ABIENWI, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found OMDC failed to comply with three of the requirements of the ICE Performance Based National Detention Standards 2011.

1. **Medical Care, Section (V)(I)(3):** ERAU reviewed the credential files for the medical staff involved in ABIENWI's care. One radiology technician's license remained unverified by OMDC medical for her entire tenure at OMDC, while an RN's license was still not verified by OMDC as of the date of ERAU's on-site visit.
2. **Medical Care, Section (V)(P):** ABIENWI reported being a victim of sexual abuse in December 2017 to both security and medical staff, the former during the admission process and the latter during his initial medical and mental health assessment. Although the booking officer properly notified her chain of command, there is no documented referral to a qualified health professional in ABIENWI's records.
3. **Medical Care, Section (V)(T)(1)(d):** During its site visit, ERAU reviewed the records of the medical professionals involved in ABIENWI's care. Two records reviewed were void of emergency first aid training within the preceding year, and another two did not have any record of first aid training.

Although not violations of the ICE PBNDS 2011, ERAU also noted five areas of concern regarding ABIENWI's medical care, safety, and security at OMDC.

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) (202) 732-(b)(6);

*Enclosure*

Nebane ABIENWI Detainee Death Review Report





# GEORGIA DEATH CERTIFICATE

State File Number **2019GA000085460**

|                                                                                                                                                                                                                                                                  |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|
| 1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last)<br><b>PEDRO ARRIAGO SANTOYA</b>                                                                                                                                                                              |                                                                                                                 | 1a. IF FEMALE, ENTER LAST NAME AT BIRTH                                                                             |                                           | 2. SEX<br><b>MALE</b>                                                                                                                                                                                                                 | 2a. DATE OF DEATH (Mo., Day, Year)<br><b>ACTUAL DATE OF DEATH 07/24/2019</b> |                                                                                   |
| 3. SOCIAL SECURITY NUMBER<br><b>UNKNOWN</b>                                                                                                                                                                                                                      | 4a. AGE (Years)<br><b>44</b>                                                                                    | 4b. UNDER 1 YEAR<br>Mos.                                                                                            | 4c. UNDER 1 DAY<br>Days                   | 5. DATE OF BIRTH (Mo., Day, Year)<br><b>07/15/1975</b>                                                                                                                                                                                |                                                                              |                                                                                   |
| 6. BIRTHPLACE<br><b>UNKNOWN</b>                                                                                                                                                                                                                                  | 7a. RESIDENCE - STATE<br><b>GEORGIA</b>                                                                         | 7b. COUNTY<br><b>MUSCOGEE</b>                                                                                       |                                           | 7c. CITY, TOWN<br><b>COLUMBUS</b>                                                                                                                                                                                                     |                                                                              |                                                                                   |
| 7d. STREET AND NUMBER<br><b>710 CENTER STREET</b>                                                                                                                                                                                                                | 7e. ZIP CODE<br><b>31901</b>                                                                                    | 7f. INSIDE CITY LIMITS?<br><b>UNKNOWN</b>                                                                           |                                           | 8. ARMED FORCES?<br><b>NO</b>                                                                                                                                                                                                         |                                                                              |                                                                                   |
| 8a. USUAL OCCUPATION<br><b>UNKNOWN</b>                                                                                                                                                                                                                           |                                                                                                                 | 8b. KIND OF INDUSTRY OR BUSINESS<br><b>UNKNOWN</b>                                                                  |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 9. MARITAL STATUS<br><b>NOT OBTAINABLE</b>                                                                                                                                                                                                                       | 10. SPOUSE NAME                                                                                                 |                                                                                                                     |                                           | 11. FATHER'S FULL NAME (First, Middle, Last)<br><b>UNKNOWN</b>                                                                                                                                                                        |                                                                              |                                                                                   |
| 12. MOTHER'S MAIDEN NAME (First, Middle, Last)<br><b>UNKNOWN</b>                                                                                                                                                                                                 | 13a. INFORMANT'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>                                                   |                                                                                                                     |                                           | 13b. RELATIONSHIP TO DECEDENT<br><b>UNKNOWN</b>                                                                                                                                                                                       |                                                                              |                                                                                   |
| 13c. MAILING ADDRESS<br><b>UNKNOWN</b>                                                                                                                                                                                                                           |                                                                                                                 |                                                                                                                     |                                           | 14. DECEDENT'S EDUCATION<br><b>NONE</b>                                                                                                                                                                                               |                                                                              |                                                                                   |
| 15. ORIGIN OF DECEDENT (Italian, Mex., French, English, etc.)<br><b>YES, MEXICAN/MEXICAN-AMERICAN/CHICANO, YES, OTHER</b>                                                                                                                                        |                                                                                                                 | 16. DECEDENT'S RACE (White, Black, American Indian, etc.) (Specify)<br><b>GUAMANIAN OR CHAMORRO, Other: MEXICAN</b> |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 17a. IF DEATH OCCURRED IN HOSPITAL<br><b>INPATIENT</b>                                                                                                                                                                                                           |                                                                                                                 | 17b. IF DEATH OCCURRED OTHER THAN HOSPITAL (Specify)                                                                |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 18. HOSPITAL OR OTHER INSTITUTION NAME (If not in either give street and no.)<br><b>MEDICAL CENTER COLUMBUS</b>                                                                                                                                                  |                                                                                                                 |                                                                                                                     |                                           | 19. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBUS</b>                                                                                                                                                                                |                                                                              | 20. COUNTY OF DEATH<br><b>MUSCOGEE</b>                                            |
| 21. METHOD OF DISPOSITION (specify)<br><b>BURIAL</b>                                                                                                                                                                                                             | 22. PLACE OF DISPOSITION<br><b>FOREST HILLS MEMORIAL GARDENS, INC 722 CONLEY ROAD FOREST PARK GEORGIA 30297</b> |                                                                                                                     |                                           | 23. DISPOSITION DATE (Mo., Day, Year)<br><b>08/20/2019</b>                                                                                                                                                                            |                                                                              |                                                                                   |
| 24a. EMBALMER'S NAME<br><b>NOT EMBALMED</b>                                                                                                                                                                                                                      | 24b. EMBALMER LICENSE NO.                                                                                       | 25. FUNERAL HOME NAME<br><b>STOCKS FUNERAL HOME INC</b>                                                             |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 25a. FUNERAL HOME ADDRESS<br><b>1970 HOSEA L. WILLIAMS DR. N. E. ATLANTA GEORGIA 30317</b>                                                                                                                                                                       |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 26a. SIGNATURE OF FUNERAL DIRECTOR<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                                                                                                   |                                                                                                                 |                                                                                                                     | 26b. FUN. DIR. LICENSE NO.<br><b>4909</b> | AMENDMENTS                                                                                                                                                                                                                            |                                                                              |                                                                                   |
| 27. DATE PRONOUNCED DEAD (Mo., Day, Year)<br><b>07/24/2019</b>                                                                                                                                                                                                   |                                                                                                                 | 28. HOUR PRONOUNCED DEAD<br><b>03:10 PM</b>                                                                         |                                           |                                                                                                                                                                                                                                       | 29. LICENSE NUMBER<br><b>034676</b>                                          |                                                                                   |
| 29a. DATE SIGNED<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                                                                                                                     |                                                                                                                 |                                                                                                                     | 29b. DATE SIGNED<br><b>07/24/2019</b>     |                                                                                                                                                                                                                                       | 29c. DATE SIGNED<br><b>07/24/2019</b>                                        |                                                                                   |
| 30. TIME OF DEATH<br><b>03:10 PM</b>                                                                                                                                                                                                                             |                                                                                                                 | 31. WAS CASE REFERRED TO MEDICAL EXAMINER<br><b>YES</b>                                                             |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 32. Part I. Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              | Approximate interval between onset and death                                      |
| IMMEDIATE CAUSE (Final disease or condition resulting in death)                                                                                                                                                                                                  |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              | <b>UNKNOWN</b>                                                                    |
| A. VALVULAR HEART DISEASE WITH CARDIOMEGALY                                                                                                                                                                                                                      |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              | <b>UNKNOWN</b>                                                                    |
| B. HEPATIC CIRRHOSIS                                                                                                                                                                                                                                             |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              | <b>UNKNOWN</b>                                                                    |
| C.                                                                                                                                                                                                                                                               |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| D.                                                                                                                                                                                                                                                               |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| Part II. Enter significant conditions contributing to death but not related to cause given in Part 1A. If female, indicate if pregnant or birth occurred within 90 days of death.                                                                                |                                                                                                                 |                                                                                                                     |                                           | 33. WAS AUTOPSY PERFORMED?<br><b>YES</b>                                                                                                                                                                                              |                                                                              | 34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?<br><b>YES</b> |
| 35. TOBACCO USE CONTRIBUTED TO DEATH<br><b>UNKNOWN</b>                                                                                                                                                                                                           |                                                                                                                 | 36. IF FEMALE (range 10-54) PREGNANT<br><b>NOT APPLICABLE</b>                                                       |                                           | 37. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify)<br><b>NATURAL</b>                                                                                                                                                             |                                                                              |                                                                                   |
| 38. DATE OF INJURY (Mo., Day, Year)                                                                                                                                                                                                                              | 39. TIME OF INJURY                                                                                              | 40. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify)                                           |                                           |                                                                                                                                                                                                                                       | 41. INJURY AT WORK? (Yes or No)                                              |                                                                                   |
| 42. LOCATION OF INJURY (Street, Apartment Number, City or Town, State, Zip, County)                                                                                                                                                                              |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 43. DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                 |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       | 44. IF TRANSPORTATION INJURY                                                 |                                                                                   |
| 45. To the best of my knowledge death occurred at the time, date and place and due to the cause(s) stated. Medical Certifier (Name, Title, License No.)                                                                                                          |                                                                                                                 |                                                                                                                     |                                           | 46. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. Medical Examiner/Coroner (Name, Title, License No.)<br><b>/S/ SYBIL AMMONS CORONER</b> |                                                                              |                                                                                   |
| 45a. DATE SIGNED (Mo., Day, Year)                                                                                                                                                                                                                                | 45b. HOUR OF DEATH                                                                                              | 46a. DATE SIGNED (Mo., Day, Year)<br><b>01/28/2020</b>                                                              | 46b. HOUR OF DEATH<br><b>03:10 PM</b>     |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 47. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH<br><b>SYBIL AMMONS PO BOX 154 LUMPKIN, GA 31815 LUMPKIN GEORGIA 31815</b>                                                                                                                    |                                                                                                                 |                                                                                                                     |                                           |                                                                                                                                                                                                                                       |                                                                              |                                                                                   |
| 48. REGISTRAR (Signature)<br><b>(b)(6); (b)(7)(C)</b>                                                                                                                                                                                                            |                                                                                                                 |                                                                                                                     |                                           | 49. DATE FILED - REGISTRAR (Mo., Day, Year)<br><b>02/14/2020</b>                                                                                                                                                                      |                                                                              |                                                                                   |

**DETAINEE DEATH REVIEW: Pedro ARRIAGO-Santoya, A216428457**  
**Healthcare and Security Compliance Analysis**  
**Stewart Detention Center**  
**Lumpkin, Georgia**

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 Pedro ARRIAGO-Santoya (ARRIAGO) while in the custody of the Stewart Detention Center (SDC) in Lumpkin, Georgia. On August 27 and 28, 2019, a team consisting of ERAU personnel (b)(6); (b)(7)(C) Inspection and Compliance Specialist and (b)(6); (b)(7)(C) Acting Section Chief and Inspection and Compliance Specialist; and Creative Corrections subject matter experts (SME) (b)(6); (b)(7)(C) RN, healthcare SME and (b)(6); (b)(7)(C), security SME, visited SDC to conduct this review. ERAU requested contractor participation to assess compliance with the ICE 2011 PBNDS, revised 2016, governing medical care and security operations.

This analysis is a collaborative effort on the part of (b)(6); (b)(7)(C) (b)(6); Program Manager for the OPR/ERAU contract. Included in this report is a case synopsis, description of the facility's healthcare services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of ARRIAGO's medical record and detention file; tour of the medical clinic and housing unit; interviews of staff; and review of policy, video surveillance footage, and emergency services and hospital records.

## **SYNOPSIS**

Pedro ARRIAGO-Santoya, 44 years old, was detained at the Folkston ICE Processing Center from April 24, 2019 to July 10, 2019 when he was transferred to SDC. He reported no chronic health issues at either facility and none were identified; however, results of laboratory tests completed at SDC included multiple abnormal findings. On July 20, 2019, before the laboratory test results were available, he was taken to Southwest Georgia Regional Hospital for complaints of severe abdominal pain. He was admitted, then transferred to Piedmont Midtown Medical Center on July 21, 2019 for a higher level of care. On July 22, 2019, ARRIAGO suffered a cardiac arrest and was moved to the intensive care unit. On July 24, 2019, he again went into cardiac arrest and did not survive. His death was pronounced at 3:10 p.m.

As of the date of this report, a certificate of death and autopsy report are not available.



## HEALTHCARE SERVICES

CoreCivic became SDC's healthcare provider starting November 11, 2019, replacing ICE Health Services Corps (IHSC). Healthcare is provided 24 hours a day, seven days a week by personnel employed by CoreCivic and its subcontractor, Correctional Medical Associates. The staffing plan authorizes 64.46 full and part-time positions. Leadership positions include the Medical Director who is an internal medicine physician, the Health Services Administrator (HSA), and two assistant HSAs. The HSA and Assistant HSAs are registered nurses (RN). There is a staff physician, ten advanced practice providers (APP), three nursing supervisors, and ten RNs, including RNs with designated responsibility for infectious disease control, quality improvement, and pharmacy. Mental health positions include a psychiatrist, psychologist, two licensed mental health counselors and one mental health specialist. There are two dentists, two dental assistants, an x-ray technician, five medical records clerks, and two administrative clerks. As-needed positions include six Licensed Practical Nurses (LPNs), eight RNs, and two optometrists. As reported by the HSA, vacancies at the time of ARRIAGO's death included the staff physician, psychiatrist, psychologist, dentist, five full-time RNs, and three as-needed LPNs. All nurses work 12-hour shifts, with a minimum of three nurses on each.

The medical department is spacious with offices for the HSA, assistant HSAs, physician, mental health staff, and medical records. There are four examination rooms, a laboratory, urgent care room, a two-chair dental operatory, nurses' station, medication room, hazardous waste storage, and staff bathroom. An officer supervises a large detainee waiting room. An observation area within the medical department has four negative pressure rooms, a suicide watch cell, and two additional cells. In addition to clinic space, each general population housing unit has a dedicated medical office for basic sick call triage and limited care, and there are five medical offices and a radiology room in the receiving area of the facility.

CoreCivic introduced the AllScripts electronic medical record (EMR) at the time of the transition from IHSC healthcare. System-generated time stamps document the time staff initiate their entries. According to (b)(6); (b)(7)(C) CoreCivic Regional Director of Healthcare, the system locks encounter notes when staff electronically sign them. Although the time of sign-off does not appear on the notes (b)(6); (b)(7)(C) stated the times are available by way of an AllScripts programmed report. ERAU verified all encounter notes included electronic signatures.

SDC last earned reaccreditation by the National Commission on Correctional Health Care on November 20, 2018. Credentials of medical personnel involved in ARRIAGO's care were current and complete.

## NARRATIVE

### Folkston ICE Processing Center<sup>1</sup>

On April 24, 2019 at 12:45 a.m., (b)(6); (b)(7)(C) LPN, conducted ARRIAGO's intake screen, documenting the following<sup>2</sup>:

- ARRIAGO spoke Spanish, requiring use of a professional interpretation service.
- ARRIAGO admitted to drinking three beers a day, the last being two weeks prior. He denied symptoms of alcohol withdrawal.
- ARRIAGO reported an allergy to latex.
- ARRIAGO denied any medical, dental, or mental health problems, and the systems review was normal. Vital signs were within normal limits, as follows: temperature 99.2, pulse 74, respirations 18, and blood pressure 108/57. He was five feet, six inches and weighed 143 pounds.

The intake screening disposition was placement in general population.<sup>3</sup>

On April 25, 2019, (b)(6); (b)(7)(C) MD, Radiologist signed a chest x-ray report, noting there were no abnormalities of the lungs, heart, chest, or abdomen, and there was no evidence of tuberculosis.<sup>4</sup>

On May 7, 2019 at 10:40 a.m., (b)(6); (b)(7)(C) nurse practitioner (NP), documented findings and disposition of the initial physical examination.<sup>5</sup> ARRIAGO's vital signs were within normal limits and the history and findings were consistent with the intake screening. (b)(6); (b)(7)(C) described ARRIAGO as having a malodorous body scent.

On July 1, 2019, ARRIAGO submitted a request for a wheelchair due to knee pain and difficulty ambulating.<sup>6</sup> (b)(6); (b)(7)(C) LPN, who completed the sick call nursing protocol, noted ARRIAGO arrived for sick call in a wheelchair. She documented she provided him with a supply of acetaminophen 650mg to be taken twice daily for three days, to be kept on his person. The LPN did not document referral to a provider, although on the same day a provider issued a lower bunk pass for thirty days.<sup>7</sup>

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<sup>1</sup> ERAU did not visit the Folkston facility to interview staff; therefore, this information is based on the Folkston medical record and does not include analysis. Unless specified, the first names of medical professionals are unknown.

<sup>2</sup> See GEO Intake Screening, dated April 24, 2019.

<sup>3</sup> *Id.*

<sup>4</sup> See Tech Care X-ray Radiology Report, dated April 25, 2019.

<sup>5</sup> See GEO Medical History and Physical Assessment, dated May 29, 2019.

<sup>6</sup> See GEO Request for Health Services, dated June 30, 2019.

<sup>7</sup> See GEO Nursing Assessment Protocols, dated July 1, 2019.



**On July 4, 2019**, an officer completed a sick call form stating ARRIAGO was incapable of writing the request himself. The officer wrote that the detainee was having severe, debilitating pain in his leg; also, that other detainees reported he had not showered in days, was barely eating, and did not leave his bed.<sup>8</sup> (b)(6); (b)(7)(C) RN, responded to the request with a note stating ARRIAGO was scheduled for an appointment the following day. On July 5, 2019, an LPN<sup>9</sup> documented a sick call assessment addressing ARRIAGO's complaint of right knee pain. His vital signs were within normal limits, and the LPN described his overall appearance as being in mild distress. The LPN gave him a supply of ibuprofen 400mg for self-administration three times daily for three days.<sup>10</sup>

**On July 10, 2019**, (b)(6); (b)(7)(C) LPN, completed a Prisoner in Transit Medical Summary documenting ARRIAGO's chronic right knee pain and as-needed medications Tylenol<sup>11</sup> and Motrin<sup>12</sup>. She also noted his latex allergy and negative chest x-ray.<sup>13</sup>

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### Stewart Detention Center

**On July 10, 2019** at 5:08 p.m., Officer (b)(6); (b)(7)(C) booked ARRIAGO into SDC.<sup>14</sup> On the Inmate/Detainee Commitment Summary, Officer (b)(6); (b)(7)(C) left blank the following data fields: housing assignment, population status, gang affiliation, religion, aliases, tattoos, and custody level. She also did not record a custody level, although Officer (b)(6); (b)(7)(C) (first name unknown) classified ARRIAGO medium-high custody the same day.<sup>15</sup> Officer (b)(6); (b)(7)(C) left blank the data field documenting the language used during the interview. A supervisor (signature illegible) approved the rating on July 12, 2019.

The Inmate/Detainee Commitment Summary form does not include a field for recording primary language or the language in which the booking staff complete the process.<sup>16</sup> Officer (b)(6); (b)(7)(C) stated that for Spanish-speaking detainees, staff provide written yes or no questions in Spanish.<sup>17</sup> For detainees who speak a language other than Spanish or English, staff use the Language Solutions telephonic interpretation service. The detention file has only one form with yes or no questions, the Assessment/Questionnaire Information form which assesses risk for sexual assault

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<sup>8</sup> See GEO Request for Health Services, dated July 4, 2019.

<sup>9</sup> The LPN's name is illegible.

<sup>10</sup> See GEO Nursing Assessment Protocols, dated July 5, 2019.

<sup>11</sup> Tylenol is brand-name acetaminophen.

<sup>12</sup> Motrin is brand-name ibuprofen.

<sup>13</sup> See Prisoner in Transit Medical Summary, dated July 10, 2019. LPN (b)(6); (b)(7)(C) first name is unknown.

<sup>14</sup> See Stewart Detention Center Inmate/Detainee Commitment Summary, print date July 10, 2019.

<sup>15</sup> See ICE Custody Classification Worksheet, dated July 10, 2019. Based on available information, ERAU determined S. Berry properly applied the rating of Medium High.

<sup>16</sup> See Stewart Detention Center Inmate/Detainee Commitment Summary, print date July 10, 2019.

<sup>17</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 27, 2019.

or predatory risk.<sup>18</sup> Offi (b)(6); (b)(7)(C) entered no responses to all questions. The detention file also includes four forms that provide information in Spanish as well as English, all signed by ARRIAGO, including the Receiving and Discharge Checklist acknowledging receipt of the detainee handbook and Prison Rape Elimination Act (PREA) pamphlet, and acknowledgement of orientation.<sup>19</sup> ARRIAGO also signed forms providing information only in English. They include a property inventory listing his clothing items and leaving blank the medication and funds sections blank, and receipt for facility issued property.<sup>20</sup>

(b)(6); (b)(7)(C), RN, completed ARRIAGO's initial intake screening at 11:37 p.m.<sup>21</sup> She used a professional interpreter to complete the screening in Spanish. (b)(6); (b)(7)(C) documented the following:

- ARRIAGO's vital signs within normal limits were as follows<sup>22</sup>: temperature 98.3, pulse 92, respirations 18, and pulse oxygen 98. In her intake screening entry, RN (b)(6); (b)(7)(C) entered a blood pressure reading of 9/59; on the Vitals page of the Inmate Condensed Chart Report, she recorded ARRIAGO's blood pressure was 129/54.<sup>23</sup>
- ARRIAGO reported an allergy to latex.
- ARRIAGO reported a history of alcohol use and denied problems upon cessation.
- ARRIAGO reported knee pain at a level five of ten.<sup>24</sup>
- ARRIAGO denied regular use of medication or carrying medications on his person.
- ARRIAGO reported missing or broken teeth.
- ARRIAGO denied mental health problems.
- ARRIAGO denied symptoms of tuberculosis.

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<sup>18</sup> See Assessment/Questionnaire Information form, dated July 10, 2019.

<sup>19</sup> See Receiving and Discharge Checklist and form listing orientation topics, dated July 10, 2019. See also, Detainee Radio Issuance form and form authorizing forwarding of funds. Officer (b)(6); (b)(7)(C) (first name unknown) completed the Detainee Radio Issuance, authorization to send funds, and acknowledgement of orientation, dated July 10, 2019.

<sup>20</sup> See Disposition of Non-Allowable Property and Facility Issued Property Receipt forms, dated July 10, 2019. See also, Allowable Personal Property Inventory/Receipt, Property Disclaimer, Monitoring of Inmate/Detainee Telephone Calls, Inmate/Detainee Mail forms, dated July 10, 2019.

<sup>21</sup> See Initial Intake Screening, dated July 10, 2019.

<sup>22</sup> See Initial Intake Screening, dated July 10, 2019 and Inmate Condensed Chart Report, Vitals, dated July 10, 2019.

<sup>23</sup> RN (b)(6); (b)(7)(C) stated to ERAU that the entry of 9/59 on the intake screening note was an error and that 129/54 recorded on the Vitals report was the correct blood pressure reading. ERAU Interview with RN (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>24</sup> 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.



Screenings for tuberculosis, MRSA<sup>25</sup>, varicella<sup>26</sup>, mumps<sup>27</sup>, and influenza<sup>28</sup> were negative.

(b)(6); (b)(7)(C) entered a disposition of placement in general population, and she referred him to a licensed independent practitioner (LIP)<sup>29</sup> within two to 14 days. ARRIAGO signed a Spanish version of informed consent for treatment.<sup>30</sup>

**On July 11, 2019** at 12:10 a.m., security personnel assigned ARRIAGO to Unit 6A, cell 117.<sup>31</sup> Unit 6A is a two-tiered, direct supervision, general population unit housing detainees classified Medium to High.<sup>32</sup> Cell 6A has a bunk bed set, a metal desk with attached stool, a stainless-steel combination sink/toilet fixture and mirror, and a duress button that annunciates in Control. The unit and corridors leading to it have multiple security cameras, live footage from which is monitored by the Control officer who also operates the doors. The dayroom has tables with seating, telephones, mounted televisions, and a kiosk system.

**On July 16, 2019** at 11:26 a.m., (b)(6); (b)(7)(C) physician assistant (PA), conducted ARRIAGOS's initial physical examination using a professional Spanish interpreter<sup>33</sup>. She noted the following:

- ARRIAGOS's vital signs were within normal limits, as follows: temperature 97.2, pulse 98.8, respirations 18, and blood pressure 124/53. He was 65 inches in height and weighed 138 pounds.
- ARRIAGO denied a history of diabetes, hypertension, hypersensitivity lung disease<sup>34</sup>, HIV<sup>35</sup>, hepatitis<sup>36</sup>, asthma<sup>37</sup>, seizure disorder, depression, anxiety.
- ARRIAGO reported an allergy to latex examination gloves.
- ARRIAGO denied any past hospitalizations or surgeries.

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<sup>25</sup> MRSA stands for methicillin-resistant staphylococcus aureus, a contagious bacterial infection which can affect many parts of the body.

<sup>26</sup> Varicella is the virus that causes chicken pox and shingles.

<sup>27</sup> Mumps is a viral infection that affects the salivary glands.

<sup>28</sup> Influenza is a common viral infection that can be deadly in high-risk groups.

<sup>29</sup> A LIP is a physician, dentist, nurse practitioner, or other health care professional who is permitted by law to provide care and services without supervision, within the scope of licensure and granted privileges.

<sup>30</sup> See Health Care Services-General Consent, dated July 10, 2019.

<sup>31</sup> See Stewart Detention Center Cellmate Housing History and Inmate Housing History Report, print date July 31, 2019. The Cellmate Housing History report documents ARRIAGO had two cellmates while detained; one moved four days after his assignment to the cell; the second placed in the cell on July 16, 2019 and remaining there through ARRIAGO's transfer to the hospital. Both detainees were released prior to ERAU's site visit.

<sup>32</sup> ERAU tour, August 27, 2019.

<sup>33</sup> See Inmate/Resident Health Appraisal, dated July 16, 2019.

<sup>34</sup> Hypersensitivity lung disease refers to an inflammation of the alveoli (airspace) within the lung caused by inhaled organic dusts.

<sup>35</sup> HIV stands for human immunodeficiency virus, which causes the body to lose the ability to fight disease and can cause AIDS.

<sup>36</sup> Hepatitis is inflammation of the liver.

<sup>37</sup> Asthma is a lung disease that makes breathing difficult.

- ARRIAGO appeared weak for his stated age.
- ARRIAGO had abnormal heart sounds at the second right intercostal space and the fourth left intercostal space of the ribs.<sup>38</sup>
- ARRIAGO did not present with flapping of hands.<sup>39</sup>

(b)(6); (b)(7)(C) was unable to describe to ERAU what she found abnormal about the heart sounds, referring to them as “weird”.<sup>40</sup> Except for noting the abnormal heart sounds, her physical examination findings were within normal limits.<sup>41</sup> Her Plan of Care included an electrocardiogram (EKG)<sup>42</sup>, laboratory studies, and a follow up appointment with the assigned APP on July 31, 2019.<sup>43</sup> The reason for the appointment with the APP was to follow up on the EKG and lab work.<sup>44</sup>

(b)(6); (b)(7)(C) documented the EKG was to be completed on July 17, 2019, but records do not indicate it was ever completed.<sup>45</sup> The Orders include the lab studies, specifying the blood samples were to be drawn on July 17, 2019; however, nursing staff did not draw the samples until July 18, 2019.<sup>46</sup> (b)(6); (b)(7)(C) informed ERAU that her intent was for nursing staff to both draw the blood samples and complete the EKG on Thursday, July 18, 2019, explaining she normally schedules tests on Tuesdays and Thursdays in consideration of nursing schedules.<sup>47</sup> She further offered that it is common for testing to be delayed.<sup>48</sup> (b)(6); (b)(7)(C) CoreCivic Regional Director of Healthcare, supported this statement, commenting that testing delays have been an ongoing problem because nurses avoid the tasks, not because of staffing limitations.<sup>48</sup> The lab test results, received and reviewed by (b)(6); (b)(7)(C) the day after ARRIAGO was transferred to the hospital, included multiple abnormal results and panic values.<sup>49</sup>

<sup>38</sup> Intercostal space is the anatomic space between two ribs.

<sup>39</sup> (b)(6); (b)(7)(C) Medical Director, explained that hand flapping is addressed because it is a possible symptom of alcohol withdrawal. ERAU interview with (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>40</sup> ERAU Interview with (b)(6); (b)(7)(C) dated August 27, 2019.

(b)(6); (b)(7)(C) did not conduct a dental screening.

<sup>41</sup> An EKG is a test that records the electrical signals in a patient’s heart.

(b)(6); (b)(7)(C) stated detainees are assigned to a provider based on the last two numbers of their alien number.

(b)(6); (b)(7)(C) PA, was the assigned provider. ERAU Interview with PA (b)(6); (b)(7)(C) dated August 27, 2019. , PA

(b)(6); (b)(7)(C) had no face-to-face encounters with ARRIAGO during his detention.

<sup>44</sup> See Orders, Inmate Condensed Chart Report.

<sup>45</sup> *Id.*

<sup>46</sup> *Id.*

<sup>47</sup> ERAU Interview with (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>48</sup> ERAU interviews with (b)(6); (b)(7)(C) dated August 27 and 28, 2019. As a corrective measure implemented during ERAU’s site visit, CoreCivic assigned an LPN responsibility for managing laboratory draws and performing EKGs.

<sup>49</sup> See laboratory results, Stewart Detention Center, dated July 21, 2019. See also, Table 1 summarizing the lab results. Panic values, also known as critical values, are laboratory results that fall outside the normal range to a degree that might constitute an immediate health risk to the patient or require immediate action on the part of the ordering provider.



**On July 19, 2019** at 12:35 p.m., (b)(6); (b)(7)(C) Mental Health Counselor, completed a Comprehensive Mental Health Evaluation using the telephonic interpretation service.<sup>50</sup> He denied a history of alcohol abuse, reporting consumption of three to four beers a week. She concluded ARRIAGO appeared mentally stable.

**On July 20, 2019** shortly after 2:00 p.m., ARRIAGO was taken to the local hospital by ambulance. ERAU viewed surveillance footage for the three hours prior to his departure captured in four different areas: housing unit 6A, the corridor outside the dining hall, medical waiting area, and corridor within the medical clinic examination area. Video footage from inside the housing unit starts at 11:00 a.m. and shows ARRIAGO leaving for the dining hall at 11:44 a.m.<sup>51</sup> ERAU observed no incidents or events involving ARRIAGO during the 44-minute period; however, officer supervision of detainees in the unit was absent or lacking during the two hours of housing unit video reviewed, from 11:00 a.m. to approximately 1:00 p.m. The video shows that between 11:00 a.m. and 11:24 a.m. when Officer (b)(6); (b)(7)(C) entered, no officer was present in the housing unit. In fact, ERAU confirmed during the site visit that there was no officer in unit 6A beginning at 6:00 a.m. until Officer (b)(6); (b)(7)(C) arrived five hours and 24 minutes later. The Shift Roster lists (b)(6); (b)(7)(C) as the officer originally assigned to 6A for the shift, documenting that he was moved but not specifying where.<sup>52</sup> The Shift Roster also documents Officer (b)(6); (b)(7)(C)'s assignment to the unit at 10:20 a.m., with no documentation of an interim assignment explaining why he arrived more than an hour later. Captain (b)(6); (b)(7)(C) confirmed that Officer (b)(6); (b)(7)(C) assignment to 6A was changed to a different post.<sup>53</sup> She also stated that due to an oversight, she did not identify and enter a replacement officer on the roster until 10:20 a.m. Instead, she tasked the unit counselor with providing coverage on the unit. The counselor's office is outside the unit and video footage does not show he ever entered the unit.<sup>54</sup>

At 11:02 a.m. and for the duration of the housing unit video, detainees pushed the intercom button near the door to alert the Control officer that they wished to exit. In response, the Control officer electronically opened the door, allowing detainees to move in and out without being pat-searched or accounted for. (b)(6); (b)(7)(C) Assistant Chief of Security (ACOS), stated to ERAU that detainees are allowed to use the unit intercom button whenever no officer is present.<sup>55</sup> He then stated detainees are authorized to use the unit intercom button only in the event of an emergency. He confirmed this information is not included in the orientation book or written postings, but stated detainees receive verbal instruction during unit orientation and/or town hall announcements that they are prohibited from using intercoms intended for staff use.

After Officer (b)(6); (b)(7)(C) entered the unit at 11:24 a.m., he sat briefly at the officer's desk, then walked through part of the dayroom, ascended the stairs to the upper tier, walked the tier without

<sup>50</sup> See Comprehensive Mental Health Evaluation, dated July 19, 2019.

<sup>51</sup> Video surveillance footage, housing unit 6A, hallways, food service and medical unit, July 20, 2019.

<sup>52</sup> See Shift Roster, dated July 20, 2019.

<sup>53</sup> ERAU interview of (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>54</sup> ERAU tour, August 27, 2019.

<sup>55</sup> ACOS (b)(6); statement implies that officers' absence from housing units is allowed practice.



looking into the cells, and descended the stairs to return to his desk. At 11:31 a.m., a detainee entered the unit and walked past Officer (b)(6); who was sitting back in his chair, in a reclined position. He did not check the detainee's identity or appear to note his entry. At 11:37 a.m., the video shows Officer (b)(6); still reclined in his chair, extended his arm above and behind his head to push the intercom button. After five minutes, at 11:42 a.m., Officer (b)(6); (b)(7)(C) pushed the intercom button again, the unit door opened and numerous detainees exited without pat search. Officer (b)(6); also exited the unit and held the door open as the detainees exited. ARRIAGO is among the detainees who left, exiting at 11:44 a.m. Officer (b)(6); held the door and remained out of the unit for 11 minutes, returning at 11:55 a.m. At 11:58 a.m. Officer (b)(6); exited again and did not return until 1:03 p.m., one hour and five minutes later. During this time, numerous detainees entered and exited the unit, often carefully ensuring the door closed but did not secure behind them. This is evidenced by the fact that detainees were able to push on the door to open it.

Officer (b)(6); had five entries to the housing unit logbook after he assumed the post<sup>56</sup>, although the video viewed by ERAU does not show him writing in the log at any point. Three of the entries were timed between 11:00 a.m. and 1:00 p.m., the time period for which ERAU reviewed video. In the first entry, timed 1100 hours, he falsely documented that he assumed the post at that time. He also noted that that no officer had been assigned there all day. In the second (time illegible) he wrote that he was relieved by (b)(6); (b)(7)(C) to use the restroom.<sup>57</sup> He logged his return to the pod at 1245 hours. In the next entry, timed 1300 hours, Officer (b)(6); (b)(7)(C) wrote that it was count time, then that count cleared. Officer (b)(6); did not make entries to the log documenting activities observed on the video, including exit and entry of individual detainees and departure of a large group for the lunch meal.

As noted above, ARRIAGO left the housing unit at 11:44 a.m. en route to the dining hall. The video footage of the corridor outside the dining hall showed ARRIAGO exited the dining hall with another detainee at 12:04 p.m. and approached Captain (b)(6); (b)(7)(C). Captain (b)(6); (b)(7)(C) told ERAU that through the other detainee, who acted as his translator, ARRIAGO said he was experiencing abdominal pain.<sup>59</sup> Because he was holding his stomach, she instructed Officer (b)(6); (b)(7)(C) via radio to retrieve a wheelchair and escort ARRIAGO to the medical department. Captain (b)(6); (b)(7)(C) confirmed she did not notify medical staff that she was sending a detainee to the clinic. Officer (b)(6); (b)(7)(C) stated Captain (b)(6); did not tell him why she directed ARRIAGO's escort to the clinic, and that he did not alert the clinic officer that he was on his way.<sup>60</sup>

<sup>56</sup> See Unit logbook entry, dated July 20, 2019.

<sup>57</sup> The video evidence does not support that Officer (b)(6); (b)(7)(C) was relieved by another officer or staff person during any of his absences from the pod.

<sup>58</sup> Video surveillance footage, dining hall corridor.

<sup>59</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>60</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 27, 2019.



Video footage from the medical department waiting area shows Officer (b)(6); (b)(7)(C) entered with ARRIAGO in a wheelchair at 12:08 p.m.<sup>61</sup> Once there, ARRIAGO moved from the wheelchair to a waiting room chair. Officer (b)(6); (b)(7)(C) told ERAU that she heard the captain's radio transmission requesting the wheelchair and that when Officer (b)(6); (b)(7)(C) arrived with ARRIAGO, she asked him the issue.<sup>62</sup> Consistent with Officer (b)(6); (b)(7)(C) statement to ERAU, Officer (b)(6); (b)(7)(C) said he informed her he did not know ARRIAGO's complaint; only that the captain instructed him to bring him to the medical department. Officer (b)(6); (b)(7)(C) stated he telephoned the nurses' station and informed a nurse that ARRIAGO was in the medical waiting area. He recalled that the nurse told him it could take more than 30 minutes before ARRIAGO was seen, depending on activity in the clinic area. (b)(6); (b)(7)(C), RN, reported she vaguely recalled taking a call about a detainee experiencing stomach pain, but perceived no urgency because the detainee was in the waiting room.<sup>63</sup> She explained that security brings detainees with urgent needs through the back door to the clinic, bypassing the waiting room. RN (b)(6); (b)(7)(C) Acting HSA (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) all stated that on a daily basis, detainees arrive in the waiting area on their own with no prior notification to healthcare staff, and triage consisting of nurses looking at walk-in patients to identify any visible needs that may require immediate attention.<sup>64</sup>

The video footage shows ARRIAGO sat in the waiting area for 36 minutes before healthcare staff escorted him to the examination section of the clinic.<sup>65</sup> As he waited, ARRIAGO intermittently held his stomach, leaned forward, then sat back in his chair. On two occasions, a medical staff person opened the door between the sections and spoke to Officer (b)(6); (b)(7)(C) both times returning to the examination area without approaching or speaking to ARRIAGO. Two other detainees, identified as detainee workers by ACOS (b)(6); (b)(7)(C) were intermittently present in the waiting room area after ARRIAGO arrived. At one point, as the detainees ate lunch in waiting room chairs, one concealed an item in a plastic bag under his shirt. After they finished lunch, one of them pushed the intercom button, following which the control officer opened the door and they both exited the medical waiting area without pat search and discovery of the concealed item.

At 12:45 p.m., RN (b)(6); (b)(7)(C) escorted ARRIAGO from medical waiting to the examination area<sup>67</sup> and motioned for him to take a seat in the hallway.<sup>68</sup> Three minutes later, ARRIAGO followed the RN into an examination room. RN (b)(6); (b)(7)(C) documented her assessment findings on an

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<sup>61</sup> Video surveillance footage, medical department waiting area.

<sup>62</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>63</sup> ERAU interview with RN (b)(6); (b)(7)(C).

<sup>64</sup> ERAU interviews with RN (b)(6); (b)(7)(C) dated August 28, 2019. Director (b)(6); (b)(7)(C) noted arrival of detainees in the waiting room on an unscheduled basis, and without notification of healthcare staff challenges the ability of nurses to prioritize care in cases where there may be urgent needs.

<sup>65</sup> Video surveillance footage, medical department waiting area.

<sup>66</sup> ERAU interview with ACOS (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>67</sup> Video surveillance footage, medical department waiting area.

<sup>68</sup> Video surveillance footage, medical examination area corridor.

Abdominal Pain/Constipation/Diarrhea protocol form noting ARRIAGO's chief complaint was pain in his stomach, inability to eat, and inability to keep food down.<sup>69</sup> She did not document whether she used an interpreter during the encounter, although she reported to ERAU that she did.<sup>70</sup> RN (b)(6); (b)(7)(C) entries on the form and corresponding progress note included the following<sup>71</sup>:

- ARRIAGO's symptoms began one to one and a half months ago.
- ARRIAGO appeared calm, alert and oriented, and he answered questions appropriately.
- ARRIAGO denied having taken any medications on that day.
- ARRIAGO reported the location of his pain was in the right, lower quadrant of his abdomen. He described the pain as constant.<sup>72</sup>
- ARRIAGO reported nausea and vomiting, but denied fever, chills, diarrhea, bloody or tarry stools, or constipation. He denied any injury or trauma that may explain the pain.
- ARRIAGO reported he did not eat breakfast that day but ate his lunch, resulting in intensified pain. He stated his last bowel movement was that morning.
- ARRIAGO denied a history of chronic constipation, abdominal surgeries, bowel obstruction, cancer, gallbladder disease, or ulcer disease.
- ARRIAGO's vital signs were all within normal limits, as follows: blood pressure 110/52, pulse 95, temperature 97.6, respirations 18, and oxygen saturation 97. His weight was 138 pounds. His respirations were even and unlabored, and his lungs were clear to auscultation.
- ARRIAGO's abdomen was tender to palpation, and bowel sounds were present in all four quadrants. Gentle abdominal palpation<sup>73</sup> induced or increased the pain.

Based on her findings, and per direction in the protocol requiring immediate consultation with a provider, RN (b)(6); (b)(7)(C) notified NP (b)(6); (b)(7)(C). NP (b)(6); (b)(7)(C) is seen leading ARRIAGO into the triage room at 1:30 p.m.<sup>74</sup> In a late entry to the medical record, NP (b)(6); (b)(7)(C) noted that ARRIAGO denied worsening of the pain, but stated he had recently been unable to eat due to nausea and pain.<sup>75</sup> He was alert and oriented and he ambulated without difficulty, but guarded his abdomen. (b)(6); (b)(7)(C) did not document in her late entry that she personally evaluated ARRIAGO, but confirmed to ERAU that she did and that an interpreter was already on the telephone to provide interpretation assistance. NP (b)(6); (b)(7)(C) instructed RN (b)(6); (b)(7)(C) to have ARRIAGO transferred to the

<sup>69</sup> See Abdominal Pain/Constipation/Diarrhea protocol form and corresponding Progress Note dated July 20, 2019.

<sup>70</sup> ERAU Interviews with RN (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>71</sup> See Abdominal Pain/Constipation/Diarrhea protocol form, dated July 20, 2019.

<sup>72</sup> RN (b)(6); (b)(7)(C) stated she attempted to obtain a pain level, but ARRIAGO would not provide a rating. ERAU Interview with RN (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>73</sup> Palpation is the use of the examiner's hands to press on and/or feel an object in or on the body to determine its size and characteristic.

<sup>74</sup> See Abdominal Pain/Constipation/Diarrhea protocol form, dated July 20, 2019.

<sup>75</sup> Video surveillance footage, medical examination area corridor.

<sup>76</sup> See Addendum late entry for July 20, 2019. It appears NP (b)(6); (b)(7)(C) generated the entry outside the electronic medical record; therefore, there is no system-generated date or time stamp.



emergency department via Emergency Medical Services (EMS) for further evaluation. (b)(6); (b)(7)(C) explained that although ARRIAGO appeared stable, she opted in favor of an ambulance versus a facility vehicle because she was unsure of the source of his abdominal pain and believed it necessary for him to be under medical supervision during the transport. (b)(6); (b)(7)(C) noted NP (b)(6); (b)(7)(C) order and that she notified the emergency department.<sup>78</sup>

At 1:40 p.m., the Control officer logged that he or she contacted EMS per direction of Captain (b)(6); (b)(7)(C).<sup>79</sup> According to the Stewart County Fire and EMS Prehospital Care Report, a unit was dispatched at 1:43 p.m., en route at 1:44 p.m., at the scene at 1:51 p.m., and at the patient's side at 1:59 p.m.<sup>80</sup> The video shows two EMS responders left their gurney in the hallway when they entered the triage room, exiting at 2:01 p.m. with ARRIAGO following.<sup>81</sup> He got on the gurney without assistance and departed the area with the EMS responders at 2:03 p.m.

Officer (b)(6); (b)(7)(C) were the officers assigned to the hospital detail, Officer (b)(6); (b)(7)(C) accompanying ARRIAGO in the ambulance and Officer (b)(6); (b)(7)(C) following in the chase vehicle.<sup>82</sup> Officer (b)(6); (b)(7)(C) stated he received the required documents authorizing ARRIAGO's temporary release for hospitalization and that he applied hand and leg restraints but no belly chain for medical reasons.

The ambulance departed the facility at 2:12 p.m. in non-emergent mode.<sup>83</sup> EMS responders noted ARRIAGO was oriented, responded appropriately and smiled; however, they were unable to converse with him due to the language barrier. They arrived at the Southwest Georgia Regional Medical Center (SGRMC) at 2:37 p.m. Officer (b)(6); (b)(7)(C) made his first entry to the hospital logbook at 2:42 p.m.<sup>84</sup>

Following evaluation and testing in the emergency department, ARRIAGO was admitted to SGRMC. The admitting physician, (b)(6); (b)(7)(C) Doctor of Osteopathy, noted right lower quadrant abdominal pain as the primary impression, and cardiomegaly<sup>85</sup>, nausea and vomiting, colitis<sup>86</sup>, elevated liver enzymes, and hepatomegaly<sup>87</sup> as secondary impressions.<sup>88</sup> A CT scan of the abdomen and pelvis<sup>89</sup> showed the following system disorders:

<sup>77</sup> ERAU interview of (b)(6); (b)(7)(C) NP, dated August 27, 2019.

<sup>78</sup> See Abdominal Pain/Constipation/Diarrhea protocol form, dated July 20, 2019.

<sup>79</sup> See untitled and undated logbook page, 1340 hours. The first name of the Control officer is not documented.

<sup>80</sup> See Stewart County Fire and EMS Prehospital Care Report, dated July 20, 2019.

<sup>81</sup> Video surveillance footage, medical examination area corridor.

<sup>82</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>83</sup> See Stewart County Fire and EMS Prehospital Care Report, dated July 20, 2019.

<sup>84</sup> See hospital logbook entry, July 20, 2019.

<sup>85</sup> Cardiomegaly refers to an enlarged heart.

<sup>86</sup> Colitis is an inflammation of the colon.

<sup>87</sup> Hepatomegaly is an enlarged liver.

<sup>88</sup> See SGRMC emergency department record, dated July 20, 2019.

<sup>89</sup> A CT scan is an x-ray image taken from different angles, followed by computer processing to create cross-sectional images (slices).

- Enlarged heart, with small pericardial effusion<sup>90</sup> and compressive atelectasis<sup>91</sup>.
- Enlarged liver.
- Abnormal gallbladder, with significant wall thickening.
- A simple appearing cyst in the right kidney.
- A small amount of ascites<sup>92</sup>.
- Diffuse collapse of various sections of the colon.

Officer (b)(6); (b)(7)(C) did not make any entries to the logbook documenting ARRIAGO's admission to the hospital.<sup>93</sup> He made no entries between 5:55 p.m. and 7:21 p.m., both entries documenting only that ARRIAGO's restraints were secure. In an entry timed 8:42 p.m., Officer (b)(6); (b)(7)(C) documented ARRIAGO was admitted to room 118.

At 11:11 p.m., Officers (b)(6); (b)(7)(C) took over the hospital detail.<sup>94</sup> Between 12:30 a.m. and 2:00 a.m., Officer (b)(6); (b)(7)(C) documented restraint checks every 30 minutes rather than every 15 minutes.<sup>95</sup>

**On July 21, 2019,** (b)(6); (b)(7)(C) signed a Discharge Summary documenting he consulted (b)(6); (b)(7)(C) of Piedmont Columbus Midtown Hospital, who agreed to accept ARRIAGO.<sup>96</sup> The discharge diagnoses were as follows:

- Right lower quadrant abdominal pain;
- Nausea and vomiting;
- Elevated liver enzymes;
- Colitis;
- Cholecystitis;
- Hepatomegaly;
- Cardiomegaly.

(b)(6); (b)(7)(C) noted that although intravenous antibiotics were administered, ARRIAGO's white blood cell count increased.<sup>97</sup> (b)(6); (b)(7)(C) MS arrived at SGRMC at 1:22 p.m., departed at 1:38 p.m., arrived at the Piedmont Midtown Campus at 2:46 p.m., and transferred care at 2:55 p.m.<sup>98</sup>

<sup>90</sup> Pericardial effusion is an abnormal accumulation of fluid in the space between two layers of pericardium, the protective sac surrounding the heart.

<sup>91</sup> Compressive atelectasis refers to external pressure on the lungs and drives air out, also known as partial or collapse of the lung.

<sup>92</sup> Ascites refers to abdominal swelling caused by accumulation of fluid, most often related to liver disease.

<sup>93</sup> See hospital logbook entry, July 20, 2019.

<sup>94</sup> See shift roster, July 20, 2019.

<sup>95</sup> Post Order, COR-PO-19, Off-Site Hospital Officer, section (III)(E)(7) requires restraint checks every 15 minutes.

<sup>96</sup> See SGRMC Discharge Summary, dated July 21, 2019.

<sup>97</sup> An increase in the white blood cell count indicates an infection.

<sup>98</sup> See (b)(6); (b)(7)(C) EMS report, dated July 21, 2019.



**On July 22, 2019** at 3:53 a.m., Officer (b)(6); (b)(7)(C) logged that a Code Blue was called, following which ARRIAGO was moved to the intensive care unit (ICU). At 4:14 a.m., Officer (b)(6); (b)(7)(C) logged that he or she removed ARRIAGO's restraints for nurses and reapplied them at 4:54 a.m.<sup>100</sup>

(b)(6); (b)(7)(C) visited ARRIAGO at 12:46 p.m.<sup>101</sup> He was intubated and on mechanical ventilation after suffering a cardiac arrest in the early morning hours.<sup>102</sup> He was unresponsive, and according to the ICU attending physician, ARRIAGO's prognosis was grave and he was in multi-organ system failure with severe dilated cardiomyopathy.<sup>103</sup> Treatment included three medications to help maintain his blood pressure.

**On July 23, 2019**, the ICU attending physician reported to (b)(6); (b)(7)(C) that ARRIAGO's condition had not changed and at the time, he was in a state of disseminated intravascular coagulation.<sup>104</sup>

In a 1:15 a.m. log entry, Officer (b)(6); (b)(7)(C) documented that ARRIAGO's restraints were removed so nurses could turn and bathe him.<sup>105</sup> The officer did not document supervisory approval of removal of restraints. At 2:04 a.m., the officer logged that a hand restraint was reapplied and at 2:30 a.m., that Captain (b)(6); (b)(7)(C) authorized leaving off leg restraints. The relieving officer (b)(6); (b)(7)(C) logged that there were no restraints applied to ARRIAGO when he assumed the post at 7:42 a.m. and that restraints remained off throughout the shift. Likewise, Officer (b)(6); (b)(7)(C) who relieved Officer (b)(6); (b)(7)(C) logged ARRIAGO had no restraints during his shift.<sup>107</sup>

**On July 24, 2019**, Officer (b)(6); (b)(7)(C) assumed vigil duty at 7:40 a.m.<sup>108</sup> At 7:45 a.m., she Officer (b)(6); (b)(7)(C) logged a restraints check. Asked to clarify because officers on the last shift documented ARRIAGO was not in restraints, Officer (b)(6); (b)(7)(C) stated he was in a left

<sup>99</sup> Officer (b)(6); (b)(7)(C) first name is unknown.

<sup>100</sup> See hospital logbook entry, July 22, 2019. Officer (b)(6); (b)(7)(C) did not document the reason nurses requested removal of restraints and supervisory notification.

<sup>101</sup> See hospital logbook entry, July 22, 2019.

<sup>102</sup> See Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019. Mechanical ventilation is a machine that helps a person breathe when they are unable to do so on their own.

<sup>103</sup> Dilated cardiomyopathy is a condition in which the heart's ability to pump blood is decreased because the heart's main pumping chamber, the left ventricle, is enlarged and weakened.

<sup>104</sup> See untimed Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019. Disseminated intravascular coagulation (DIC) is a condition in which blood clots form inside blood vessels. These clots use up the blood's clotting factors, which can lead to massive bleeding in other parts of the body.

<sup>105</sup> See hospital logbook entry, dated July 23, 2019. Officer (b)(6); (b)(7)(C) first name is unknown.

<sup>106</sup> Officer (b)(6); (b)(7)(C) first name is unknown.

<sup>107</sup> It is unclear whether by documenting that no restraints were applied during their shifts, Officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) were referring to leg restraints and that ARRIAGO was, in fact, in a hand restraint. As noted, before their shifts (b)(6); (b)(7)(C) received authorization to remove leg restraints but a hand restraint remained in place.

<sup>108</sup> See hospital logbook entry dated July 24, 2019

arm restraint when she and Officer (b)(6); (b)(7)(C) assumed the post.<sup>109</sup> She further stated that she called Captain (b)(6); (b)(7)(C) to ask if she could remove the restraints. He denied the request, stating a third officer would have to be present to remove restraints; therefore, ARRIAGO remained restrained.<sup>110</sup> Officer J (b)(6); (b)(7)(C) did not document the information reported to ERAU in the log.

At 2:28 p.m., the attending physician reported to (b)(6); (b)(7)(C) that ARRIAGO's condition had worsened and he had developed endocarditis<sup>111</sup>, dilated cardiomyopathy, and multi-organ failure.<sup>112</sup> He had no pulse in his lower extremities. ARRIAGO remained intubated with mechanical ventilation. Consultations with vascular surgery, infectious disease, and cardiology were pending. His prognosis remained grave, and he was not expected to survive.

At 2:40 p.m., Officer (b)(6); (b)(7)(C) logged that Code Blue was called. At 3:27 p.m., the attending physician notified (b)(6); (b)(7)(C) that ARRIAGO's death was pronounced at 3:10 p.m. following the code.

In the Discharge Summary<sup>113</sup>, (b)(6); (b)(7)(C) MD, Intensivist<sup>114</sup> for Piedmont Healthcare, noted ARRIAGO was believed to have acute cholecystitis; also, that a chest x-ray showed cardiomegaly, consistent with a cardiomyopathy.<sup>115</sup> ARRIAGO had a history of ethanol abuse and his transaminase<sup>116</sup> and bilirubin<sup>117</sup> levels had increased. He was in multi-organ system failure syndrome.<sup>118</sup> Just before the cardiorespiratory arrest that resulted in his death, an EKG was consistent with anterolateral myocardial infarction.<sup>119</sup> Despite several episodes of cardiopulmonary resuscitation during the cardiorespiratory arrest, ARRIAGO had no return of spontaneous circulation and ultimately did not survive.

At approximately 5:10 p.m., Piedmont hospital personnel notified the Muscogee County Coroner and the Columbus Police Department of ARRIAGO's death.<sup>120</sup> At 5:42 p.m., SDC Warden

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<sup>109</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 28, 2019. Her statement is inconsistent with her first entry and Officer (b)(6); (b)(7)(C) last entry for his shift stating there were no restraints.

<sup>110</sup> Post Order COR-PO-19, Off-Site Hospital Officer, does not require the presence of a third officer when restraints are removed.

<sup>111</sup> Endocarditis is an infection of the heart valve.

<sup>112</sup> See Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>113</sup> See Piedmont Healthcare Discharge Summary, dated July 24, 2019.

<sup>114</sup> An intensivist is a physician who specializes in the care of critically ill patients, most often in the ICU.

<sup>115</sup> Cardiomyopathy refers to disease of the heart muscle.

<sup>116</sup> Transaminase is an enzyme produced by the liver. Elevations are most often associated with liver disease.

<sup>117</sup> Bilirubin is an orange-yellow pigment which occurs normally when red blood cells break down. The liver takes the bilirubin from the blood and chemically changes it so it can pass through feces as bile.

<sup>118</sup> Multiorgan system failure syndrome refers to the eventual loss of function of two or more organs when the body responds with an inflammatory process.

<sup>119</sup> Anterolateral myocardial infarction refers to a heart attack as a result of insufficient blood supply to the inner wall of the heart.

<sup>120</sup> See ICE Significant Incident Report, dated July 25, 2019.



(b)(6); (b)(7)(C) completed an entry initiated by Officer (b)(6); (b)(7)(C) at 3:10 p.m., documenting that ARRIAGO coded and his death was pronounced at that time.<sup>121</sup>

On July 31, 2019, SDC property officer (b)(6); (b)(7)(C) released ARRIAGO's personal property to ERO (b)(6); (b)(7)(C).<sup>122</sup> Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) received ARRIAGO's property on August 2, 2019.<sup>123</sup> The Mexican Consulate declined to accept the property when offered by ERO because they were unable to confirm ARRIAGO was a citizen of Mexico.<sup>124</sup> ERO returned the property to SDC to hold in storage in the event the Mexican Consulate verifies ARRIAGO's citizenship.

## CONCLUSIONS

ERAU found the following deficiencies in the ICE PBNDS 2011 (revised 2016).

1. ICE PBNDS, Medical Care, Section (V)(A), which states, "Every facility shall directly or contractually provide its detainee population with the following: (2) Medically necessary and appropriate medical, dental and mental health care and pharmaceutical services."

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

<sup>121</sup> See logbook for Off-Site Hospital Officer post, dated July 24, 2019. Officer (b)(6); (b)(7)(C) completed no log entries after she documented the Code Blue at 2:40 p.m., including notification of her supervisors; instructions received; arrival of coroner and police department personnel if either or both occurred during her shift; and time authorized to return to the facility. Neither Officer (b)(6); (b)(7)(C) or her partner, Officer (b)(6); (b)(7)(C), wrote incident reports describing events prior to and following ARRIAGO's death. ERAU's analysis of Post Order COR-PO-19, Off-Site Hospital Officer, and SDC policy 14-100, Detainee Death Procedures, found no requirements addressing deaths occurring at hospitals.

<sup>122</sup> See Chain of Custody form dated July 24, 2019.

<sup>123</sup> See email from (b)(6); (b)(7)(C) dated August 2, 2019, detailing ERO personnel involved and status of detainee's property.

<sup>124</sup> See email from (b)(6); (b)(7)(C) OIC ICE, dated August 28, 2019.

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

2. ICE PBNDS, Medical Care, Section (V)(R), which states, “An initial dental screening shall be performed within 14 days of the detainee’s arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider.”

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

3. ICE PBNDS, Admission and Release, Section (II)(9), which states, “The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English Language Proficiency (LEP)... The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translations services, to provide them with meaningful access to its programs and activities.”

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

4. ICE PBNDS, Custody Classification System, Section (V)(C), which states, “Classification staff shall utilize translation services when necessary.”

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

5. ICE PBNDS, Facility Security and Control, Section (V)(A), which states, “Each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staff levels and, where applicable, video monitoring, to protect detainees against sexual abuse assault, other forms of violence or harassment, and to prevent significant self-harm and suicide.”

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

6. ICE PBNDS, Facility Security and Control, Section (V)(D)(2), which states, “As prescribed by standard “2.9 Post Orders,” staff shall observe, supervise and control movement of detainees from one area to another. No detainee may ever be given authority over, or be permitted to exert control over, any other detainee.”



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

7. ICE PBNDS, Facility Security and Control, Section (V)(F), which states, "Frequent unannounced security inspections shall be conducted on day and night shifts to control the introduction of contraband; identify and deter sexual abuse of detainees; ensure facility safety, security and good order; prevent escapes; maintain sanitary standards; and eliminate fire and safety hazards. Each facility shall prohibit staff from alerting others that these security inspections are occurring, unless such announcement is related to the legitimate operational functions of the facility. Each officer who assumes a post assignment shall conduct a security check of the area, record the results in the post logbook, and prepare and submit maintenance work requests as necessary."

(b)(6);

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

(b)(5)

### Areas of Concern

The following expands on deficiencies and describes concerns not addressed in the ICE detention standards.

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

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



• (b)(5)

## APPENDIX

### Laboratory Results

| TEST                                | RESULT | REFERENCE RANGE | FLAG/INDICATION |
|-------------------------------------|--------|-----------------|-----------------|
| Absolute Neutrophils <sup>125</sup> | 8.11   | 1.56-8.10       | Abnormally High |
| Basophils <sup>126</sup>            | 0.3    | 0-2             | Normal          |
| Eosinophils <sup>127</sup>          | 0.2    | 0-8             | Normal          |
| Hematocrit <sup>128</sup>           | 28.1   | 41-53           | Panic Low       |
| Hemoglobin <sup>129</sup>           | 8.6    | 13.5-17.5       | Panic Low       |

<sup>125</sup> Absolute Neutrophils are white blood cells that fight infection. Elevated neutrophils can indicate malnutrition, malignancies, or bone marrow depression.

<sup>126</sup> Basophils are a type of white blood cells that fight infection.

<sup>127</sup> Eosinophils are a type of white blood cells that fight infection.

<sup>128</sup> Hematocrit is the ratio of the volume of red blood cells to the total volume of blood. A low hematocrit can signify anemia, hemodilution, or leukemia.

<sup>129</sup> Hemoglobin is the protein molecule in red blood cells that carries oxygen from the lungs to the body's tissues and returns carbon dioxide from the tissues back to the lungs. A low hemoglobin signifies anemia.

DETAINEE DEATH REVIEW: Pedro ARRIAGO-Santoya, A216428457

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Healthcare and Security Compliance Analysis

October 15, 2019



|                                     |       |           |                 |
|-------------------------------------|-------|-----------|-----------------|
| Lymphocytes <sup>130</sup>          | 17.7  | 14-51     | Normal          |
| MCH <sup>131</sup>                  | 27.2  | 27-33     | Abnormally Low  |
| MCHC <sup>132</sup>                 | 30.6  | 31-37     | Abnormally Low  |
| Monocytes <sup>133</sup>            | 4.3   | 0-13.3    | Normal          |
| MPV <sup>134</sup>                  | 10.8  | 7.4-12.0  | Normal          |
| Neutrophils <sup>135</sup>          | 76.7  | 39-81     | Normal          |
| Platelets <sup>136</sup>            | 273   | 140-400   | Normal          |
| RBC <sup>137</sup>                  | 3.16  | 4.41-5.51 | Panic Low       |
| RDW <sup>138</sup>                  | 17.3  | 11.0-14.5 | Abnormally High |
| WBC <sup>139</sup>                  | 10.56 | 4.0-10.0  | Panic High      |
| Albumin <sup>140</sup>              | 3.5   | 3.5-5.5   | Normal          |
| Alkaline Phosphatase <sup>141</sup> | 83    | 53-128    | Normal          |
| ALT (SGPT) <sup>142</sup>           | 91    | 7-45      | Abnormally High |
| AST (SGOT) <sup>143</sup>           | 122   | 15-40     | Panic High      |
| Total Bilirubin <sup>144</sup>      | 1.1   | 0.2-1.2   | Normal          |
| BUN <sup>145</sup>                  | 12    | 7-18      | Normal          |
| Calcium <sup>146</sup>              | 9.0   | 8.4-10.7  | Normal          |
| Carbon Dioxide <sup>147</sup>       | 19    | 22-33     | Abnormally Low  |

<sup>130</sup> Lymphocytes are white blood cells that fight infection. They are made in the bone marrow and found in the blood and lymph tissue.

<sup>131</sup> MCH (mean corpuscular hemoglobin) levels are the average amount of hemoglobin found in the red blood cells in the body. Low MCH signifies anemia.

<sup>132</sup> MCHC (mean corpuscular hemoglobin concentration) is a measure of the average concentration of hemoglobin inside a single red blood cell.

<sup>133</sup> Monocytes are a type of white blood cell that fight infection.

<sup>134</sup> MPV (mean platelet volume) measures the number of platelets in the blood.

<sup>135</sup> Neutrophils are a type of white blood cell that fights infection.

<sup>136</sup> Platelets are blood cells that help the body form clots to stop bleeding.

<sup>137</sup> RBC (red blood cells) carry oxygen and carbon dioxide through the blood. A low RBC can signify various types of anemia, thalassemia (low RBCs), cancer, or rheumatoid arthritis.

<sup>138</sup> RDW (red blood cell distribution) is the distribution width of red blood cells. Elevated RDW can indicate a nutrient deficiency or a form of anemia.

<sup>139</sup> WBC (white blood cells) fight infection. An elevated WBC can indicate an infection.

<sup>140</sup> Albumin is a protein made by the liver that helps keep fluid in the bloodstream and prevents leakage into other body tissue.

<sup>141</sup> Alkaline Phosphatase is an enzyme found in several tissues throughout the body, with the highest concentrations in the cells that comprise bone and the liver.

<sup>142</sup> ALT SGPT (alanine aminotransferase), is an enzyme made by cells in the liver. An elevated SGPT can indicate liver disease, myocardial infarction, congestive heart failure, renal failure and/or alcohol abuse.

<sup>143</sup> AST SGOT (aspartate aminotransferase) is an enzyme made by cells in the liver. An elevated SGOT can indicate liver or biliary disorder, myocardial infarction, congestive heart failure, cerebral vascular accident, infection, or inflammation of muscle tissue.

<sup>144</sup> Bilirubin is a byproduct of the breakdown of red blood cells, excreted by the liver.

<sup>145</sup> BUN (blood urea nitrogen) is a byproduct of protein digestion that is excreted by the liver.

<sup>146</sup> Calcium, the most abundant mineral in the body, is a chemical element essential for living organisms.

<sup>147</sup> Carbon Dioxide is a colorless, odorless gas produced during respiration. A low carbon dioxide level can indicate metabolic acidosis, diarrhea, renal failure, use of salicylates, or use of diuretic.



|                                    |       |         |                  |
|------------------------------------|-------|---------|------------------|
| Chloride <sup>148</sup>            | 101   | 98-107  | Normal           |
| Serum Creatinine <sup>149</sup>    | 0.80  | 0.7-1.3 | Normal           |
| GFR <sup>150</sup>                 | 112   | 60-300  | Normal           |
| Glucose <sup>151</sup>             |       | 70-105  | Unable to Report |
| Potassium <sup>152</sup>           |       | 3.5-5.1 | Unable to Report |
| Total Serum Protein <sup>153</sup> | 7.6   | 6.0-8.3 | Normal           |
| Serum Sodium <sup>154</sup>        | 131   | 136-145 | Abnormally Low   |
| TSH <sup>155</sup>                 | 3.222 | 0.4-4.0 | Normal           |

<sup>148</sup> Chloride is a compound of chlorine with another alkaline element

<sup>149</sup> Serum Creatinine is a compound produced by metabolism of creatinine and excreted in the urine. Elevated levels signify impaired kidney function

<sup>150</sup> GFR (glomerular filtration rate) measures the level of kidney function and determines the stage of kidney disease.

<sup>151</sup> Glucose is a simple sugar that serves as an energy source in the body.

<sup>152</sup> Potassium is an electrolyte mineral that conducts electrical impulses throughout the body.

<sup>153</sup> Total Serum Protein is a test that measures the amount of protein in the blood.

<sup>154</sup> Serum Sodium levels are tested to assess electrolyte, acid-base, water balance, and renal function. Low sodium is associated with renal disorders, diabetic ketoacidosis, or diaphoresis.

<sup>155</sup> TSH (thyroid stimulating hormone) is a hormone produced by the thyroid, a small gland located near the throat.

# Official Report



Division of Forensic Sciences  
Georgia Bureau of Investigation  
State of Georgia

Headquarters

DOFS Case #: 2019-1020585

Report Date: 11/06/2019

Cleveland Miles  
Deputy Director

\* NAME Accredited \*



## Requested Service: Autopsy

Agency: Stewart Co. Coroner

Agency Ref#:

Requested by: (b)(6); (b)(7)(C)

## Case Individuals:

Victim: Pedro Arriago-Santoya

## Evidence:

On 07/26/2019, the laboratory received the following evidence via Delivery Services,  
2019-1020585-001                      DECEDENT

## Results and Conclusions:

Evidence Submission: 001

A limited examination was performed on the body of Pedro Arriago-Santoya (formerly UID Stewart) at the Georgia Bureau of Investigation, Division of Forensic Sciences, in Decatur, Georgia on the 26th day of July 2019 commencing at 0845 hours, pursuant to the Georgia Death Investigation Act. The autopsy was performed by (b)(6); (b)(7)(C)

### EXTERNAL EXAMINATION:

The body was received in the supine position in a white plastic disaster bag. An identification tag bearing the decedent identifier "UID Stewart Stewart Co." and "Arriago-Santoya, Pedro" were attached to the zipper. A matching white identification band encircled the right wrist. A yellow identification tag was attached to the left first toe.

The body was that of an unembalmed, well-developed, well-nourished White male who weighed 168 pounds, was 5'4" in height, and appeared compatible with the reported age of 44 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

The body was received clad in a blue hospital gown that was appropriately disposed. Personal effects received with the body included: a blue hair tie. The hair tie was returned with the body.

### Evidence of medical therapy:

1. A pulse oximetry monitor was attached to the right earlobe.
2. An endotracheal tube was emanating from the oral cavity and was secured with a strap device. A syringe sealed the end of the tube.
3. A circular red contusion was on the center of the chest.
4. A Foley catheter was present in the urethra and was secured to an adhesive patch on the anterior-medial aspect of the left mid-thigh. An attached collection device contained 30 mL of amber urine.
5. A pink bandage was present over the lower back in the sacral region.
6. An intravascular line was in the anterior aspect of the right mid-arm and was covered with a bio-occlusive dressing labeled "7-23."
7. Multiple needle puncture sites were in the right antecubital fossa and were covered with a bio-occlusive dressing and tape.
8. A needle puncture site was in the left antecubital fossa.
9. Needle puncture sites were in the anterior left distal forearm and was covered with gauze and tape.

Report Date: 11/06/2019

Report id: (b)(6); (b)(7)(C)

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10. Electrocardiogram pads were on the anterior distal right and left thighs.
11. Protective boots were on the distal legs and covered spontaneous compressive devices.
12. A black ink pen marking "X" was on the medial aspect of the left ankle.

There was generalized jaundice and anasarca of the body surfaces.

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, straight, and was worn at a long length in a ponytail. The facial hair consisted of a long beard and moustache. 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 fair state of repair. 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. 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 male; the testes were bilaterally descended within the scrotal sac. The anus was unremarkable. The posterior torso was normally formed and palpably unremarkable with an irregular hyperpigmented patch (birthmark) on the lateral aspect of the right hip.

The extremities were symmetrical, well-developed, and appropriately hair bearing with mottled red discoloration of the distal right leg extending over the right foot. The appendicular skeleton was stable to palpation and manipulation. All digits were present with pronounced clubbing of the distal fingers. The fingernails were long, clean and intact. There was bilateral peripheral edema. Needle tracks were not observed. Tattoos were not readily apparent.

#### EVIDENCE OF INJURY:

There was no evidence of significant recent injury.

#### INTERNAL EXAMINATION:

##### BODY CAVITIES:

The body was opened by the usual thoraco-abdominal incision and the chest plate was removed. There were fractures of bilateral ribs #4,5 (anterior) with associated soft tissue hemorrhage. No adhesions were present in any of the body cavities. Clear straw colored fluid was present in the cavities measuring 250 mL in the right chest cavity, 100 mL in the left chest cavity, and 400 mL in the peritoneal cavity. 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 1300 grams.

**CARDIOVASCULAR SYSTEM:**

The pericardial surfaces were smooth, glistening and unremarkable; the pericardial sac was free of 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 positional relationship with trabeculations of the right ventricle extending to the apex. Vegetations were noted on the aortic valve leaflets and the mitral valve leaflets. The epicardium, 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 1.7 cm; the ventricular septum thickness was 1.7 cm; the right ventricular free wall thickness was 0.4 cm. The aorta and its major branches arose normally, followed the usual course and were palpably unremarkable. The vena cava and its major tributaries returned to the heart in the usual distribution and were palpably unremarkable. The heart weighed 680 grams.

**RESPIRATORY SYSTEM:**

The pleural surfaces were smooth, glistening and unremarkable bilaterally. The pulmonary parenchyma was purple, exuding copious amounts of bloody fluid; no focal lesions were noted.

**LIVER & BILIARY SYSTEM:**

The liver had a smooth, glistening and intact capsule, covering yellow-green, firm, micronodular, minimally congested parenchyma with no focal lesions noted. The gallbladder was palpably unremarkable.

**ALIMENTARY TRACT:**

The stomach, small and large bowel serosae were unremarkable. The pancreas had a normal yellow-tan lobulated appearance. The appendix was in the right lower abdominal quadrant.

**GENITOURINARY SYSTEM:**

The urinary bladder was not distended.

**RETICULOENDOTHELIAL SYSTEM:**

The spleen had a smooth, intact capsule covering red-purple, moderately firm parenchyma. The regional lymph nodes appeared normal.

**MUSCULOSKELETAL SYSTEM:**

Muscle development was normal. No palpable bone or joint abnormalities were noted. A dissection of the posterior surfaces of the body was unremarkable for subcutaneous hemorrhage.

**OTHER PROCEDURES:**

1. Documentary photographs were obtained.
2. The organs were returned to the body.
3. Specimens for toxicological analysis: heart blood and vitreous fluid
4. Serology: one blood-stain card
5. Radiology: one anterior-posterior film demonstrated medical therapy.
6. Evidence: plucked head hair and postmortem fingerprints
7. Materials reviewed: investigative report, Stewart Detention Center Medical Director Dr. (b)(6); summary timeline report (3 pages), Stewart County Fire and EMS Prehospital Care Report Incident 50769, Southwest Georgia Regional Medical Center medical records (7/20/2019 admission), Piedmont Healthcare medical records (7/21/19 admission), Inmate/Resident Health Appraisal (20 pages), transfer paperwork to detention center (21 pages)

**PATHOLOGIC DIAGNOSES**

- I. Valvular Heart Disease with Cardiomegaly
- II. Hepatic Cirrhosis



- III. Multiple Rib Fractures, secondary to resuscitation
- IV. Postmortem Toxicology, Heart Blood
  - A. Negative for: THC
  - B. Midazolam: 31 mcg/L
  - C. Fentanyl: 13 mcg/L
  - D. Morphine: 26 mcg/L
  - E. Ethyl alcohol: negative

OPINION:

This 44 year old, White male, Pedro Arriago-Santoya, died of Valvular Heart Disease with Cardiomegaly. As per investigation, he was transferred to the Stewart Detention Center on 7/10/2019. His initial transfer paperwork included a chest x-ray from 4/24/19 that noted "heart borders mediastinum and pulmonary avascular pattern are normal. No evidence of ASCVD" at this time, his heart sounds were marked normal. The transfer paperwork notes a primary complaint of right knee pain only. There is a documented history of alcohol use at 3 beers a day.

He had a physical examination on 7/16/19 while at the detention center that documented a normal abdominal exam and abnormal heart sounds "at 2RIS and 4LIS". At this time, he denied alcohol and drug use though the comprehensive mental health evaluation on 7/19/19 notes both no history and an added description of "4 beer - two to three times a week." On 7/18/19, a complete blood count demonstrated leukocytosis (elevated white blood cell count) of 10.56 th/mm<sup>3</sup>, with an increased absolute neutrophil count, and anemia with a hemoglobin level of 8.6 g/dL. The comprehensive metabolic panel demonstrated an elevated AST (SGOT) level of 122 U/L and an elevated ALT (SPGT) level of 91 U/L. He returned to the medical center on 7/20/19 for right lower quadrant abdominal pain, nausea, and vomiting that started that morning (per medical records at Southwest Georgia Regional Hospital), around 7/17/19 (per medical records at Piedmont Columbus Hospital), or lasting the past month and a half (per detention center records and the summary timeline). The pain increased with food. He did not appear in acute distress; the medical team was concerned for cholecystitis and determined the need for additional evaluation. Emergency medical services (EMS) were contacted at 1343 hours and upon initial assessment the decedent was alert and oriented with stable vital signs. He was transported to Southwest Georgia Regional Hospital (SGRH).

He was admitted to SGRH and the initial physical exam was again remarkable for right lower quadrant tenderness. Laboratory studies from 7/20/19 at 1515 demonstrated leukocytosis of 12.8 k/mm<sup>3</sup>, elevated liver enzymes (AST/SGOT 833 U/L, ALT/SGPT 778 U/L, total bilirubin 1.7 mg/dL, alkaline phosphatase 121 U/L). Laboratory studies of pancreatic enzymes were not remarkable (amylase 24 U/L, lipase 35 U/L). A CT scan of the abdomen and pelvis demonstrated "hepatomegaly [enlargement of the liver] with no masses or duct dilation. Diffuse gallbladder wall thickening. No stones", cardiomegaly (enlargement of the heart), and possible colitis (inflammation of the colon). A urine drug screen collected at 1955 was negative for common drugs of abuse. The laboratory studies were repeated on 7/21/19 at 0515 and demonstrated worsening leukocytosis at 18.8 k/mm<sup>3</sup> and significantly worsened liver function (AST 2185 U/L, ALT 1458 U/L, total bilirubin 2.7 mg/dL).

He was transferred to Piedmont Midtown Medical Center on 7/21/19 and arrived at 1505. During the initial history, the decedent noted a history of ethanol use but stated "he has not drunk in the last 4 months." On physical exam around 2130 hours, he was in mild respiratory distress at 32 bpm. His vital signs were otherwise unremarkable and he was started on two antibiotics. An abdominal ultrasound was suggestive of acalculus cholecystitis. A hepatitis panel was non-reactive for Hepatitis A, B (core IgM and surface Ag), and C Ab. On 7/22/19 at 0353, he had a cardiac arrest and a code blue was called. Resuscitative measures including chest compressions and defibrillation successfully restored circulation at 0406 hours. An electrocardiogram taken 7/22/19 at 04:36:25 was reviewed; no cardiac enzyme labs available. He was intubated and transferred to the intensive care unit and developed post anoxic encephalopathy. Labs drawn on 7/22/19 at 0437 showed more pronounced leukocytosis of 21.39 k/mm<sup>3</sup> prompting concern for sepsis. An echocardiogram performed on 7/22/19 at 1551 demonstrated a dilated, concentrically hypertrophic (enlarged) left ventricle with a decreased

ejection fraction of 35-40%, a dilated right ventricle, aortic valve vegetations with mild regurgitation and moderate stenosis, mitral valve vegetations with moderate to severe mitral valve stenosis, and severe pulmonary hypertension. He ultimately developed DIC and multiorgan failure.

A BNP level taken on 7/24/19 at 0412 was significantly elevated at >5,000. His leukocytosis and liver function tests continued to worsen. The lactic acid level was elevated at 17.40 mmol/L. An electrocardiogram performed sinus tachycardia (rapid heart rate) with 1st degree AV block and ST elevations "Acute MI/STEMI". Blood cultures drawn at 0949 and at 1019 had no growth at 36 hours and no growth at 5 days, though he was on two intravascular antibiotics when these were drawn.

Based on information available at this time the manner of death is certified as natural.

**CAUSE OF DEATH:**

Valvular Heart Disease with Cardiomegaly

**CONTRIBUTING CAUSE OF DEATH:**

Hepatic Cirrhosis

**MANNER OF DEATH:**

Natural

Only those items discussed in the results above were analyzed for this report. The above represents the interpretations/opinions of the undersigned analyst. Unless noted above, evidence analyzed in this report will be returned to the submitting agency. Biological evidence (body fluids and tissues) and proof determination evidence 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

404-270-7176

(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

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

**End of Official Report**





U.S. Immigration  
and Customs  
Enforcement

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

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

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

SUBJECT: Detainee Death Review Findings – Pedro ARRIAGO-Santoya  
(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 Pedro ARRIAGO-Santoya (ARRIAGO), who died on July 24, 2019, at the Stewart Detention Center (SDC) in Lumpkin, Georgia (GA), while in the custody of ICE. The State of Georgia Associate Medical Examiner documented the cause of death as valvular heart disease<sup>1</sup> with cardiomegaly<sup>2</sup> and hepatic cirrhosis,<sup>3</sup> and the manner of death as natural.<sup>4</sup>

### Abbreviated Chronology<sup>5</sup>

On April 1, 2019, the ICE Enforcement and Removal Operations (ERO) Atlanta field office encountered ARRIAGO at the Appling County Jail (ACJ) in Baxley, GA. ERO Atlanta lodged an immigration detainer and served ARRIAGO with a Notice to Appear, charging ARRIAGO with inadmissibility pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled by an immigration officer.

On April 24, 2019, ACJ released ARRIAGO into the custody of ERO Atlanta, who subsequently transferred him to the Folkston ICE Processing Center in Folkston, GA.

On July 10, 2019, ERO Atlanta transferred ARRIAGO to SDC.

<sup>1</sup> Valvular heart disease is damage to or a defect in the one of the heart valves.

<sup>2</sup> Cardiomegaly is an enlarged heart.

<sup>3</sup> Hepatic cirrhosis is a condition in which the liver does not function properly due to long-term damage.

<sup>4</sup> See State of Georgia, Autopsy Official Report, dated November 6, 2019.

<sup>5</sup> See accompanying Detainee Death Review for complete chronology.

On July 20, 2019, during lunch, ARRIAGO approached a security captain complaining of abdominal pain. The captain instructed an officer to escort ARRIAGO to medical. Thirty-six minutes after his arrival to the medical clinic, a registered nurse and nurse practitioner evaluated ARRIAGO and decided to transfer him to Southwest Georgia Regional Medical Center (SGRMC) in Cuthbert, GA, via Emergency Medical Services. SGRMC admitted ARRIAGO for pain in the right lower quadrant of his abdomen, cardiomegaly, nausea and vomiting, elevated liver enzymes, colon inflammation, and an enlarged liver.

On July 21, 2019, SGRMC transferred ARRIAGO to Piedmont Columbus Regional Midtown Hospital (PCRMH) in Columbus, GA, for a higher level of care because his white blood cell count had increased despite administration of intravenous antibiotics, indicative of an infection.

On July 22, 2019, ARRIAGO went into cardiac arrest; PCRMH staff administered three rounds of epinephrine and shocked him with an automated external defibrillator. PCRMH staff detected a pulse, intubated ARRIAGO, and placed him on a ventilator.

On July 24, 2019, ARRIAGO had multiple cardiac arrests but PCRMH staff were unable to resuscitate him. A doctor pronounced ARRIAGO dead at 3:10 p.m.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care SDC provided ARRIAGO, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found seven deficiencies in SDC's compliance with the ICE Performance-Based National Detention Standards (PBNDs) 2011.

1. **Admission and Release, Section (II)(9):** During intake, several officers did not utilize interpretation services or provide forms in a language ARRIAGO could understand.
2. **Custody Classification System, Section (V)(C):** A classification officer did not document the language used to communicate with ARRIAGO during his classification review.
3. **Facility Security and Control, Section (V)(A):** On July 20, 2019, a security captain confirmed that housing unit 6A was unsupervised from 6:00 a.m. to 11:24 a.m. After the assigned officer assumed his post, he left the unit unsupervised from 11:44 a.m. to 11:55 a.m. and again from 11:58 a.m. to 1:03 p.m.
4. **Facility Security and Control, Section (V)(D)(1):** On July 20, 2019, before and after the officer arrived at housing unit 6A, detainees entered and exited the unit without accountability or documentation of their movements.
5. **Facility Security and Control, Section (V)(F):** On July 20, 2019, video surveillance shows the officer in housing unit 6A made one partial security check in two hours, during which he did not look in the cells or make entries in the logbook.



6. **Medical Care, Section (V)(A)(2)(3):**

- On July 16, 2019, the physician's assistant (PA) ordered an electrocardiogram (EKG) and laboratory tests for July 17, 2019; however, nursing staff never completed the EKG and the laboratory tests were taken a day later.
- On July 20, 2019, after ARRIAGO arrived at the medical waiting room, nurses did not visually observe him or ask about his complaint until 36 minutes later.

7. **Medical Care, Section (V)(R):** On July 16, 2019, the PA completed ARRIAGO's initial physical examination; however, there is no evidence of a dental screening in the medical record.

Although not violations of the ICE PBNDS 2011, ERAU noted 5 areas of concern regarding ARRIAGO'S medical care, safety, and security at SDC.

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

*Enclosure*

Pedro ARRIAGO-Santoya Detainee Death Review Report



## Detainee Death Review Report

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# Pedro ARRIAGO-Santoya

Date of Death: July 24, 2019

Alien File Number: 216 428 457

Joint Integrity Case Management System (JICMS) Number: 201909724

June 26, 2020

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



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## **DETAILS OF REVIEW**

From August 27 to 29, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Stewart Detention Center (SDC) in Lumpkin, Georgia (GA) to review the circumstances surrounding Pedro ARRIAGO-Santoya's (ARRIAGO) 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.<sup>1</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to ARRIAGO, in addition to conducting in-person interviews of individuals employed at SDC and the local ICE Enforcement and Removal Operations (ERO). ARRIAGO was detained at SDC from July 10, 2019 to July 20, 2019, where he remained until his transfer to the hospital. The State of Georgia Associate Medical Examiner documented the cause of death as valvular heart disease<sup>2</sup> with cardiomegaly<sup>3</sup> and hepatic cirrhosis,<sup>4</sup> and the manner of death as natural.<sup>5</sup>

## **FACILITY PROFILE**

SDC is owned and operated by CoreCivic, and the ERO Atlanta field office provides oversight. Operations at SDC are dedicated to housing ICE detainees exclusively and are governed by an Intergovernmental Service Agreement, which mandates compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011. CoreCivic provides medical care and security services for SDC. SDC can house male detainees in excess of 72 hours and has a bed capacity of 1,966; the average detainee population was 1,906.<sup>6</sup> On the day of ARRIAGO's death, SDC housed 1,862 detainees.<sup>7</sup>

## **IMMIGRATION AND CRIMINAL HISTORY**

At an unknown time and place, ARRIAGO entered the United States.<sup>8</sup>

On March 5, 2004, the Okeechobee County Sheriff's Office in Okeechobee, Florida (FL) arrested ARRIAGO for disorderly intoxication.<sup>9</sup> Though he was convicted of this charge on March 24, 2004,<sup>10</sup> the sentence is unknown.

On January 1, 2006, the Suwannee County Sheriff's Office in Live Oak, FL, arrested ARRIAGO for disorderly intoxication.<sup>11</sup> The case disposition and sentence are unknown.

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<sup>1</sup> See Exhibit 1: ARRIAGO Detainee Death Review Health and Security Compliance Analysis, dated October 15, 2019.

<sup>2</sup> Valvular heart disease is damage to or a defect in one of the heart valves.

<sup>3</sup> Cardiomegaly is an enlarged heart.

<sup>4</sup> Hepatic cirrhosis is a condition in which the liver does not function properly due to long-term damage.

<sup>5</sup> See Exhibit 2: State of Georgia, Autopsy Official Report, dated November 6, 2019.

<sup>6</sup> See ERO Facility List, dated July 22, 2019.

<sup>7</sup> See ERO Records Request, dated August 6, 2019.

<sup>8</sup> See Record of Deportable/Inadmissible Alien (Form I-213), dated April 1, 2019.

<sup>9</sup> See U.S. Customs and Border Protection NNSV Query Result, dated July 19, 2019.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*



On May 14, 2006, the Lafayette County Sheriff's Office in Mayo, FL, arrested ARRIAGO for larceny;<sup>12</sup> however, the Suwannee County State Attorney's Office subsequently dismissed the larceny charge against him.<sup>13</sup>

On April 21, 2015, the Savannah Chatham County Metropolitan Police Department in Savannah, GA, arrested ARRIAGO for disorderly conduct.<sup>14</sup> He was convicted on May 7, 2015 and sentenced to jail with time served credited.<sup>15</sup>

On March 30, 2019, the Appling County Sheriff's Office in Baxley, GA, arrested ARRIAGO for violating his probation and public intoxication.<sup>16</sup> On April 1, 2019, ERO Atlanta encountered ARRIAGO at the Appling County Jail (ACJ), lodged an immigration detainer against ARRIAGO<sup>17</sup> and served him with a Notice to Appear (Form I-862) pursuant to Section 212(a)(6)(A)(i) of the Immigration and Nationality Act, as an alien present in the United States without being admitted or paroled by an immigration officer.<sup>18</sup>

On April 24, 2019, the ACJ released ARRIAGO into the custody of ERO Atlanta, who transferred him to the Folkston ICE Processing Center (FIPC) in Folkston, GA.<sup>19</sup>

On June 6, 2019, an immigration judge ordered ARRIAGO removed from the United States to Mexico.<sup>20</sup>

On July 10, 2019, ERO Atlanta transferred ARRIAGO to SDC.<sup>21</sup>

On July 17, 2019, ERO Atlanta issued ARRIAGO a Warrant of Removal/Deportation (Form I-205).<sup>22</sup>

## **Chronology of Events**

### **April 24, 2019 – July 10, 2019**

During this period, ARRIAGO was housed at FIPC. Consequently, ERAU reviewed ARRIAGO's FIPC medical and detention files and did not identify any deficiencies or areas of concern regarding FIPC's security or the care provided to ARRIAGO during this time.

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<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> See Arrest/Booking Report, dated March 30, 2019.

<sup>17</sup> See Form I-247A, dated April 1, 2019.

<sup>18</sup> See Form I-862, dated April 1, 2019.

<sup>19</sup> See ENFORCE Alien and Removal Module (EARM).

<sup>20</sup> See Order of the Immigration Judge, dated June 6, 2019.

<sup>21</sup> See EARM.

<sup>22</sup> See Form I-205, dated July 17, 2019.

At 5:08 p.m., Officer (b)(6); (b)(7)(C) admitted ARRIAGO into SDC.<sup>23</sup> During intake processing, Officer (b)(6); (b)(7)(C) left the following data fields blank: housing assignment; population status; gang affiliation; religion; and scars/tattoos. Although Officer (b)(6); (b)(7)(C) also did not document a custody level, Officer (b)(6); (b)(7)(C) (first name unknown) appropriately classified ARRIAGO as medium-high.<sup>24</sup> However, Officer (b)(6); (b)(7)(C) did not document the language used during the classification interview. A supervisor (signature illegible) approved the classification rating on July 12, 2019.

ARRIAGO's detention file included signed acknowledgement forms in both English and Spanish, to include the orientation form, the receiving and discharge checklist, the facility handbook, and the Prison Rape Elimination Act pamphlet. However, there were several signed acknowledgement forms, such as the personal property inventory, facility-issued property, and telephone monitoring and mail disclaimer, that were only in English, and officers did not indicate on those forms whether they utilized interpretation services.

At approximately 11:37 p.m., Registered Nurse (RN) (b)(6); (b)(7)(C) completed ARRIAGO's medical intake screening, documenting<sup>25</sup> the following:

- ARRIAGO's primary language was Spanish; therefore, she utilized interpretation services to converse with him.<sup>26</sup>
- ARRIAGO arrived with a medical transfer summary from FIPC.<sup>27</sup>
- ARRIAGO's vital signs were listed within normal limits;<sup>28</sup> however, RN (b)(6); (b)(7)(C) erroneously documented his blood pressure as 9/59.<sup>29</sup>
- ARRIAGO reported an allergy to latex.
- ARRIAGO reported a history of alcohol use and denied problems upon cessation.
- ARRIAGO complained of knee pain and rated his pain level as five on the standardized pain scale.<sup>30</sup>
- ARRIAGO reported he had missing or broken teeth.
- ARRIAGO denied any mental health problems.
- ARRIAGO denied having any symptoms of tuberculosis (TB)<sup>31</sup> and methicillin-resistant staphylococcus aureus (MRSA).<sup>32</sup>

<sup>23</sup> See Stewart Detention Center Inmate/Detainee Commitment Summary, dated July 10, 2019.

<sup>24</sup> *Id.*; see also ICE Custody Classification Worksheet, dated July 10, 2019.

<sup>25</sup> See Initial Intake Screening, dated July 10, 2019.

<sup>26</sup> Throughout the remainder of the report, only lack of interpretation services used will be noted.

<sup>27</sup> See Prisoner in Transit Medical Summary, dated July 10, 2019.

<sup>28</sup> 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%.

<sup>29</sup> During her interview with ERAU on August 27, 2019, RN (b)(6); (b)(7)(C) stated the blood pressure entry of 9/59 was in error and that she recorded the correct reading, 129/54, on the Vital Report, which was elevated. See Inmate Condensed Chart Report, Vitals, dated July 10, 2019.

<sup>30</sup> 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.

<sup>31</sup> Per the FIPC Transfer Summary, FIPC completed a TB screening on April 24, 2019, and it was negative for active TB.

<sup>32</sup> MRSA is a contagious bacterial infection that can affect many parts of the body.



- ARRIAGO's screenings for varicella,<sup>33</sup> mumps,<sup>34</sup> and influenza<sup>35</sup> were negative.<sup>36</sup>

(b)(6); (b)(7)(C) cleared ARRIAGO for general population and referred him to a provider for a routine physical examination. ARRIAGO signed a Spanish version of the general medical consent form.<sup>37</sup>

## July 11, 2019

At 12:10 a.m., an unknown officer assigned ARRIAGO to housing unit 6A, cell 117, where he remained until his transfer to Southwest Georgia Regional Medical Center (SGRMC) on July 20, 2019.<sup>38</sup>

## July 16, 2019

At 11:26 a.m., Physician Assistant (PA) (b)(6); (b)(7)(C) completed ARRIAGO's initial physical examination, documenting<sup>39</sup> the following:

- ARRIAGO's vital signs were within normal limits.
- ARRIAGO reported an allergy to latex.
- ARRIAGO denied any past hospitalizations or surgeries and any history of disease.
- ARRIAGO appeared weak for his age and had abnormal heart sounds.
- ARRIAGO did not have flapping of the hands.<sup>40</sup>

(b)(6); (b)(7)(C) plan of care included an getting ARRIAGO an electrocardiogram (EKG),<sup>41</sup> laboratory tests, and an appointment with an Advanced Practice Provider (APP) on July 31, 2019, to discuss the EKG and laboratory results. With the exception of abnormal heart sounds and general weak appearance, PA (b)(6); (b)(7)(C) physical examination findings were normal. ERAU notes that (b)(6); (b)(7)(C) did not document a dental screening during the physical examination.

Although (b)(6); (b)(7)(C) plan of care included an EKG, ARRIAGO's medical record did not contain EKG results. (b)(6); (b)(7)(C) orders specified the laboratory tests were to be completed on July 17, 2019; however, nursing staff did not complete the laboratory tests until July 18, 2019. (b)(6); (b)(7)(C) stated that her intent was, in fact, for nursing staff to complete the EKG and laboratory tests on Thursday, July 18, 2019, explaining she normally schedules tests on Tuesdays and Thursdays.<sup>42</sup> The laboratory results, which included multiple abnormal results and panic

<sup>33</sup> Varicella is a virus that causes chicken pox and shingles.

<sup>34</sup> Mumps is a viral infection that affects the salivary glands.

<sup>35</sup> Influenza is a highly contagious viral infection of the respiratory passages.

<sup>36</sup> See Varicella/Mumps/Flu Screening, dated July 10, 2019.

<sup>37</sup> See Health Care Services – General Consent, dated July 10, 2019.

<sup>38</sup> See Inmate Housing History Report, print date July 31, 2019.

<sup>39</sup> See Inmate/Resident Health Appraisal, dated July 16, 2019.

<sup>40</sup> Flapping of the hands is a type of tremor that resembles a bird flapping its wings. Furthermore, during her interview on August 27, 2019, (b)(6); (b)(7)(C) SDC's Clinical Director, explained that medical staff check detainees for hand flapping because it is a possible symptom of alcohol withdrawal.

<sup>41</sup> An EKG is a test that records the electrical signals in a patient's heart.

<sup>42</sup> ERAU interview with (b)(6); (b)(7)(C) dated August 27, 2019.

values,<sup>43</sup> were reviewed by (b)(6); (b)(7)(C) on July 21, 2019, the day after ARRIAGO was transferred to the hospital.<sup>44</sup>

### July 19, 2019

At 12:35 p.m., Mental Health Counselor (MHC) (b)(6); (b)(7)(C) completed ARRIAGO's mental health evaluation and documented that ARRIAGO reported drinking four beers two to three times a week.<sup>45</sup> MHC (b)(6); (b)(7)(C) did not note any abnormal findings and concluded that ARRIAGO appeared mentally stable.

### July 20, 2019 – Day of the Emergency

From 6:00 a.m. to 10:20 a.m., no officer was assigned to housing unit 6A.<sup>46</sup> According to Captain (b)(6); (b)(7)(C) initially Officer (b)(6); (b)(7)(C) was assigned to housing unit 6A, but she reassigned him at the beginning of the shift.<sup>47</sup> Due to an oversight, Captain (b)(6); (b)(7)(C) did not find a replacement for Officer (b)(6); (b)(7)(C) but she asked an unknown unit counselor, whose office is located outside of the housing unit, to provide coverage.<sup>48</sup>

At 10:20 a.m., Captain (b)(6); (b)(7)(C) assigned Officer (b)(6); (b)(7)(C) to housing unit 6A.<sup>49</sup>

At 11:02 a.m., a detainee pushed the outdoor intercom button near the housing unit door to alert the control officer that he wished to enter housing unit 6A.<sup>50</sup> In response, Control Officer (b)(6); (b)(7)(C) electronically opened the door, allowing the detainee to enter without being pat searched or accounted for. Assistant Chief of Security (ACOS) (b)(6); (b)(7)(C) stated that detainees can use the intercom button when an officer is not present.<sup>51</sup>

At 11:24 a.m., Officer (b)(6); (b)(7)(C) entered housing unit 6A.<sup>52</sup> Captain (b)(6); (b)(7)(C) stated she did not task Officer (b)(6); (b)(7)(C) with an interim assignment, so his delayed arrival is unexplainable.<sup>53</sup> Officer (b)(6); (b)(7)(C) briefly sat at the officer's desk, then proceeded to walk through the dayroom, ascend the stairs to the upper tier, walk the upper tier without looking into the cells, and descend the stairs to return to his desk.<sup>54</sup>

<sup>43</sup> Panic values, also known as critical values, are laboratory results that fall outside the normal range to a degree that might constitute an immediate health risk to the patient or require immediate action on the part of the ordering provider.

<sup>44</sup> See Laboratory Results, collected date July 18, 2019. .

<sup>45</sup> See Comprehensive Mental Health Evaluation, dated July 19, 2019.

<sup>46</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>47</sup> See Shift Roster, dated July 20, 2019.

<sup>48</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>49</sup> *Id.*

<sup>50</sup> See Housing Unit 6A Video Surveillance, dated July 20, 2019.

<sup>51</sup> ERAU interview with ACOS (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>52</sup> See Housing Unit 6A Video Surveillance, dated July 20, 2019.

<sup>53</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>54</sup> See Housing Unit 6A Video Surveillance, dated July 20, 2019.



At 11:31 a.m., a detainee entered the housing unit and walked past Officer (b)(6); (b)(7)(C) who was sitting in his chair in a reclined position. Officer (b)(6); (b)(7)(C) did not check the detainee's identity or document his entry.<sup>55</sup>

At 11:41 a.m., Officer (b)(6); (b)(7)(C) pushed the intercom button and made an announcement to the housing unit, to which detainees responded by forming a line near the door.<sup>56</sup> The housing unit door opened, then Officer (b)(6); (b)(7)(C) and numerous detainees, including ARRIAGO, exited without a pat-down search to the dining hall.<sup>57</sup>

At 11:44 a.m., Officer (b)(6); (b)(7)(C) closed the housing unit door and did not return until 11 minutes later, despite detainees still being present in the unit.

At 11:58 a.m., Officer (b)(6); (b)(7)(C) exited the housing unit again and did not return until 1:03 p.m., one hour and five minutes later. The video surveillance does not show that Officer (b)(6); (b)(7)(C) was relieved by another officer or staff member during any of his absences from the housing unit.<sup>58</sup> During this time, numerous detainees entered and exited the housing unit, ensuring the door closed but did not lock behind them.

ERAU notes that during Officer (b)(6); (b)(7)(C) time in housing unit 6A, he made five entries in the housing unit logbook; however, the video surveillance does not show him writing in the logbook at any point or support his timeline of events.<sup>59</sup> In the first entry, marked 11:00 a.m., Officer (b)(6); (b)(7)(C) documented that he assumed the post and that an officer had not been assigned to the unit all day. In the second entry (time illegible), he documented that he was relieved by (b)(6); (b)(7)(C) to use the restroom and documented his return to housing unit 6A at 12:45 p.m. Officer (b)(6); (b)(7)(C) documented count time, then count time cleared, as occurring at 1:00 p.m. Officer (b)(6); (b)(7)(C) documented that he was relieved by the second shift officer at 1:40 p.m. Officer (b)(6); (b)(7)(C) did not document activities observed on the video surveillance, including entries and exits of detainees. During his interview, Officer (b)(6); (b)(7)(C) was unable to explain the discrepancies between his documentation and the video surveillance.<sup>60</sup>

During lunch in the dining hall, ARRIAGO and an unknown detainee, who translated for ARRIAGO, approached Captain (b)(6); (b)(7)(C) and informed her that ARRIAGO was experiencing abdominal pain.<sup>61</sup> Captain (b)(6); (b)(7)(C) instructed Officer (b)(6); (b)(7)(C) via radio to retrieve a wheelchair and escort ARRIAGO to the medical department. Officer (b)(6); (b)(7)(C) retrieved a wheelchair from the segregation unit, located across from the dining hall. Captain (b)(6); (b)(7)(C) stated she did not notify medical staff that she was sending a detainee to medical. Officer (b)(6); (b)(7)(C)

<sup>55</sup> See CoreCivic Housing Unit Post Order COR-PO-16, dated August 16, 2017.

<sup>56</sup> See Housing Unit 6A Video Surveillance, dated July 20, 2019.

<sup>57</sup> See CoreCivic Housing Unit Post Order COR-PO-16, dated August 16, 2017.

<sup>58</sup> The video surveillance does not show that Officer (b)(6); (b)(7)(C) was relieved by another officer or staff member during any of his absences from the housing unit. See Housing Unit 6A Video Surveillance, dated July 20, 2019.

<sup>59</sup> See Housing Unit 6A Logbook, dated July 20, 2019.

<sup>60</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>61</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated August 27, 2019.

stated that Captain (b)(6); (b)(7)(C) did not tell him why she directed ARRIAGO's escort to medical, nor did he alert the medical officer that he was en route to medical with ARRIAGO.<sup>62</sup>

At 12:09 p.m., Officer (b)(6); (b)(7)(C) entered the medical waiting room with ARRIAGO in a wheelchair.<sup>63</sup> ARRIAGO then transferred himself to a waiting room chair. Officer (b)(6); (b)(7)(C) who was assigned to medical, stated that she heard the captain's radio transmission requesting a wheelchair, and when Officer (b)(6); (b)(7)(C) arrived with ARRIAGO, she asked him why the detainee was there.<sup>64</sup> Consistent with Officer (b)(6); (b)(7)(C) statement, Officer (b)(6); (b)(7)(C) told ERAU that Officer (b)(6); (b)(7)(C) informed her he did not know of ARRIAGO's complaint, only that the captain instructed Officer (b)(6); (b)(7)(C) to take ARRIAGO to medical. Officer (b)(6); (b)(7)(C) stated she called the nurses' station and informed a nurse that ARRIAGO was in the medical waiting room; she recalled that the nurse told her it could take more than 30 minutes before ARRIAGO could be seen, depending on the activity in the clinic.

RN (b)(6); (b)(7)(C) vaguely recalled a phone call about a detainee experiencing stomach pain but perceived no urgency because the detainee was in the waiting room.<sup>65</sup> RN (b)(6); (b)(7)(C) explained that security typically brings detainees with urgent needs through the back door of the clinic, bypassing the waiting room. RN (b)(6); (b)(7)(C) Acting Health Services Administrator (HSA) (b)(6); (b)(7)(C) and CoreCivic Regional Director (b)(6); (b)(7)(C) all stated that, while it is common for detainees to arrive in the waiting room without prior notification to medical staff, the arrival of detainees in the waiting room on an unscheduled basis challenges the ability of nurses to prioritize care based on need. Nevertheless, nurses will triage these walk-in patients by identifying any visible needs that may require immediate attention.<sup>66</sup>

As ARRIAGO waited, he intermittently held his stomach and leaned forward.<sup>67</sup> On two occasions, medical staff opened the door between the waiting room and the clinic, spoke to Officer (b)(6); (b)(7)(C) then returned to the clinic without approaching or speaking to ARRIAGO. Additionally, two detainees<sup>68</sup> were present in the waiting room. As they ate lunch in the waiting room chairs, one of the two detainees concealed bread in a plastic bag under his shirt. After they finished their lunch, they pushed the intercom button, the door opened, and the detainees exited the waiting room without a pat-down search, allowing the concealed item to go undiscovered.<sup>69</sup>

At 12:45 p.m., RN (b)(6); (b)(7)(C) escorted ARRIAGO from the waiting room to the clinic<sup>70</sup> and motioned for him to take a seat in the hallway.<sup>71</sup> At 12:49 p.m., ARRIAGO followed RN (b)(6); (b)(7)(C) into an examination room where she evaluated ARRIAGO and documented<sup>72</sup> the following:

<sup>62</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 27, 2019.

<sup>63</sup> See Medical Department Waiting Room Video Surveillance, dated July 20, 2019.

<sup>64</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>65</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>66</sup> ERAU interviews with RN (b)(6); (b)(7)(C) and Regional Director Montford, dated August 28, 2019.

<sup>67</sup> See Medical Department Waiting Room Video Surveillance, dated July 20, 2019.

<sup>68</sup> During his visit with ERAU, ACOS Hall identified them as detainee workers, dated August 27, 2019.

<sup>69</sup> See CoreCivic Post Order, SDC-PO-111, Medical.

<sup>70</sup> See Medical Department Waiting Room Video Surveillance, dated July 20, 2019.

<sup>71</sup> See Medical Examination Corridor Video Surveillance, dated July 20, 2019.

<sup>72</sup> See Abdominal Pain/Constipation/Diarrhea Form and Progress Note Addendum, dated July 20, 2019.



- ARRIAGO's chief complaint was pain in his stomach and an inability to eat and keep food down.
- ARRIAGO's vital signs were all within normal limits.
- ARRIAGO's symptoms began one to one and a half months ago.
- ARRIAGO appeared calm, alert, and oriented, and he answered questions appropriately.
- ARRIAGO reported the location of his pain was in the right, lower quadrant of his abdomen and described the pain as constant.<sup>73</sup>
- ARRIAGO reported nausea and vomiting but denied having a fever, chills, diarrhea, bloody stool, or constipation. He further denied any injury or trauma that may explain the pain.
- ARRIAGO reported he had not eaten breakfast but ate his lunch, which resulted in intensified pain.
- ARRIAGO stated his last bowel movement was that morning.
- ARRIAGO denied a history of chronic constipation, abdominal surgeries, bowel obstruction, cancer, gallbladder disease, or ulcer disease.
- ARRIAGO's abdomen was tender to palpation<sup>74</sup> and bowel sounds were present in all four quadrants. Gentle abdominal palpation induced or increased the pain.

Based on her findings and according to the directions on the Abdominal Pain/Constipation/Diarrhea Form, RN (b)(6); (b)(7)(C) notified Nurse Practitioner (NP) M (b)(6); (b)(7)(C). Although RN (b)(6); (b)(7)(C) indicated that she used interpretation services during this encounter, there was no documentation of interpretation services either on this form or elsewhere.<sup>75</sup>

At 1:21 p.m., RN (b)(6); (b)(7)(C) led ARRIAGO to the triage room to be evaluated by NP (b)(6); (b)(7)(C). At 1:30 p.m., NP (b)(6); (b)(7)(C) arrived at the triage room and documented that ARRIAGO reported experiencing intermittent pain for approximately one month and that he had recently been unable to eat due to nausea and pain.<sup>77</sup> ARRIAGO was alert and oriented; he ambulated without difficulty but guarded his abdomen. (b)(6); (b)(7)(C) instructed RN (b)(6); (b)(7)(C) transfer ARRIAGO to the emergency room via Emergency Medical Services (EMS) for further evaluation. NP (b)(6); (b)(7)(C) stated that although ARRIAGO appeared stable, she opted in favor of an ambulance versus a facility vehicle because she was unsure of the source of his abdominal pain and believed it was necessary for ARRIAGO to be under medical supervision during the transport.<sup>78</sup>

At 1:40 p.m., an unknown control officer documented that EMS was called per Captain (b)(6); (b)(7)(C) direction.<sup>79</sup> At 1:51 p.m., EMS responders arrived at SDC.<sup>80</sup> At 1:59 p.m., they entered the triage

<sup>73</sup> During her interview with ERAU on August 28, 2019, R (b)(6); (b)(7)(C) stated she attempted to obtain a pain level but ARRIAGO would not provide a rating.

<sup>74</sup> Palpation is the process of an examiner using their hands to touch and feel the body to determine the size, consistency, location, and tenderness of an organ or body part.

<sup>75</sup> ERAU interview with (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>76</sup> See Medical Examination Corridor Video Surveillance, dated July 20, 2019.

<sup>77</sup> See Addendum Late Entry by N (b)(6); (b)(7)(C) dated July 20, 2019. Although not documented on the addendum, during her interview with ERAU on August 28, 2019, (b)(6); (b)(7)(C) stated she used interpretation assistance when she evaluated ARRIAGO.

<sup>78</sup> ERAU interview with (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>79</sup> See untitled and undated logbook, dated July 20, 2019.

<sup>80</sup> See Stewart County Fire and EMS Prehospital Care Report, dated July 20, 2019.

room, leaving their gurney in the hallway. At 2:01 p.m., ARRIAGO exited the triage room with EMS responders and sat on the gurney without assistance.<sup>81</sup> At 2:03 p.m., EMS responders departed the medical clinic with ARRIAGO and proceeded to the ambulance.

Captain (b)(6); (b)(7)(C) assigned Officers (b)(6); (b)(7)(C) to the hospital detail. Officer (b)(6); (b)(7)(C) accompanied ARRIAGO in the ambulance, and Officer (b)(6); (b)(7)(C) followed in the chase vehicle.<sup>82</sup> Officer (b)(6); (b)(7)(C) stated he applied hand and leg restraints but did not apply a belly chain for medical reasons.<sup>83</sup>

At 2:12 p.m., the ambulance departed the facility in non-emergency mode.<sup>84</sup> EMS responders documented that ARRIAGO was oriented and smiled; however, they were unable to communicate with him due to the language barrier. At 2:37 p.m., the ambulance arrived at SGRMC.

Attending physician (b)(6); (b)(7)(C) Doctor of Osteopathy, ordered multiple laboratory tests and a Computed Tomography (CT) scan<sup>85</sup> of ARRIAGO's abdomen and pelvis. The CT scan showed:<sup>86</sup>

- An enlarged heart, with small pericardial effusion<sup>87</sup> and compressive atelectasis.<sup>88</sup>
- An enlarged liver.
- Abnormal gallbladder, with significant wall thickening.
- A cyst in the right kidney.
- A small amount of ascites.<sup>89</sup>
- Collapse of various sections of the colon.

At 5:46 p.m., ARRIAGO was admitted to SGRMC.<sup>90</sup> (b)(6); (b)(7)(C) assessment findings included pain in the right lower quadrant of ARRIAGO's abdomen, cardiomegaly, nausea and vomiting, elevated liver enzymes, colon inflammation, and an enlarged liver.<sup>91</sup>

At 8:42 p.m., Officer (b)(6); (b)(7)(C) documented ARRIAGO was admitted to room 118. ERAU notes that Officer (b)(6); (b)(7)(C) did not document ARRIAGO's admission to the hospital or any events, to include restraints checks, that occurred between 5:55 p.m. to 7:21 p.m.<sup>92</sup>

At 11:11 p.m., Officers (b)(6); (b)(7)(C) assumed hospital duty.<sup>93</sup>

<sup>81</sup> See Medical Examination Corridor Video Surveillance, dated July 20, 2019.

<sup>82</sup> See ICE Incident Notification Form, dated July 20, 2019.

<sup>83</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>84</sup> See Stewart County Fire and EMS Prehospital Care Report, dated July 20, 2019.

<sup>85</sup> A CT scan is an X-ray image taken from different angles, followed by computer processing to create cross-sectional images (slices).

<sup>86</sup> See CT Scan Report, dated July 20, 2019.

<sup>87</sup> A pericardial effusion is excess of fluid between the heart and the sac surrounding the heart, known as pericardium.

<sup>88</sup> Compressive atelectasis, also known as a collapsed lung, refers to external pressure on the lung that drives air out.

<sup>89</sup> Ascites is abdominal swelling caused by the accumulation of fluid and is most often related to liver disease.

<sup>90</sup> See SGRMC Patient Record, fax date July 23, 2019.

<sup>91</sup> See SGRMC History and Physical, dated July 20, 2019.

<sup>92</sup> See Hospital Logbook, dated July 20, 2019; see also, CoreCivic Post Order, COR-PO-19, Off-Site Hospital Officer.

<sup>93</sup> See Hospital Logbook and Daily Shift Roster, both dated July 20, 2019.



## July 21, 2019

Between 12:00 a.m. to 2:00 a.m. and 4:00 a.m. to 7:00 a.m., Officer (b)(6); (b)(7)(C) documented restraint checks every 30 minutes rather than every 15 minutes.<sup>94</sup>

At 7:30 a.m., Officers (b)(6); (b)(7)(C) (first names unknown) assumed hospital duty.<sup>95</sup>

At 12:27 p.m., after consulting with (b)(6); (b)(7)(C) at Piedmont Columbus Regional Midtown Hospital (PCRMH) in Columbus, GA, concerning ARRIAGO's medical diagnoses (b)(6); (b)(7)(C) discharged ARRIAGO and transferred care to (b)(6); (b)(7)(C).<sup>96</sup> On the discharge summary, (b)(6); (b)(7)(C) documented that although intravenous antibiotics were administered, ARRIAGO's white blood cell count had increased.<sup>97</sup>

At 1:22 p.m., EMS responders arrived at SGRMC and departed at 1:38 p.m.<sup>98</sup> At 2:46 p.m., EMS responders arrived at PCRMH. At 3:05 p.m., ARRIAGO was admitted to the PCRMH Intensive Care Unit (ICU).

At 7:19 p.m., Officers (b)(6); (b)(7)(C) (first names unknown) assumed hospital duty.<sup>99</sup>

## July 22, 2019

At 3:53 a.m., Officer (b)(6); (b)(7)(C) documented that a code blue was called.<sup>100</sup> Medical staff administered three rounds of epinephrine, shocked ARRIAGO with the automated external defibrillator (AED),<sup>101</sup> and detected a pulse.<sup>102</sup> Medical staff then intubated ARRIAGO and placed him on a ventilator.

At 4:14 a.m., Officer (b)(6); (b)(7)(C) documented that ARRIAGO's restraints were removed for nurses and re-applied at 4:54 a.m.; however, he did not document supervisory approval or the reason the nurses requested the restraints be removed.<sup>103</sup>

At 12:46 p.m.,<sup>104</sup> (b)(6); (b)(7)(C) visited ARRIAGO at PCRMH; hospital staff informed her that he suffered a cardiac arrest earlier that morning.<sup>105</sup> ARRIAGO was unresponsive and, according to the ICU attending physician, his prognosis was grave as he was in multi-organ system failure<sup>106</sup> with severe dilated cardiomyopathy.<sup>107</sup>

<sup>94</sup> See CoreCivic Post Order, COR-PO-19, Off-Site Hospital Officer.

<sup>95</sup> See Hospital Logbook, dated July 21, 2019.

<sup>96</sup> See SGRMC Discharge Summary, dated July 21, 2019.

<sup>97</sup> An increase in the white blood cell count indicates an infection.

<sup>98</sup> See Grady EMS report, dated July 21, 2019.

<sup>99</sup> See Hospital Logbook, dated July 21, 2019.

<sup>100</sup> See Hospital Logbook, dated July 22, 2019.

<sup>101</sup> An AED is a portable device that delivers an electric shock through the chest to the heart.

<sup>102</sup> See SDC RN (b)(6); (b)(7)(C) e-mail: "Detainee Coded," dated July 22, 2019.

<sup>103</sup> See Hospital Logbook, dated July 22, 2019.

<sup>104</sup> *Id.*

<sup>105</sup> See Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>106</sup> Multi-organ system failure refers to the loss of function of at least two organs.

<sup>107</sup> Dilated cardiomyopathy is a condition in which the heart's ability to pump blood has decreased because the heart's main pumping chamber, the left ventricle, is enlarged and weakened.

At 7:22 p.m., Officer (b)(6); (b)(7)(C) (first names unknown) assumed hospital duty.<sup>108</sup>

At an unknown time, ERO Atlanta notified the Consulate General of Mexico in Atlanta, GA, of ARRIAGO's condition and requested assistance in locating his next of kin.<sup>109</sup>

### July 23, 2019

At an unknown time, the ICU attending physician reported to (b)(6); (b)(7)(C) that ARRIAGO's condition had not changed, and he was in a state of disseminated intravascular coagulation.<sup>110</sup>

At 1:15 a.m., Officer (b)(6); (b)(7)(C) documented that ARRIAGO's restraints were removed so nurses could turn and bathe him.<sup>111</sup> Officer (b)(6); (b)(7)(C) did not document supervisory approval to remove the restraints.

At 2:04 a.m., Officer (b)(6); (b)(7)(C) documented that the nurse had finished bathing ARRIAGO and a hand restraint was re-applied.<sup>112</sup> At 2:30 a.m., Captain (b)(6); (b)(7)(C) authorized leaving off the leg restraints.

At 7:42 a.m., Officer (b)(6); (b)(7)(C) assumed hospital duty and documented there were no restraints on ARRIAGO and that restraints remained off throughout the shift. Likewise, at approximately 7:30 p.m., Officer (b)(6); (b)(7)(C) assumed hospital duty and documented that ARRIAGO had no restraints during that shift.<sup>113</sup>

### July 24, 2019 – Day of Death

At 7:40 a.m., Officer (b)(6); (b)(7)(C) documented she assumed hospital duty with Officer (b)(6); (b)(7)(C). At 7:45 a.m., Officer (b)(6); (b)(7)(C) documented a restraint check and indicated that ARRIAGO was in a left arm restraint when she assumed the post.<sup>115</sup>

At 2:28 p.m., the ICU attending physician reported to (b)(6); (b)(7)(C) that ARRIAGO's condition had worsened and that he had an infection in the heart valve, dilated cardiomyopathy, no pulse in his legs, and was in multi-organ system failure.<sup>116</sup> PCRMH had put ARRIAGO on four medications

<sup>108</sup> See Hospital Logbook, dated July 22, 2019.

<sup>109</sup> See ERO Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) e-mail: "FW: Next of kin for Pedro ARRIAGO-Santoya, A216 428 457," dated August 1, 2019.

<sup>110</sup> DIC is a condition in which small blood clots develop throughout the blood stream, blocking blood vessels. The increased blood clots deplete the platelets and clotting factors needed to control bleeding, causing excessive bleeding. See Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>111</sup> See Hospital Logbook, dated July 23, 2019.

<sup>112</sup> *Id.*

<sup>113</sup> As previously noted, Officer (b)(6); (b)(7)(C) received authorization to remove leg restraints, but a hand restraint remained in place. It is unclear whether by documenting that no restraints were applied during their shifts, Officers (b)(6); (b)(7)(C) and Ogden were referring to leg restraints and that ARRIAGO was, in fact, in a hand restraint. As noted in the next shift, upon assuming the post, the relief officer stated ARRIAGO was in a left arm restraint. See Hospital Logbook, dated July 23, 2019.

<sup>114</sup> See Hospital Logbook, dated July 24, 2019.

<sup>115</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated August 28, 2019.

<sup>116</sup> See Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019.



to maintain his blood pressure, and he remained intubated and on a ventilator. Consultations with vascular surgery, infectious disease, and cardiology were pending. ARRIAGO's prognosis remained grave, and he was not expected to survive.<sup>117</sup>

At 2:40 p.m., Officer Johnson documented that a code blue was called; however, no further entries were documented after the code blue.<sup>118</sup> At 3:27 p.m.,<sup>119</sup> the ICU attending physician notified Dr. (b)(6); (b)(7)(C) that ARRIAGO had multiple cardiac arrests beginning at 2:40 p.m. and that he was pronounced dead at 3:10 p.m.<sup>120</sup>

In the Discharge Summary, (b)(6); (b)(7)(C) a PCRMH Intensivist,<sup>121</sup> documented<sup>122</sup> the following:

- ARRIAGO was suspected of having acute cholecystitis<sup>123</sup> and cardiomegaly, consistent with a cardiomyopathy.
- ARRIAGO had a history of alcohol abuse.
- ARRIAGO's liver enzymes and bilirubin<sup>124</sup> levels had increased.
- ARRIAGO was in multi-organ system failure. EKG results detailed findings consistent with anterolateral myocardial infarction.<sup>125</sup>

At 3:47 p.m., (b)(6); (b)(7)(C) informed ERO Atlanta and Warden (b)(6); (b)(7)(C) of ARRIAGO's death, first via telephone and then via e-mail.<sup>126</sup> ERO Atlanta notified the Consulate General of Mexico of ARRIAGO's death.<sup>127</sup>

At approximately 5:10 p.m., PCRMH staff notified the Muscogee County Coroner and the Columbus Police Department of ARRIAGO's death.<sup>128</sup>

### Post-Death Actions

On July 25, 2019, SDC Shift Supervisor (b)(6); (b)(7)(C) notified ERO that ARRIAGO's next of kin had not been identified for notification purposes.<sup>129</sup>

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<sup>117</sup> *Id.*

<sup>118</sup> See Hospital Logbook, dated July 24, 2019.

<sup>119</sup> See Clinic Note by (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>120</sup> See (b)(6); (b)(7)(C) e-mail: "RE: A#216428457," dated July 24, 2019.

<sup>121</sup> An intensivist is a physician who specializes in the care of critically ill patients, most often in the ICU.

<sup>122</sup> See PCRMH Discharge Summary, dated July 24, 2019.

<sup>123</sup> Acute cholecystitis is inflammation of the gallbladder.

<sup>124</sup> (b)(6); (b)(7)(C) is an orange-yellow compound that occurs when red blood cells break down. The liver takes the bilirubin from the blood and chemically changes it so it can pass through feces as bile.

<sup>125</sup> Anterolateral myocardial infarction refers to a heart attack due to insufficient blood supply to the inner wall of the heart.

<sup>126</sup> See Clinic Note by (b)(6); (b)(7)(C); see also (b)(6); (b)(7)(C) e-mail: "RE: A#216428457," dated July 24, 2019.

<sup>127</sup> See ICE Significant Incident Report, dated July 25, 2019.

<sup>128</sup> *Id.*

<sup>129</sup> See Shift Supervisor (b)(6); (b)(7)(C) e-mail: "7-24-19 COTR Detainee Death by Apparent Natural Causes," dated July 25, 2019.

On July 31, 2019, Officer A (b)(6); (b)(7)(C) released ARRIAGO's personal property to Captain (b)(6); (b)(7)(C) who then released it to Deportation Officer (DO) (b)(6); (b)(7)(C).

On August 2, 2019, SDDO (b)(6); (b)(7)(C) took custody of ARRIAGO's property.<sup>131</sup> The Mexican Consulate declined to accept the property when offered by ERO because they were unable to confirm ARRIAGO was a Mexican citizen.<sup>132</sup> ERO then returned the property to SDC to be held in storage in the event the Mexican Consulate verified ARRIAGO's citizenship.

On August 6, 2019, SDDO (b)(6); (b)(7)(C) e-mailed Deputy Field Office Director (DFOD) (b)(6); (b)(7)(C) informing him that DOs from ERO (b)(6); (b)(7)(C) had visited ARRIAGO's last known residence in an attempt to obtain information from former neighbors about his next of kin but were unsuccessful.<sup>133</sup>

On November 6, 2019, the State of Georgia Associate Medical Examiner (b)(6); (b)(7)(C) documented ARRIAGO's cause of death as valvular heart disease with cardiomegaly and hepatic cirrhosis, and the manner of death as natural.<sup>134</sup>

On January 28, 2020, the Georgia Department of Public Health issued ARRIAGO's death certificate and documented his cause of death as valvular heart disease with cardiomegaly and hepatic cirrhosis.<sup>135</sup>

## **FINDINGS**

ERAU reviewed the medical care SDC provided ARRIAGO, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found SDC failed to comply with 7 of the requirements of the ICE PBNDS 2011. Additionally, ERAU has included other areas of concern that are not covered by the PBNDS 2011. 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. **Admission and Release, Section (II)(9):** "The facility shall provide communication assistance to detainees with disabilities and detainees who are limited in their English Language Proficiency (LEP)... The facility will also provide detainees who are LEP with language assistance, including bilingual staff or professional interpretation and translations services, to provide them with meaningful access to its programs and activities."

(b)(5)

<sup>130</sup> See Chain of Custody form, dated July 24, 2019.

<sup>131</sup> See DO (b)(6); (b)(7)(C) e-mail: "RE: Information Request: OPR Detainee Death Review of Perez [sic] ARRIAGO-Santoya #A216 428 457," dated August 2, 2019.

<sup>132</sup> See Officer in Charge (b)(6); (b)(7)(C) e-mail: "RE: Personal Property for PEDRO ARRIAGO-SANTOYA (#A216 428 457)," dated August 28, 2019.

<sup>133</sup> See SDDO Eccles e-mail: "FW: Next of kin for Pedro ARRIAGO-Santoya, A216 428 457," dated August 6, 2019.

<sup>134</sup> See Exhibit 2: State of Georgia, Autopsy Official Report, dated November 6, 2019.

<sup>135</sup> See Exhibit 3: Georgia Department of Public Health, Georgia Death Certificate, State File Number: 2019GA000085460, signed January 28, 2020.



2. **Custody Classification System, Section (V)(C):** “Classification staff shall utilize translation services when necessary.”

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

3. **Facility Security and Control, Section (V)(A):** “Each facility shall ensure that it maintains sufficient supervision of detainees, including through appropriate staffing levels and, where applicable, video monitoring, to protect detainees against sexual abuse assault, other forms of violence or harassment to prevent significant self-harm and suicide.”

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

or the Shift Supervisor/Unit Manager.”

4. **Facility Security and Control, Section (V)(D)(1):** “As prescribed by standard “2.9 Post Orders,” staff shall observe, supervise and control movement of detainees from one area to another. No detainee may ever be given authority over, or be permitted to exert control over, another detainee.”

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

5. **Facility Security and Control, Section (V)(F):** “Frequent unannounced security inspections shall be conducted on day and night shifts to control the introduction of contraband; identify and deter sexual abuse of detainees; ensure facility safety, security and good order; prevent escapes; maintain sanitary standards; and eliminate fire and safety hazards ... Each officer who assumes a post assignment shall conduct a security check of the area, record the results in the post logbook, and prepare and submit maintenance work requests as necessary.”

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

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

6. **Medical Care, Section (V)(A)(2)(3):** “Every facility shall directly or contractually provide its detainee population with the following: ... 2) Medically necessary and appropriate medical, dental, and mental health care and pharmaceutical services; 3) Comprehensive, routine and preventive health care, as medically indicated.”

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

7. **Medical Care, Section (V)(R):** “An initial dental screening shall be performed within 14 days of the detainee’s arrival. The initial dental screening may be performed by a dentist or a properly trained qualified health provider.”

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

### **AREAS OF CONCERN**

Although not violations of the ICE PBNDS 2011, ERAU noted the following concerns regarding ARRIAGO’S medical care, safety, and security at SDC:

1. **CoreCivic Housing Unit Post Order, Section (III)(B)(1):** “Perform random pat searches of inmates/residents entering or exiting the unit.”

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



2. *CoreCivic Medical Post Order*, Section (III)(D): “Pat search all detainees as they enter and exit the infirmary.”

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

3. *CoreCivic Off-Site Hospital Officer Post Order*, Section (III)(E)(2): “When in a hospital bed, the inmate/resident will have two (2) appendages/extremities secured to the movable bed at all times. If the inmate/resident cannot be restrained to the bed with two (2) appendages/extremities immediately notify the Shift Supervisor. Any exception to this rule must be approved by the on-duty Shift Supervisor prior to the removal of mechanical restraints.”

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

4. *CoreCivic Off-Site Hospital Officer Post Order*, Section (III)(E)(7): “[Officers] are required to conduct restraint checks every fifteen (15) minutes and must log completion of the check in the post logbook.”

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

5. The officers present at the time of ARRIAGO’s death did not complete a logbook entry *contemporaneously* documenting pronouncement of death and the events that occurred thereafter, nor did they complete incident reports. *CoreCivic Off-site Hospital Officer Post Order* COR-PO-19 and Facility Policy 14-100, *Detainee Death Procedures*, are silent on expectations for officers following the death of a detainee, including submission of incident reports and completion of after-action reviews. While ARRIAGO’s transport to the hospital did not follow a medical emergency, for which an after-action review surrounding the emergency would have been appropriate, written reports by officers present at the hospital at the time of a detainee’s death supports accountability.

## **EXHIBITS**

1. ARRIAGO Detainee Death Review Health and Security Compliance Analysis, dated October 15, 2019.
2. State of Georgia, Autopsy Official Report, dated November 6, 2019.
3. Georgia Department of Public Health, Georgia Death Certificate, State File Number: 2019GA000085460, signed January 28, 2020.



# STATE OF LOUISIANA

## CERTIFICATION OF VITAL RECORD

### CERTIFICATION OF DEATH

BIRTH NUMBER:

STATE FILE NUMBER: 2019-039-00198

7302954

|                                                      |                                                                                                                                                                                                                                                                  |                          |                                                          |                           |                                      |
|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------|---------------------------|--------------------------------------|
| <b>DECEDENT</b>                                      | DECEDENT'S NAME - (LAST, FIRST, MIDDLE, SUFFIX)                                                                                                                                                                                                                  |                          | DATE OF BIRTH                                            | DATE OF DEATH             | TIME OF DEATH                        |
|                                                      | HERNANDEZ DIAZ, ROYLAN                                                                                                                                                                                                                                           |                          | 09/25/1976                                               | 10/15/2019                | 02:15 PM                             |
|                                                      | PLACE OF BIRTH - (CITY, STATE, COUNTRY)                                                                                                                                                                                                                          |                          | SEX                                                      | SOCIAL SECURITY NUMBER    | AGE                                  |
|                                                      | PINAR DEL RIO, CUBA                                                                                                                                                                                                                                              |                          | MALE                                                     | UNKNOWN                   | 43 YEARS                             |
| <b>PERSONAL</b>                                      | DECEDENT'S ALIAS NAME(S) - (LAST, FIRST, MIDDLE, SUFFIX):                                                                                                                                                                                                        |                          |                                                          |                           |                                      |
|                                                      | RESIDENCE OF DECEDENT - (STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTRY)                                                                                                                                                                                         |                          |                                                          | WITHIN CITY LIMITS?       | PARISH/COUNTY                        |
|                                                      | 180 PINE BAYOU CIR., RICHWOOD, LA 71202 UNITED STATES                                                                                                                                                                                                            |                          |                                                          | YES                       | OUACHITA                             |
|                                                      | EVER IN U.S. ARMED FORCES?                                                                                                                                                                                                                                       |                          | OCCUPATION                                               | INDUSTRY OF OCCUPATION    |                                      |
|                                                      | NO                                                                                                                                                                                                                                                               |                          | MAINTENANCE                                              | PROPERTY MANAGEMENT       |                                      |
|                                                      | MARITAL STATUS                                                                                                                                                                                                                                                   |                          | NAME OF SURVIVING SPOUSE - (LAST, FIRST, MIDDLE, SUFFIX) |                           |                                      |
|                                                      | NEVER MARRIED                                                                                                                                                                                                                                                    |                          |                                                          |                           |                                      |
|                                                      | FATHER/PARENT NAME - (LAST, FIRST, MIDDLE, SUFFIX)                                                                                                                                                                                                               |                          | FATHER/PARENT PLACE OF BIRTH - (CITY, STATE, COUNTRY)    |                           |                                      |
|                                                      | HERNANDEZ OLIVER, ROBERTO                                                                                                                                                                                                                                        |                          | PINAR DEL RIO, CUBA                                      |                           |                                      |
|                                                      | MOTHER/PARENT NAME - (LAST, FIRST, MIDDLE, SUFFIX)                                                                                                                                                                                                               |                          | MOTHER/PARENT PLACE OF BIRTH - (CITY, STATE, COUNTRY)    |                           |                                      |
| DIAZ ARTETA, XIOMARA                                 |                                                                                                                                                                                                                                                                  | PINAR DEL RIO, CUBA      |                                                          |                           |                                      |
| INFORMANT'S NAME - (LAST, FIRST, MIDDLE, SUFFIX)     |                                                                                                                                                                                                                                                                  | RELATIONSHIP TO DECEDENT | INFORMANT'S ADDRESS                                      |                           |                                      |
| GUTIERREZ BARROS, YARELIS                            |                                                                                                                                                                                                                                                                  | FIANCEE                  | 4905 PLANTATION DR., TAMPA, FL 33615 UNITED STATES       |                           |                                      |
| EDUCATION: HIGH SCHOOL GRADUATE, OR GED COMPLETED    |                                                                                                                                                                                                                                                                  |                          |                                                          |                           |                                      |
| OF HISPANIC ORIGIN?: YES, CUBAN                      |                                                                                                                                                                                                                                                                  |                          |                                                          |                           |                                      |
| RACE: OTHER (CUBAN)                                  |                                                                                                                                                                                                                                                                  |                          |                                                          |                           |                                      |
| <b>DEATH INFO</b>                                    | PLACE OF DEATH                                                                                                                                                                                                                                                   |                          |                                                          | FACILITY NAME             |                                      |
|                                                      | OTHER RICHWOOD CORRECTIONAL CENTER                                                                                                                                                                                                                               |                          |                                                          |                           |                                      |
|                                                      | FACILITY ADDRESS - (STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTRY)                                                                                                                                                                                              |                          |                                                          | PARISH/COUNTY             |                                      |
| 180 PINE BAYOU DR., RICHWOOD, LA 71202 UNITED STATES |                                                                                                                                                                                                                                                                  |                          | OUACHITA                                                 |                           |                                      |
| <b>DISPOSITION</b>                                   | METHOD OF DISPOSITION                                                                                                                                                                                                                                            |                          |                                                          | PLACE OF DISPOSITION      |                                      |
|                                                      | REMOVAL FROM STATE                                                                                                                                                                                                                                               |                          |                                                          | CUBA                      |                                      |
|                                                      | PLACE OF DISPOSITION - (CITY, STATE, COUNTRY)                                                                                                                                                                                                                    |                          |                                                          | DATE OF DISPOSITION       |                                      |
|                                                      | MIAMI, FL UNITED STATES                                                                                                                                                                                                                                          |                          |                                                          | 11/13/2019                |                                      |
| <b>FUNERAL FACILITY</b>                              | FUNERAL FACILITY NAME                                                                                                                                                                                                                                            |                          | ADDRESS OF FUNERAL FACILITY                              |                           |                                      |
|                                                      | MULHEARN FUNERAL HOME, INC. - MONROE                                                                                                                                                                                                                             |                          | 2308 STERLINGTON RD., MONROE, LA 71203 UNITED STATES     |                           |                                      |
|                                                      | NAME OF FUNERAL DIRECTOR (LAST, FIRST, MIDDLE, SUFFIX)                                                                                                                                                                                                           |                          | LICENSE NUMBER                                           | CORONER NOTIFIED?         |                                      |
|                                                      | ANTIS, GUS                                                                                                                                                                                                                                                       |                          | E2592                                                    | Y                         |                                      |
|                                                      | SIGNATURE OF FUNERAL DIRECTOR                                                                                                                                                                                                                                    |                          | DATE                                                     |                           |                                      |
|                                                      |                                                                                                                                                                                                                                                                  | 11/27/2019               |                                                          |                           |                                      |
| <b>MEDICAL INFO</b>                                  | MANNER OF DEATH                                                                                                                                                                                                                                                  |                          | SUICIDE                                                  |                           |                                      |
|                                                      | IF FEMALE?                                                                                                                                                                                                                                                       |                          | NOT APPLICABLE                                           |                           |                                      |
|                                                      | DID TOBACCO USAGE CONTRIBUTE TO DEATH?                                                                                                                                                                                                                           |                          | NO                                                       |                           |                                      |
| <b>CAUSE OF DEATH</b>                                | PART I. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. |                          |                                                          |                           | APPROXIMATE INTERVAL: Onset to Death |
|                                                      | IMMEDIATE CAUSE - (Final disease or condition resulting in death)                                                                                                                                                                                                |                          |                                                          |                           | a. HANGING                           |
|                                                      | Sequentially list conditions, if any, leading to the cause listed on line a.                                                                                                                                                                                     |                          |                                                          |                           | b.                                   |
|                                                      | Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST                                                                                                                                                                 |                          |                                                          |                           | c.                                   |
|                                                      |                                                                                                                                                                                                                                                                  |                          |                                                          |                           | d.                                   |
|                                                      | PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.                                                                                                                                     |                          |                                                          |                           |                                      |
|                                                      |                                                                                                                                                                                                                                                                  |                          |                                                          |                           |                                      |
|                                                      | WAS AN AUTOPSY PERFORMED?                                                                                                                                                                                                                                        |                          |                                                          |                           |                                      |
|                                                      | YES                                                                                                                                                                                                                                                              |                          |                                                          |                           |                                      |
|                                                      | FINDINGS USED IN DETERMINING CAUSE?                                                                                                                                                                                                                              |                          |                                                          |                           |                                      |
| YES                                                  |                                                                                                                                                                                                                                                                  |                          |                                                          |                           |                                      |
| <b>INJURY INFORMATION</b>                            | PLACE OF INJURY                                                                                                                                                                                                                                                  |                          | DATE OF INJURY                                           | TIME OF INJURY            | INJURY AT WORK                       |
|                                                      | JAIL                                                                                                                                                                                                                                                             |                          | 10/15/2019                                               | 99:59 PM                  | N                                    |
|                                                      | LOCATION OF INJURY - (STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTRY)                                                                                                                                                                                            |                          | PARISH/COUNTY                                            |                           |                                      |
|                                                      | 180 PINE BAYOU CIRCLE, MONROE, LA 71202 UNITED STATES                                                                                                                                                                                                            |                          | OUACHITA                                                 |                           |                                      |
|                                                      | DESCRIBE HOW INJURY OCCURRED                                                                                                                                                                                                                                     |                          |                                                          |                           |                                      |
|                                                      |                                                                                                                                                                                                                                                                  | HANGING                  |                                                          |                           |                                      |
| <b>CERTIFIER</b>                                     | I CERTIFY THIS 'CORONER CASE' BASED ON MY EXAMINATION OR INVESTIGATION AND, IN MY OPINION, DEATH OCCURRED AT THE TIME, DATE, AND PLACE, AND DUE TO THE CAUSE(S) AND MANNER STATED.                                                                               |                          |                                                          |                           |                                      |
|                                                      | SIGNATURE OF CERTIFIER:                                                                                                                                                                                                                                          |                          | DATE                                                     |                           | 11/28/2019                           |
|                                                      | CERTIFIER NAME - (LAST, FIRST, MIDDLE, SUFFIX)                                                                                                                                                                                                                   |                          | (b)(6)                                                   |                           |                                      |
|                                                      | CERTIFIER TITLE: CORONER                                                                                                                                                                                                                                         |                          |                                                          |                           |                                      |
|                                                      | CERTIFIER ADDRESS - (STREET ADDRESS, CITY, STATE, ZIP CODE, COUNTRY)                                                                                                                                                                                             |                          |                                                          |                           |                                      |
|                                                      | 103 MCMILLAN RD., WEST MONROE, LA 71291 UNITED STATES                                                                                                                                                                                                            |                          |                                                          |                           |                                      |
|                                                      | BURIAL TRANSIT PERMIT                                                                                                                                                                                                                                            | PARISH OF ISSUE          | DATE OF ISSUE                                            | DATE FILED WITH REGISTRAR |                                      |
|                                                      | 335101                                                                                                                                                                                                                                                           | ORLEANS                  | 11/07/2019                                               | 11/27/2019                |                                      |
| <b>REGISTRAR</b>                                     | SIGNATURE OF REGISTRAR                                                                                                                                                                                                                                           |                          |                                                          |                           |                                      |
|                                                      | DEVIN GEORGE *e-sign*                                                                                                                                                                                                                                            |                          |                                                          |                           |                                      |

ISSUED BY: Thompson, Kimberly R.

Issued On: 12/2/2019 4:40:00 PM



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I CERTIFY THAT THIS IS A TRUE AND CORRECT COPY OF A CERTIFICATE OR DOCUMENT REGISTERED WITH THE VITAL RECORDS REGISTRY OF THE STATE OF LOUISIANA, PURSUANT TO LSA - R.S.40:32, ET SEQ.

A REPRODUCTION OF THIS DOCUMENT IS VOID AND INVALID. DO NOT ACCEPT

*Devin George*  
DEVIN GEORGE  
STATE REGISTRAR

DHS-20-0638-C-000101



**DETAINEE DEATH REVIEW: Roylan HERNANDEZ-Diaz, A203637060**  
**Healthcare and Security Compliance Analysis**  
**Richwood Correctional Center**  
**Monroe, Louisiana**

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 Roylan HERNANDEZ-Diaz (HERNANDEZ) while in the custody of the Richwood Correctional Center in Monroe, Louisiana. A team consisting of ERAU team leader (b)(6); (b)(7)(C) Inspection and Compliance Specialist, (b)(6); (b)(7)(C) ERAU Acting Section Chief, and Creative Corrections contract personnel (b)(6); (b)(7)(C) Program Manager (b)(6); (b)(7)(C) Security Subject Matter Expert, and (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert conducted an on-site review on November 18-20, 2019. ERAU requested contractor participation to assess compliance with the ICE 2011 PBNDS governing healthcare and security operations.

Included in this report is a case synopsis, overview of the facility's healthcare services, detention summary, a narrative chronology of events, and conclusions. The information and findings herein are based on analysis of detainee HERNANDEZ's medical record and detention file, tour of pertinent areas of the facility, interviews of staff, and review of policies, video surveillance footage, and available incident related documentation.

## **SYNOPSIS**

Roylan HERNANDEZ-Diaz, 42 years old, entered ICE Enforcement and Removal Operations (ERO) custody on May 20, 2019. He was detained at the Tallahatchie County Correctional Facility, Tutwiler, MS, from May 23, 2019 until June 13, 2019 when transferred to the Richwood Correctional Center.

During his detention, HERNANDEZ was treated for irritable bowel syndrome, a condition he reported having for several years. Providers changed his medication regimen when he reported that they were ineffective, and twice ordered a bland diet. Nurses' documentation of medication administration was inconsistent, and the orders for a bland diet were not processed.

HERNANDEZ was twice placed in segregation for hunger strike monitoring after refusing multiple meals. On October 15, 2019 while on that status, HERNANDEZ was found by security staff hanging by a bed sheet from the top bunk. Staff last visually observed him more than two and a half hours earlier, and last spoke with him four hours earlier. Medical and additional security staff immediately responded to the emergency call for assistance, but command staff disallowed entry to cut HERNANDEZ down and initiate cardio pulmonary resuscitation because

HERNANDEZ appeared to be dead. They declared the cell a crime scene on the basis they could not be certain his death was by suicide. Emergency medical services responders found no vital signs or heart activity when they arrived in under 15 minutes, and local law enforcement and crime scene investigators arrived quickly thereafter. Responding law enforcement personnel contacted the coroner, who arrived, declared death, and cut HERNANDEZ down more than an hour after staff discovered HERNANDEZ hanging.

Autopsy and law enforcement reports are not available as of the date of this report.

## HEALTHCARE SERVICES

LaSalle Corrections, LLC staffs RCC's clinic 24 hours a day. (b)(6); (b)(7)(C) corporate Clinical Director and designated Clinical Director for RCC, informed ERAU that her time at the facility varies, but she is typically on site one to two times per week. She also stated that at the time HERNANDEZ's death, the company was in the process of making changes to the staffing plan to enhance administrative oversight and increase provider and nursing coverage. Specifically, LaSalle Corrections hired a Health Services Administrator (HSA) who coincidentally started on the day of the death, replacing the former Director of Nurses who also acted as HSA. In addition, LaSalle Corrections hired a full-time Advanced Practice Provider (APP) who will start in December, supplementing the coverage of four APPs who rotate between LaSalle Corrections facilities. The complement of licensed practical nurses (LPN) has been doubled, from four to eight. Other nursing positions include the Director of Nurses, a nurse manager, and five registered nurses (RN). The staffing plan includes a mental health specialist; however, the position was vacant during HERNANDEZ's detention. In the absence of an on-site mental health professional, RCC uses telemedicine for both psychiatric and routine mental health care. Other allocated positions include a part time dentist and two medical assistants.

ERAU confirmed the credentials of all healthcare professionals involved in the care of detainee HERNANDEZ were current and primary source verified; also, that healthcare and security personnel who responded to the emergency had current certification in cardio-pulmonary resuscitation, suicide prevention and intervention, and hunger strikes. According to Captain (b)(6); (b)(7)(C) who served as training coordinator as a collateral duty, the hunger strike training consisted of issuing RCC's policy and requiring staff to sign acknowledging receipt and understanding. (b)(6); (b)(7)(C) stated that following HERNANDEZ's death, she developed a user-friendly packet to guide nurses in expected actions.

RCC does not have an electronic medical record system. ERAU found its hard-copy system disorganized and set up in a way that made it difficult to chronologically track HERNANDEZ's care. Many signatures were illegible and name stamps were not used, challenging the ability of the reviewer to determine which healthcare professionals conducted encounters. In addition, according to one of the providers interviewed, locating medical files for patient encounters has



been problematic. (b)(6); (b)(7)(C) tated LaSalle Corrections plans to consider converting to an electronic system after the first of the year.

## DETENTION SUMMARY

HERNANDEZ was classified low custody during the term of his detention. Except when segregated for hunger strike monitoring, he was housed in general population. He had no disciplinary incidents and filed no grievances or requests related to general facility matters. His medical requests are described in this report.

HERNANDEZ had no social or attorney visits. He placed 96 calls, the last placed seven days before his suicide. All personal calls were in Spanish.

## NARRATIVE

### Tallahatchie County Correctional Facility (TCCF), Tutwiler, Mississippi

On May 24, 2019 at 3:13 a.m. (b)(6); (b)(7)(C) RN, conducted HERNANDEZ's medical and mental health intake screening with the assistance of a Spanish interpreter.<sup>1</sup> Vital signs were within normal limits, as follows: temperature 98.6, pulse 55, respirations 16, and blood pressure 106/67. He was five feet, six inches tall and weighed 171.8. HERNANDEZ reported colon problems and acid reflux<sup>2</sup>, and that he was taking dicyclomine<sup>3</sup> and Senokot<sup>4</sup>. HERNANDEZ stated he was careful about what he ate to avoid reflux, and that the medications were ineffective in resolving his discomfort. He reported pain at level eight in the lower abdomen and on both sides of his back<sup>5</sup> but refused to take the dicyclomine and Senokot because they did not help. He reported no history of tuberculosis (TB), and (b)(6); (b)(7)(C) observed no signs or symptoms of the disease.<sup>6</sup> She cleared HERNANDEZ for general population.

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<sup>1</sup> See Initial Intake Screening, dated May 24, 2019.

<sup>2</sup> Acid reflux, commonly referred to as heart burn, is a digestive disease in which stomach acid or bile flows into the esophagus and irritates the lining.

<sup>3</sup> Dicyclomine Hydrochloride is an antispasmodic drug used to treat spasms of the colon.

<sup>4</sup> Senokot is an over-the-counter laxative plus stool softener.

<sup>5</sup> The pain level is based on 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.

<sup>6</sup> See TB Intake/TB Annual Symptom Screening form, dated May 24, 2019. Based on available evidence, ERAU concludes nursing staff did not plant a purified protein derivative (PPD) skin test at the time of HERNANDEZ's intake.

**On May 29, 2019,** (b)(6); (b)(7)(C) Licensed Professional Counselor, completed a Comprehensive Mental Health Evaluation documenting all normal findings.<sup>7</sup> HERNANDEZ denied current thoughts of self-harm and the need for mental health services.

The same day, (b)(6); (b)(7)(C) nurse practitioner (NP), conducted HERNANDEZ's initial health appraisal.<sup>8</sup> He reported a diagnosis of irritable bowel syndrome (IBS)<sup>9</sup> for which he was prescribed dicyclomine and Senokot brought with him to TCCF. The NP ordered the medications and referred HERNANDEZ for chronic care follow-up.

**On June 12, 2019,** a chest X-ray found no infiltrates or masses, and no findings suggestive TB.<sup>10</sup> The report states the chest X-ray was completed because HERNANDEZ had a nonspecific reaction to a tuberculin skin test; however, the intake screening documentation does not note testing by way of purified protein derivative (PPD) skin test. A late entry by (b)(6); (b)(7)(C) RN, states (b)(6); (b)(7)(C) RN, planted a PPD; however, RN (b)(6); (b)(7)(C) does not provide the date or when the test was read.<sup>11</sup> The late entry references a computer outage from May 23 to 26, 2019, ostensibly to explain the missing PPD documentation.<sup>12</sup>

The same day (b)(6); (b)(7)(C) LPN, prepared a Prisoner in Transit Medical Summary noting HERNANDEZ had IBS and listing his medications; also, that the June 12, 2019 chest X-ray was negative for TB.<sup>13</sup>

### **Richwood Correctional Center (RCC), Monroe, Louisiana**

**On June 13, 2019,** ERO transferred HERNANDEZ from TCCF to RCC.<sup>14</sup> Admission documentation reflects the following:

- Deputy (b)(6); (b)(7)(C) classified HERNANDEZ low custody using a Spanish interpreter.<sup>15</sup> Sergeant (b)(6); (b)(7)(C) approved the rating the same day. HERNANDEZ consented to

<sup>7</sup> See Comprehensive Mental Health Evaluation, dated May 29, 2019.

<sup>8</sup> See Inmate/Resident Health Appraisal, dated May 29, 2019.

<sup>9</sup> Irritable bowel syndrome (IBS), also referred to as spastic colon, is a common intestinal disorder causing belly pain, gas, diarrhea, and constipation.

<sup>10</sup> See Radiology Interpretation report dated June 12, 2019. The document was in the RCC medical record, but not in the record provided by TCCF.

<sup>11</sup> See PPD Administered, undated, electronically signed on June 15, 2019.

<sup>12</sup> ERAU did not visit TCCF and therefore, was unable to obtain clarification of HERNANDEZ's TB testing.

<sup>13</sup> See Prisoner in Transit Medical Summary, dated June 12, 2019. The transfer summary was in the RCC medical record, but not in the record provided by TCCF.

<sup>14</sup> See ICE Significant Incident Report (SIR), dated October 16, 2019. The time HERNANDEZ arrived at RCC is not documented in the SIR or in RCC security admission records.

<sup>15</sup> See ICE Custody Classification Worksheet, dated June 13, 2019. ERAU concludes the classification was correct based on the fact HERNANDEZ had no criminal history and had no known security threat group involvement.



use of an interpreter<sup>16</sup> and acknowledged he was notified of the classification by signing a Spanish language acknowledgment form.<sup>17</sup>

- A staff person determined that HERNANDEZ was not at risk for sexual abuse and did not pose a predatory risk.<sup>18</sup> The screening form does not document whether interpretation assistance was used. HERNANDEZ acknowledged receipt of the facility's Prison Rape Elimination Act zero tolerance policy by signing a Spanish language version acknowledgment form.<sup>19</sup>
- HERNANDEZ signed Spanish-language forms acknowledging receipt of handbooks and video orientation.<sup>20</sup>
- HERNANDEZ acknowledged receipt of information related to disposition of personal property.<sup>21</sup> He arrived with funds totaling \$19.58.<sup>22</sup> The RCC property officer was Deputy E (b)(6); (b)(7)(C) however, HERNANDEZ's detention records provided to ERAU do not include a property inventory and receipts for his property and funds, and do not include documentation of issuance of facility clothing, linens, and hygiene items.

At 11:07 a.m., (b)(6); (b)(7)(C) RN, noted HERNANDEZ was cleared for TB at the previous facility by way of chest X-ray.<sup>24</sup> At 2:05 p.m., (b)(6); (b)(7)(C) NP, completed the medical intake screening using telephonic interpretation assistance.<sup>25</sup> The findings were as follows:

- HERNANDEZ's vital signs were within normal limits, as follows: temperature 98.3 degrees, pulse 74, respirations 20, blood pressure 114/68, and pulse oxygen 98 percent. He weighed 172.5 pounds and was 169.5 inches tall.<sup>26</sup>
- HERNANDEZ replied yes when asked if he had any medical, mental, or dental problems needing immediate attention. He reported chronic IBS but denied a history of other physical illness, surgeries, dental problems, and serious infectious or communicable illness. HERNANDEZ reported daily intermittent pain at level two.
- HERNANDEZ was taking Bentyl<sup>27</sup> and Senakote for IBS.

<sup>16</sup> See Interpreter Consent form, dated June 13, 2019. The form does not document whether the interpreter was a staff person or a detainee.

<sup>17</sup> See Classification Acknowledgement, dated June 13, 2019.

<sup>18</sup> Screening for Risk of Sexual Victimization and Abusiveness, dated June 13, 2019. The signature of the person who completed the form is illegible.

<sup>19</sup> See PREA Zero Tolerance Acknowledgement for Detainees, dated June 13, 2019.

<sup>20</sup> See Reconocimiento de Detenido and ICE Handbook forms, dated June 13, 2019.

<sup>21</sup> See Reconocimiento de Detenido, dated June 13, 2019.

<sup>22</sup> See Detainee Funds report showing HERNANDEZ's account history.

<sup>23</sup> See Intake Booking form, Section A, dated June 13, 2019. The form does not document Deputy (b)(6); (b)(7)(C) first name.

<sup>24</sup> See TB Screening and Testing form, Section A, dated June 13, 2019.

<sup>25</sup> See TB Screening and Testing form, Sections B, C and D, dated June 13, 2019.

<sup>26</sup> The recorded height of 169.5 inches (more than 14 feet) is an apparent error. HERNANDEZ was five feet, six inches tall per the TCCF record.

<sup>27</sup> Bentyl is brand name dicyclomine.

- HERNANDEZ requested housing in general population.

(b)(6); (b)(7)(C) mental health screening findings were as follows:<sup>28</sup>

- HERNANDEZ reported no history of mental illness, no past or current thoughts of suicide, and no sexual assault prior to arrival.
- HERNANDEZ denied tobacco use or abuse of alcohol and other substances.
- HERNANDEZ admitted to having been a victim of physical abuse in Cuba. He declined referral to mental health.

(b)(6); (b)(7)(C) also completed a form on which he recorded findings of a physical examination.<sup>29</sup> He noted the following:

- HERNANDEZ was a new intake with reported IBS. His last colonoscopy was in 2018 while in Peru. He suffered lower abdominal pain daily on a chronic basis, especially in the left lower quadrant following meals. He reported some constipation.
- HERNANDEZ's current medications were Bentyl and Senakote.
- HERNANDEZ reported he had not taken his medications in several weeks due to a misunderstanding.<sup>30</sup>
- HERNANDEZ's vital signs were within normal limits as follows: temperature 98.3, pulse 74, respirations 20, and blood pressure 114/68. He weighed 172.5 pounds.
- HERNANDEZ's physical examination was normal.

(b)(6); (b)(7)(C) assessment conclusion was that HERNANDEZ had IBS. The plan was to continue the current medications, both of which were given during the encounter, and to follow up in three months. (b)(6); (b)(7)(C) ordered dicyclomine 20 milligram (mg) twice daily for six months, and Senokot 8.6 mg, two tablets every night for three months.<sup>31</sup> (b)(6); (b)(7)(C) noted the order and correctly transcribed them onto Medication Administration Records (MAR).<sup>32</sup> She also correctly recorded the medications on a Medication Order Form the next day; however, she documented (b)(6); (b)(7)(C) was the ordering provider.<sup>33</sup> Neither (b)(6); (b)(7)(C) signed the form.

<sup>28</sup> See Intake Summary, Mental Health dated June 13, 2019.

<sup>29</sup> The form is not titled and is undated. ERAU concludes (b)(6); (b)(7)(C) completed the examination following the intake screening because on the form, he noted HERNANDEZ was a new intake; also, because the vital signs and interpreter identification number were the same on both forms.

<sup>30</sup> NP (b)(6); (b)(7)(C) did not explain the nature of the misunderstanding.

<sup>31</sup> See Doctor's Order, dated June 13, 2019.

<sup>32</sup> See Doctor's Order, dated June 13, 2019 and June MAR.

<sup>33</sup> See Medication Order Form, dated June 14, 2019. RCC's Medication Order Form is an internal form that provides secondary documentation of provider orders. The orders themselves, which must be signed by the provider and noted by nurses, and MARs, onto which nurses must transcribe the orders, are primary documentation. ERAU addresses Medication Order Forms in this report because although not necessary, they are part of the medical record.



ERAU's review of MARs for dicyclomine and Senokot and subsequent medications found nurses did not clearly document administration. They often did not enter their initials, made checks or indistinguishable marks, circled the boxes, or left them blank, leaving unclear whether the medications were given, offered and refused, or not offered. In addition, two pages of the MARs do not show the month and year, and three remaining pages are labeled with the wrong month.

ERAU's analysis of the MARs for dicyclomine and Senokot finds the following<sup>34</sup>:

- Nurses did not account for doses of the medications scheduled for June 18 – 22, 2019.
- Nurses did not account for morning doses of dicyclomine scheduled for July 1-4, 2019, and evening doses scheduled for July 2, 6, and 7, 2019.
- Nurses did not account for Senokot doses on July 2, August 4, 13, 19, and 20, 2019.

HERNANDEZ signed Spanish language versions of consent for treatment and Authorization to Release Healthcare Information.<sup>35</sup>

Following completion of the intake process, security staff moved HERNANDEZ to general population unit C, upper bunk 88, in F building.<sup>36</sup>

**On June 14, 2019**, security staff moved HERNANDEZ was moved to general population housing unit 4, upper bunk 80, in B Hall.<sup>37</sup>

**On June 19, 2019**, HERNANDEZ submitted a sick call request complaining of IBS symptoms and stating the medications were not working.<sup>38</sup> The request was written in Spanish with English translation handwritten on the form. At 10:45 a.m., (b)(6); (b)(7)(C) RN, documented HERNANDEZ refused to be seen for sick call and refused to sign the form to acknowledge his refusal.<sup>39</sup> RN (b)(6); (b)(7)(C) did not document use of an interpreter, but stated to ERAU that nurses document interpretation assistance only when they use the telephonic service, not when a deputy interprets.<sup>40</sup> RN (b)(6); (b)(7)(C) concurred, stating there are designated deputies on every shift who provide interpretation assistance.<sup>41</sup>

During the encounter with RN (b)(6); (b)(7)(C) HERNANDEZ announced he was going to refuse to eat.<sup>42</sup> Announcement of refusal to eat may be considered declaration of hunger strike, which,

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<sup>34</sup> See MARs.

<sup>35</sup> See Consent form and Authorization to Release Healthcare Information form, dated June 13, 2019.

<sup>36</sup> See Activity Sheet, dated June 13, 2019.

<sup>37</sup> See Activity Sheet dated June 14, 2019. The record does not document the reason for the move.

<sup>38</sup> See Request for Sick Call, dated June 19, 2019.

<sup>39</sup> See Nurse's Note, dated June 19, 2019. See also, Request for Sick Call and Refusal Form, dated June 19, 2019.

RCC's refusal forms provide information in both English and Spanish.

<sup>40</sup> ERAU interview with RN (b)(6); (b)(7)(C) November 19, 2019.

<sup>41</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>42</sup> See Nurse's Note, dated June 19, 2019.

according to RCC policy HC 4.2, Hunger Strikes, requires certain actions including referral to mental health, notification of the HSA, and placement in a single-occupancy cell. N (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) ated to ERAU that in practice, when a detainee says he is not going to eat his consumption is monitored, but he is not necessarily moved to a cell for initiation of the hunger strike protocol.<sup>43</sup>

At approximately 7:10 p.m., Lieutenant (b)(6); (b)(7)(C) responded to HERNANDEZ's housing unit when notified he was refusing to eat and take his medication.<sup>44</sup> Lieutenant (b)(6); (b)(7)(C) noted HERNANDEZ had missed six consecutive meals and refused his medication on two consecutive days.<sup>45</sup> When questioned through an interpreter, HERNANDEZ stated he was trying to get the attention of ICE because they were ignoring him. When Lieutenant (b)(6); (b)(7)(C) advised him to submit an ICE form rather than refusing his food and medication, HERNANDEZ claimed no one was responding to his requests. Lieutenant (b)(6); (b)(7)(C) notified his immediate supervisor.

**On June 20, 2019** at 10:00 a.m. (b)(6); (b)(7)(C), RN, conducted a Physical/Health Assessment.<sup>46</sup> Except for a slightly elevated blood pressure of 129/74<sup>47</sup>, HERNANDEZ's vital signs were within normal limits as follows: temperature 97.2, pulse 79, and respirations 16. He weighed 173 pounds. In the Mental Health Evaluation section of the form, RN (b)(6); (b)(7)(C) noted HERNANDEZ reported he was physically assaulted in Cuba in 1994 and 2000. In the Physical Health Evaluation section, RN (b)(6); (b)(7)(C) noted all normal findings. HERNANDEZ had no complaints, and his health history consisted of foot surgery in 2008. RN (b)(6); (b)(7)(C) did not note IBS, current medications, HERNANDEZ's complaint the day before that the medications were ineffective, and that he was refusing to take them or accept meals. She stated to ERAU that she did not could not offer an explanation because she did not recall the assessment.<sup>48</sup> RN (b)(6); (b)(7)(C) concluded the assessment by instructing HERNANDEZ how to access medical care.<sup>49</sup>

(b)(6); (b)(7)(C) NP, reviewed the physical assessment approximately six weeks later, on August 6, 2019.

At 3:55 p.m. RN (b)(6); (b)(7)(C) documented HERNANDEZ was assigned to cell SM2 for hunger strike.<sup>50</sup> The cell is one of five used for medical observation and segregation purposes because

<sup>43</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>44</sup> See Unusual Occurrence Report, completed June 20, 2019 at 5:49 a.m.

<sup>45</sup> On the MARs for June 18 and 19, 2019, nurses did not clearly document HERNANDEZ refused medications. The nurse left the MAR blank for June 18, 2019 and circled June 19, 2019.

<sup>46</sup> See Physical/Health Assessment, date June 20, 2019. As noted, N (b)(6); (b)(7)(C) examined HERNANDEZ as part of intake screening, presumably because he reported chronic IBS. ERAU concludes the assessment conducted by RN (b)(6); (b)(7)(C) is scheduled and performed as the PBNDS-mandated 14-day health appraisal.

<sup>47</sup> AHA categorizes blood pressure of 129/74 as elevated but not hypertensive. Mildly elevated blood pressures can be the result of dehydration, stress, salty food intake, smoking, some medications, or activity prior to testing.

<sup>48</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>49</sup> See Physical/Health Assessment, date June 20, 2019.

<sup>50</sup> See Nurse's Notes entry, dated June 20, 2019.



RCC does not have a designated medical observation or special management unit.<sup>51</sup> RN (b)(6); (b)(7)(C) cleared HERNANDEZ for segregation without obtaining his vital signs, noting normal assessment findings except for limited range of motion in both upper and lower extremities, a disheveled appearance, listlessness, and a disorganized and illogical thought process.<sup>52</sup> She did not refer HERNANDEZ to mental health despite her observations. (b)(6); (b)(7)(C) also initiated an Administrative Segregation Order that was co-signed by (b)(6); (b)(7)(C) MD the next day.<sup>53</sup> Security records provided to ERAU do not include the Administrative Segregation Order, security supervisory sign-off, or documentation HERNANDEZ received a copy.

In none of her documentation did RN (b)(6); (b)(7)(C) provide an explanation for HERNANDEZ's placement in segregation for hunger strike, including when he stopped eating or that the day before, he stated he was going to refuse to eat. As noted, Lieutenant (b)(6); (b)(7)(C) documented HERNANDEZ refused six consecutive meals through June 19, 2019. Records provided to ERAU do not allow substantiation of this number, or how many additional meals he may have refused as of the time of his placement in segregation.

**On June 21, 2019**, nurses made the following sequential entries to the medical record:<sup>54</sup>

- At an undocumented time, RN (b)(6); (b)(7)(C) observed HERNANDEZ was up and alert upon entry. His pulse was normal at 98 and his blood pressure was elevated at 138/98.<sup>55</sup> HERNANDEZ drank two cups of juice and RN (b)(6); (b)(7)(C) provided him Ensure, a liquid nutritional supplement. She noted no signs of acute distress and documented plans to continue monitoring for signs and symptoms of dehydration.
- At 7:50 a.m. (b)(6); (b)(7)(C) LPN, observed HERNANDEZ was resting and alert. He had consumed eight ounces of Ensure and 16 ounces of juice at approximately 9:00 p.m. the previous night<sup>56</sup> and was observed using the toilet two times during the morning hours. His pulse was normal at 90 beats per minute and his blood pressure was 124/86<sup>57</sup>. His weight was 160.6 pounds.<sup>58</sup> He displayed no signs of distress and provided a urine sample.<sup>59</sup>

<sup>51</sup> ERAU tour, dated November 18, 2019.

<sup>52</sup> See Pre-Segregation Health Evaluation, dated June 20, 2019.

<sup>53</sup> See Administrative Segregation Order, dated June 20, 2019.

<sup>54</sup> See Nurse's Notes, dated June 21, 2019.

<sup>55</sup> According to the American Heart Association (AHA), blood pressure of 138/98 is within the parameters for Stage 1 hypertension.

<sup>56</sup> LPN (b)(6); (b)(7)(C) notation that HERNANDEZ drank Ensure and juice the previous night suggests that RN (b)(6); (b)(7)(C) preceding note was a late entry.

<sup>57</sup> According to the AHA, blood pressure of 124/86 is within the parameters for Stage 1 hypertension.

<sup>58</sup> The recorded weight of 160.6 pounds, 13 pounds less than recorded the day before, is an outlier compared to past and future weights taken. ERAU concludes LPN (b)(6); (b)(7)(C) may have made a typographical error.

<sup>59</sup> Results of a urinalysis were not included in the medical record. LPN (b)(6); (b)(7)(C) dated to ERAU on November 18, 2019 that she could not recall if the urine sample was sent for laboratory testing or if it was tested in-house by way of dipstick.

- At 9:00 a.m., LPN (b)(6); (b)(7)(C) observed HERNANDEZ was resting and consumed seven ounces of Ensure.<sup>60</sup>
- At 11:45 a.m., LPN (b)(6); (b)(7)(C) noted HERNANDEZ ate 25 to 30 percent of his lunch. She informed ERAU she personally observed the amount of the lunch meal consumed because nurses are responsible for looking at each tray.<sup>61</sup> When HERNANDEZ asked to go back to the dorm, LPN (b)(6); (b)(7)(C) instructed him to continue eating and drinking.
- At 12:10 p.m., LPN (b)(6); (b)(7)(C) spoke with (b)(6); (b)(7)(C) who approved HERNANDEZ's continuation in isolation over the weekend. LPN (b)(6); (b)(7)(C) explained by stating to ERAU that she shared her concern with (b)(6); (b)(7)(C) that HERNANDEZ might start refusing meals again.<sup>62</sup> Although her note states a verbal order was written, none was included in the medical record.

At 4:35 p.m. (b)(6); (b)(7)(C) ordered HERNANDEZ's release from segregation, noting he was not on hunger strike and was not suicidal.<sup>63</sup> She also ordered a bland diet with no spices and extra vegetables.<sup>64</sup> (b)(6); (b)(7)(C) did not document an encounter with HERNANDEZ, but informed ERAU she evaluated him in person before issuing her orders.<sup>65</sup> She also did not document use of interpretation assistance but stated she typically uses deputies. (b)(6); (b)(7)(C) recalled that HERNANDEZ told her he was refusing to eat not as a protest, but because he could not tolerate the food. For that reason, she discontinued hunger strike monitoring and ordered a bland diet. RCC did not provide evidence that the order was forwarded to Food Service or that HERNANDEZ received the special diet. (b)(6); (b)(7)(C) stated that at the time, orders were not always processed because high turnover among nursing staff often resulted left them unfulfilled. (b)(6); (b)(7)(C), Case Manager responsible for managing food service in September and October 2019, stated she discovered the former manager did not have a system for documenting receipt of special diet orders.<sup>66</sup> Based on available information, ERAU cannot determine which process failure, or both, resulted in HERNANDEZ not receiving a bland diet.

**On June 23, 2019** at 12:00 p.m., HERNANDEZ refused his medications by refusing to come to pill call.<sup>67</sup> (b)(6); (b)(7)(C) LPN (first name unknown), and RN (b)(6); (b)(7)(C) signed the refusal form, noting HERNANDEZ refused to sign acknowledgment. RN (b)(6); (b)(7)(C) explained that at the time, if a detainee did not report for pill call the nurse initiated a refusal form and the unit deputy

<sup>60</sup> See Nurse's Notes, dated June 21, 2019, at 9:00 a.m.

<sup>61</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 18, 2019. As noted below, security personnel initiated Meal Intake Logs at the time of HERNANDEZ's second placement in segregation for hunger strike monitoring on October 10, 2019. This is the only occasion a nurse documented the percentage of food items consumed.

<sup>62</sup> ERAU Interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>63</sup> See Doctor's Order, dated June 21, 2019. Security records provided to ERAU do not document HERNANDEZ's transfer from segregation and the general population housing unit to which he was assigned.

<sup>64</sup> *Id.* See also, Medical Diet Order dated June 21, 2019.

<sup>65</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>66</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>67</sup> See Refusal Form, dated June 23, 2019. As noted, MARs document nurses last gave HERNANDEZ his medications on June 17, 2019.



obtained the detainee's signature.<sup>68</sup> As described by (b)(6); (b)(7)(C) the process did not necessarily involve communication between the detainee and nurse, including inquiry into the reason for refusing the medication and counseling the detainee on the risks.

**On June 24, 2019** (b)(6); (b)(7)(C) examined HERNANDEZ.<sup>69</sup> He did not document the reason for the examination or use of interpretation assistance. (b)(6); (b)(7)(C) noted HERNANDEZ was isolated over the weekend for hunger strike but was now eating; also, that he wanted a diet change, complaining that the food was spicy and low fiber. HERNANDEZ's blood pressure was elevated at 160/85<sup>70</sup>; all other vital signs were within normal limits, as follows: temperature 97.6, pulse 69, respirations 16. Physical examination findings were normal except for hypoactive bowel sounds.<sup>71</sup> (b)(6); (b)(7)(C) assessed possible IBS, noting HERNANDEZ stated the condition was confirmed via colonoscopy<sup>72</sup> in Peru. The elements of the treatment plan and fulfillment thereof were as follows<sup>73</sup>:

- A bland diet. RCC did not provide evidence that this second order for a special diet was prepared and forwarded to Food Service, or that HERNANDEZ received a bland diet.
- Recheck HERNANDEZ's blood pressure in 30 minutes. There is no evidence a nurse rechecked his blood pressure.
- Psyllium Fiber Powder<sup>74</sup>, one scoop daily for three months (b)(6); (b)(7)(C) noted the order<sup>75</sup>, but she or another nurse did not complete a Medication Order Form and incorrectly transcribed it to the MAR by noting HERNANDEZ was to receive two scoops once daily.<sup>76</sup> For the remaining days of June, nurses made no entries on the MAR documenting whether doses were offered, refused or received; in July, nurses did not account for 13 of 31 doses; in August, nurses did not account for 20 of 31 doses; in September, nurses administered fiber only three times and HERNANDEZ refused a fourth offered dose. They did not account for doses after September 13, 2019.

**On June 30, 2019**, an LPN<sup>77</sup> administered the MMR vaccine to HERNANDEZ.<sup>78</sup>

<sup>68</sup> ERAU Interview with RN (b)(6); (b)(7)(C) on November 18, 2019.

<sup>69</sup> See untitled form, dated June 24, 2019.

<sup>70</sup> According to AHA, a blood pressure of 160/85 falls within the parameters for Stage two hypertension.

<sup>71</sup> Hypoactive bowel sounds indicate a reduction in intestinal activity and possible constipation.

<sup>72</sup> A colonoscopy is an examination used to detect changes or abnormalities in the large intestine (colon).

<sup>73</sup> See untitled form, dated June 24, 2019 and Doctor's Order entry, dated June 24 2019.

<sup>74</sup> Psyllium fiber powder is an over-the-counter dietary supplement made from the husk of the psyllium plant, used to reduce constipation. Fiber is typically ordered on an open-ended basis, with periodic review.

<sup>75</sup> See Doctor's Order, dated June 24, 2019.

<sup>76</sup> See Medication Administration Records (MAR).

<sup>77</sup> The LPN's signature is illegible.

<sup>78</sup> See Spanish version of MMR Consent, dated June 30, 2019. MMR is a vaccination which combines protection for the communicable diseases of measles, mumps, and rubella.

On July 5, 2019, RN (b)(6); (b)(7)(C) law HERNANDEZ for sick call pursuant to a request written in Spanish.<sup>79</sup> RN (b)(6); (b)(7)(C) wrote her encounter note on the sick call request rather than in a nursing following the SOAPE format.<sup>80</sup> HERNANDEZ's vital signs were all within normal limits, as follows: temperature 97.4, pulse 59, respirations 16 and blood pressure 111/83. He complained of pain in his stomach and in the lower left quadrant of his abdomen related to chronic colon issues. RN (b)(6); (b)(7)(C) did not obtain a pain level. HERNANDEZ stated he was taking fiber every morning and was having no problems with bowel movements; however, he did not believe the dicyclomine effectively addressed his abdominal discomfort, and stated he was experiencing side effects of dizziness and weakness. RN (b)(6); (b)(7)(C) referred him to a provider for medication management.<sup>81</sup>

At 5:13 p.m., (b)(6); (b)(7)(C) wrote orders to discontinue dicyclomine and to obtain three occult blood cards.<sup>82</sup> Asked if she conducted an in-person encounter with HERNANDEZ in connection with her order, (b)(6); (b)(7)(C) said it would be unusual for her to write orders without seeing a patient.<sup>83</sup> A nurse noted the orders<sup>84</sup> and transcribed them onto the MAR<sup>85</sup>; however, there is no corresponding Medication Order Form. According to the MAR, nurses administered dicyclomine for three days following (b)(6); (b)(7)(C) order to discontinue the medication.<sup>86</sup> Occult blood tests were not done for over a month when reordered by (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) informed ERAU that she was unaware the tests were not completed per her order.<sup>88</sup> She speculated a nurse may not have given HERNANDEZ the hemoccult cards; or, he did not return them and nurses did not follow up. She remarked that for privacy reasons, detainees are often uncomfortable obtaining fecal samples in a dormitory setting.

On July 12, 2019, HERNANDEZ submitted a request written in Spanish asking to see the nurse for an ingrown toenail on his great toe.<sup>89</sup>

On July 13, 2019 at 11:00 a.m., RN (b)(6); (b)(7)(C) law HERNANDEZ for sick call pursuant to his request.<sup>90</sup> As before, RN (b)(6); (b)(7)(C) wrote her encounter note on the sick call request rather than in a nursing note. HERNANDEZ stated the toenail was painful and he wanted it to be cut and

<sup>79</sup> See request form received July 5, 2019. The submission date is not shown.

<sup>80</sup> The SOAPE format is standard practice for documenting patient encounters. It requires recording subjective history (S), objective findings (O), nursing assessment (A), plan (P), and patient education (E).

<sup>81</sup> *Id.* See also, MD/NP Referral Slip, dated July 5, 2019.

<sup>82</sup> See Doctor's Order, dated July 5, 2019. Patients are given blood occult cards for placement of fecal samples for laboratory testing and detection of hidden blood, which might indicate colon cancer or polyps.

<sup>83</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>84</sup> See Doctor's Order, dated July 5, 2019.

<sup>85</sup> See MAR, July 2019.

<sup>86</sup> *Id.*

<sup>87</sup> See untitled form, dated August 8, 2019.

<sup>88</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>89</sup> See sick call request form, received July 13, 2019. The form does not show the date written or submitted.

<sup>90</sup> *Id.*



lifted to prevent infection. Vital signs within normal limits were as follows: temperature 97.0, pulse 63, and respirations 18. His blood pressure was elevated at 133/82<sup>91</sup>. (b)(6); (b)(7)(C) noted no redness, swelling, or signs of an ingrown toenail, nor did she see any visual signs of problems. She directed HERNANDEZ's return to the dorm with instructions to return for sick call if necessary. (b)(6); (b)(7)(C) stated to ERAU that HERNANDEZ was angry when she decided against removing the toenail.<sup>92</sup>

**On July 29, 2019**, HERNANDEZ submitted a request in Spanish asking to see the doctor for itchy skin.<sup>93</sup>

**On July 30, 2019**, RN (b)(6); (b)(7)(C) saw HERNANDEZ for sick call.<sup>94</sup> He documented the encounter on the sick call request but not in a nurse's note. HERNANDEZ's vital signs were within normal limits, as follows: temperature 97.4, pulse 62, respirations 18, and blood pressure 108/50. RN (b)(6); (b)(7)(C) observed no rash, bumps, fungal areas, or other symptoms of rash on his skin. He instructed HERNANDEZ to apply the lotion available in the housing unit every morning, every night and after showering and to return to the clinic if the condition worsened.

**On August 5, 2019**, HERNANDEZ submitted a request in Spanish complaining of a crisis in his colon and having much pain.<sup>95</sup>

**On August 6, 2019**, (b)(6); (b)(7)(C) RN, saw HERNANDEZ for sick call.<sup>96</sup> Consistent with the practice of other RNs, she documented the encounter on the sick call request but not in a nurse's note. HERNANDEZ reported he voluntarily stopped taking dicyclomine because of its side effects, but wanted to try another medication. Vital signs were within normal limits, as follows: temperature 96.3, pulse 64, blood pressure 120/77, and pulse oxygen 100 percent.<sup>97</sup> (b)(6); (b)(7)(C) submitted an ASAP (As Soon as Possible) Provider Referral Slip noting HERNANDEZ's complaint of abdominal pain at level seven and side effects including nausea, dizziness, and headaches.<sup>98</sup> Questioned why the referral was ASAP, RN (b)(6); (b)(7)(C) stated she used the only form available and that she meant for the referral to be routine.<sup>99</sup>

**On August 8, 2019** at 9:55 a.m., (b)(6); (b)(7)(C) assessed HERNANDEZ pursuant to RN (b)(6); (b)(7)(C) referral.<sup>100</sup> (b)(6); (b)(7)(C) provided interpretation assistance. (b)(6); (b)(7)(C) noted that dicyclomine was discontinued on July 5, 2019 and that HERNANDEZ did not return the

<sup>91</sup> According to the AHA, blood pressure of 133/82 falls within parameters for stage one hypertension.

<sup>92</sup> ERAU Interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>93</sup> See sick call request form, dated July 29, 2019.

<sup>94</sup> *Id.*

<sup>95</sup> See sick call request form, dated August 5, 2019.

<sup>96</sup> *Id.*

<sup>97</sup> (b)(6); (b)(7)(C) did not record respiration count.

<sup>98</sup> See ASAP Provider Referral Slip, dated August 6, 2019.

<sup>99</sup> ERAU interview with (b)(6); (b)(7)(C) November 19, 2019.

<sup>100</sup> See untitled form, dated August 8, 2019.

hemoccult cards ordered on that date. Vital signs were essentially within normal limits, as follows: temperature 96.8, pulse 77, respirations 18, blood pressure 123/78, and pulse oxygen 98 percent. (b)(6); (b)(7)(C) documented normal physical assessment findings, including assessment of the abdomen which she described as non-tender with active bowel sounds. She ordered hemoccult cards, confirmed by (b)(6); (b)(7)(C) as given with instructions, and HERNANDEZ's return for follow up and review of occult blood results in two weeks.<sup>101</sup> The cards were returned and tested within two days, with normal findings.<sup>102</sup>

**On August 26, 2019** at 8:50 a.m. (b)(6); (b)(7)(C) NP, conducted a follow up assessment related to HERNANDEZ's complaint of abdominal pain and history of reoccurring abdominal pain for years.<sup>103</sup> She used interpretation assistance. (b)(6); (b)(7)(C) noted HERNANDEZ reported that pain was stress-induced; also, that he experienced side effects of nausea and headaches when taking dicyclomine. He did not have those symptoms at the time, and denied weakness, fatigue, chest pain, shortness of breath, edema, or bloody stools. (b)(6); (b)(7)(C) findings were normal with the exception of abdominal bloating and pain in the left lower quadrant on palpation.<sup>104</sup> Her assessment conclusion was chronic IBS, and her plan was to discontinue Senna (Senokot), continue fiber, and attempt to get pinaverium bromide<sup>105</sup>, a medication HERNANDEZ reported was effective when previously taken in Peru. If unavailable, Levsin 0.125 mg, one tablet by mouth was to be administered twice daily for one month. (b)(6); (b)(7)(C) offered to refer HERNANDEZ to mental health, which he declined. Asked why she offered the referral, NP (b)(6); (b)(7)(C) stated that because stress can aggravate abdominal issues, she suggested seeing a mental health professional might help him manage his stress.<sup>106</sup> When HERNANDEZ refused the referral, she discussed stress relieving techniques, encouraged meditation compliance, and scheduled follow-up with a provider as needed.

(b)(6); (b)(7)(C) LPN, noted the orders written by (b)(6); (b)(7)(C) for discontinuation of Senna and for pinaverium or Levsin.<sup>107</sup> The orders do not address continuation of fiber, the initial order for which was for three months starting June 24, 2019. (b)(6); (b)(7)(C) added both pinaverium and Levsin to the MAR<sup>108</sup> and completed a Medication Order Form, dating it two days before the orders were given.<sup>109</sup> (b)(6); (b)(7)(C) did not sign the form.

<sup>101</sup> See Doctor's Order, dated August 8, 2019.

<sup>102</sup> See untitled form, dated August 8, 2019.

<sup>103</sup> See untitled form, dated August 26, 2019. Because the encounter was not precipitated by a sick call request, ERAU concludes it was the follow up ordered by (b)(6); (b)(7)(C) on August 8, 2019. (b)(6); (b)(7)(C) did not reference the results of the occult blood tests in her encounter note.

<sup>104</sup> Palpation is an examination method, using one's hands to press or feel areas of the patient's body to determine presence, size, shape, firmness, or location..

<sup>105</sup> Pinaverium bromide is a medication used to restore normal contractions of the bowel.

<sup>106</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>107</sup> See Doctor's Order, dated August 26, 2019.

<sup>108</sup> See MAR.

<sup>109</sup> See Medication Order form dated August 24, 2019.



The MAR documents the following:<sup>110</sup>

- Pinaverium was not available, but nurses documented administration of the medication on the morning and evening of August 30, 2019.
- Levsin, erroneously transcribed as 0.12 mg instead of 0.125 mg, was started four days after it was ordered, on August 30, 2019. Over the 30-day prescription period, nurses documented they gave HERNANDEZ 38 of 60 scheduled doses. He refused two and 20 were unaccounted for. He received two doses after the prescription for 30 days expired.

On **August 27, 2019**, security staff moved HERNANDEZ to general population unit C, upper bunk 49, in F building.<sup>111</sup>

On **September 4, 2019** at 1:15 p.m., (b)(6); (b)(7)(C) received a sick call request written in Spanish.<sup>112</sup> English translation is not documented although loosely translated, HERNANDEZ appears to have asked to see a psychologist for help with stress. (b)(6); (b)(7)(C) referred HERNANDEZ to mental health, noting he reported he had been unable to sleep and had increased levels of stress and anxiety since being housed in unit C.<sup>113</sup> HERNANDEZ refused a mental health appointment ten days later.<sup>114</sup> He signed a refusal form on which LPN (b)(6); (b)(7)(C) wrote that he did not want to be seen.<sup>115</sup>

**September 10, 2019**, an LPN (signature illegible) saw HERNANDEZ for sick call<sup>116</sup> pursuant to a request referencing colon issues.<sup>117</sup> On a nursing protocol form titled Constipation, the LPN noted the onset of constipation four days ago, and HERNANDEZ's last bowel movement was on September 6, 2019.<sup>118</sup> She recorded a normal pulse of 67 and normal respirations of 18, but did not record temperature and weight. For blood pressure, she noted only 129. HERNANDEZ's abdomen was soft and non-distended, and bowel sounds were present but sluggish in all four quadrants. The LPN referred him to the doctor, noting on the referral that in addition to constipation, HERNANDEZ complained of being taken off Senna.<sup>119</sup> He stated Senna was the one medication that worked for him, and asked for its resumption.

On **September 13, 2019**, at 2:41 p.m., (b)(6); (b)(7)(C) conducted an assessment to address HERNANDEZ's complaint of colon pain and to review his current medication.<sup>120</sup>

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<sup>110</sup> See MAR.

<sup>111</sup> See Activity Sheet dated August 27, 2019.

<sup>112</sup> See sick call request received September 4, 2019. The date of submission is not shown.

<sup>113</sup> See undated sick call request and Mental Health Referral Slip, dated September 4, 2019.

<sup>114</sup> See notation dated September 14, 2019 on Mental Health Referral Slip, dated September 4, 2019.

<sup>115</sup> See Medication Refusal form, dated September 14, 2019.

<sup>116</sup> See Nurse's Notes entry, dated September 10, 2019.

<sup>117</sup> See request form, undated, and Nurse's Notes, dated September 10, 2019.

<sup>118</sup> See Constipation protocol form, dated September 10, 2019.

<sup>119</sup> See Chronic Provider Referral Slip, undated, referencing complaint of gastrointestinal upset and constipation. NP

(b)(6); (b)(7)(C) discontinued Senna on August 26, 2019 when she started Levsin.

<sup>120</sup> See Doctor's Notes, dated September 13, 2019.

HERNANDEZ reported he disliked the fiber and stated that without Senokot, he developed constipation and pain in the right lower quadrant and right side of his back. His vital signs within normal limits were as follows: temperature 96.9, pulse 58, and pulse oxygen 97 percent.

A respiration count was not noted, and his blood pressure was elevated at 132/90<sup>121</sup>. Dr. (b)(6); (b)(7)(C) diagnosis was chronic constipation and abdominal pain. She ordered Senokot 8.6 mg, two tablets at nighttime for six months and discontinued pinaverium.<sup>122</sup>

(b)(6); (b)(7)(C) noted the orders at 2:50 p.m.<sup>123</sup> and completed a Medication Order Form.<sup>124</sup> Dr. (b)(6); (b)(7)(C) did not sign the form. The MAR shows the following related to Senokot:<sup>125</sup>

- HERNANDEZ received 18 of 18 doses scheduled for September.
- In October, nurses did not account for one dose scheduled for October 4, 2019, and administered no doses after October 8, 2019.

On **September 15, 2019**, security staff moved HERNANDEZ to bed 97, a lower bunk in the same unit.<sup>126</sup>

On **October 10, 2019** at 10:00 a.m., HERNANDEZ was placed in SM2 for hunger strike.<sup>127</sup> RN (b)(6); (b)(7)(C) completed a Pre-Segregation Health Evaluation, clearing him for segregation based on normal assessment findings.<sup>128</sup> In her nursing note, RN (b)(6); (b)(7)(C) described HERNANDEZ as fully oriented and demonstrating no signs or symptoms of distress, his respirations even and unlabored.<sup>129</sup> HERNANDEZ refused to be weighed or have his vital signs taken. RN (b)(6); (b)(7)(C) initiated and signed an Administrative Segregation Order documenting the reason for the assignment was medical observation. Lieutenant (b)(6); (b)(7)(C) signed the order as well, noting HERNANDEZ's placement was for threatening hunger strike.<sup>130</sup> Available security and medical documentation does not clarify when or to whom HERNANDEZ either threatened or declared a hunger strike, or whether he had missed meals. Absent documentation, ERAU cannot determine whether RN (b)(6); (b)(7)(C) should have initiated the hunger strike protocol, or whether HERNANDEZ was placed in segregation for monitoring of meal consumption before declaring a hunger strike or missing consecutive meals.

<sup>121</sup> According to the AHA, blood pressure of 132/90 falls within parameters of stage one hypertension.

<sup>122</sup> See Doctor's Order entry, dated September 13, 2019. As noted, pinaverium was not available. HERNANDEZ was given Levsin instead.

<sup>123</sup> *Id.*

<sup>124</sup> See Medication Order Form, order date September 13, 2019.

<sup>125</sup> See MAR.

<sup>126</sup> See Activity Sheet dated September 15, 2019.

<sup>127</sup> See Nurse's Note entry, dated October 10, 2019. The Activity Sheet, dated October 10, 2019, documents the actual time of placement was 12:21 p.m.

<sup>128</sup> See Pre-Segregation Health Evaluation, dated October 10, 2019.

<sup>129</sup> See Nurse's Note entry, dated October 10, 2019.

<sup>130</sup> Security records do not document whether HERNANDEZ was given a copy of the Administrative Segregation Order.



At 2:31 p.m., security staff moved HERNANDEZ to lockdown cell 3 (LD 3).<sup>131</sup> He remained in LD 3 through his death on October 15, 2019. LD 3 is one of the five cells on A Hall used for segregation and medical observation purposes. LD 3, like all segregation cells on the A Hall corridor, opens directly onto the high-traffic corridor. At the time of the incident, the cells had a heavy rubberized window flap covering the windows in the solid steel doors, obscuring visibility to passers-by.<sup>132</sup> LD 3 is a rectangular cell, with the door in the facing long walls and the short walls at either end.<sup>133</sup> The cell has a single security light that is left on around the clock, and a combination toilet/sink fixture in the corner to the left of the door. At the time of the incident, the bunk bed was positioned with the side along the right, short wall, and one end against the rear, long wall opposite the door.<sup>134</sup> Without opening the cell door, observation of the space between the other end of the bunk bed and adjoining wall required careful effort. As discussed below, HERNANDEZ's apparent suicide by hanging was discovered in this location.

Nurses did not conduct any rounds following HERNANDEZ's assignment to segregation for medical observation this date.<sup>135</sup> Deputies documented irregular 30-minute security checks and that HERNANDEZ refused his supper meal.<sup>136</sup> A deputy also initiated a Meal Intake Log, listing items on the supper meal tray and that HERNANDEZ consumed zero percent.<sup>137</sup> Meal Intake Logs are forms on which deputies record items on meal trays and percentage of items consumed. The form also provides instruction stating trays are not be removed before inspected by medical. RCC provided Meal Intake Logs starting with the October 10, 2019 supper meal through the lunch meal the day before HERNANDEZ's death, October 14, 2019.<sup>138</sup> Entries were incomplete and do not allow determination of whether the instruction for medical inspection of trays was followed by either deputies or nurses.

**On October 11, 2019**, nurses documented three rounds:<sup>139</sup>

- At 4:00 a.m., a nurse (signature illegible) observed HERNANDEZ was resting in bed and showed no signs or symptoms of distress.
- At 7:00 a.m., (b)(6); (b)(7)(C) documented HERNANDEZ was fully oriented, was not in apparent distress, and voiced no complaints or sick call needs. HERNANDEZ refused to have his vital signs taken.
- At 9:20 p.m., (b)(6); (b)(7)(C) documented HERNANDEZ did not eat any of his dinner, denied needs, and was not in distress.

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<sup>131</sup> See Activity Sheet dated October 10, 2019.

<sup>132</sup> Following HERNANDEZ's death, RCC removed the flaps. None were present at the time of ERAU's visit.

<sup>133</sup> ERAU tour, November 18, 2019.

<sup>134</sup> Following HERNANDEZ's death, RCC moved the bunk bed to the rear wall of the cell, opposite the door, for better visibility.

<sup>135</sup> The materials provided by RCC did not include the policy addressing nursing requirements for detainees placed on medical observation, including frequency and expectations during rounds.

<sup>136</sup> See I-888, dated October 10, 2019.

<sup>137</sup> See Meal Intake Log, Supper, dated October 10 – 13, 2019.

<sup>138</sup> See Meal Intake Logs, Breakfast, Lunch and Supper, dated October 10-14, 2019.

<sup>139</sup> See Nurse's Notes, dated October 11, 2019.

Deputies documented irregular 30-minute security checks.<sup>140</sup> HERNANDEZ refused his breakfast and lunch meal but accepted supper. The officer did not record on the Meal Intake Log whether HERNANDEZ consumed any items on the supper tray.<sup>141</sup>

**On October 12, 2019,** nurses documented two rounds:<sup>142</sup>

- At 10:50 a.m., (b)(6); (b)(7)(C) noted HERNANDEZ had no complaints or requests. At 12:30 p.m. RN (b)(6); (b)(7)(C) checked Main Control records and the segregation chart, documenting HERNANDEZ ate supper the previous night and breakfast on this date.<sup>143</sup>
- At 8:30 p.m., (b)(6); (b)(7)(C) noted HERNANDEZ had no complaints.

Deputies documented irregular 30-minute security checks. HERNANDEZ accepted his breakfast tray and refused the lunch and supper meals.<sup>144</sup> The officer recorded on the Meal Intake Log that HERNANDEZ consumed nothing from the breakfast tray.<sup>145</sup>

**On October 13, 2019,** nurses documented two rounds:<sup>146</sup>

- At 9:05 a.m., RN (b)(6); (b)(7)(C) noted HERNANDEZ was resting and displayed no signs or symptoms of distress. He responded when addressed but refused to talk.
- At 11:05 p.m. RN (b)(6); (b)(7)(C) noted HERNANDEZ had refused lunch and supper on the previous day and all three meals on this date. He was resting and calm, with even and unlabored respirations, and he voiced no needs or concerns.

Deputies documented irregular 30-minute security checks. HERNANDEZ accepted the breakfast tray, and refused the lunch and supper meal.<sup>147</sup> On the Meal Intake Log, the deputy documented HERNANDEZ consumed nothing from the breakfast tray.<sup>148</sup>

**On October 14, 2019,** deputies documented irregular 30-minute security checks and that HERNANDEZ accepted the breakfast tray and refused the lunch and supper meal.<sup>149</sup> The deputy did not record the percentage of the breakfast meal consumed.<sup>150</sup>

<sup>140</sup> See I-888, dated October 11, 2019.

<sup>141</sup> See Meal Intake Log, Supper, dated October 10 – 13, 2019.

<sup>142</sup> See Nurse's Note, dated October 12, 2019

<sup>143</sup> RN (b)(6); (b)(7)(C) record of meals consumed is not consistent with security records or RN (b)(6); (b)(7)(C) 9:20 p.m. note the night before. HERNANDEZ accepted the dinner tray on October 11, 2019 and breakfast tray on October 12, 2019; however, RN (b)(6); (b)(7)(C) documented he did not consume any items from the former and a deputy documented he did not consume any items from the latter.

<sup>144</sup> See I-888, dated October 12, 2019.

<sup>145</sup> See Meal Intake Log, Breakfast, dated October 10 – 13, 2019.

<sup>146</sup> See Nurse's Note, dated October 12, 2019

<sup>147</sup> See I-888, dated October 13, 2019 and Meal Intake Logs, dated October 10 – 13, 2019.

<sup>148</sup> See Meal Intake Log, Breakfast, dated October 10 – 13, 2019.

<sup>149</sup> See I-888, dated October 14, 2019.

<sup>150</sup> See Meal Intake Log, Breakfast, dated October 10 – 13, 2019.



In the only nursing encounter this date, RN (b)(6); (b)(7)(C) saw HERNANDEZ at 8:00 a.m.<sup>151</sup> He was fully oriented and did not display any signs or symptoms of acute distress, but refused to have his vital signs taken and refused to sign a consent form. The consent form, which is specific to treatment while on hunger strike and lists the possible sequence of symptoms, is in English.<sup>152</sup> (b)(6); (b)(7)(C) so completed a form specifying that the vital signs HERNANDEZ refused were the initial set after missing a ninth meal.<sup>153</sup> She provided a pitcher or bottle of water and educated HERNANDEZ on the risks and possible symptoms of hunger strike, encouraged him to consume approximately two liters of water daily, and explained he would be given three meals a day and a daily supply of water. (b)(6); (b)(7)(C) did not document whether she provided the information to HERNANDEZ with interpretation assistance. In addition, she did not contact a provider to receive orders after she initiated the hunger strike protocol and did not submit a referral to mental health. There was no record of meal consumption by

**On October 15, 2019** at 12:00 p.m., LPN (b)(6); (b)(7)(C) entered a nurse's note documenting HERNANDEZ missed breakfast and lunch, making it the tenth meal missed.<sup>154</sup> She noted that per RN (b)(6); (b)(7)(C), he refused vital signs, a shower, and labs. RN (b)(6); (b)(7)(C) stated to ERAU that she did not conduct an encounter with HERNANDEZ on this date and that no nurse made a round to attempt taking his vital signs or weight.<sup>155</sup> LPN (b)(6); (b)(7)(C) notation that HERNANDEZ refused vital signs, shower and labs presumably relates RN (b)(6); (b)(7)(C) encounter with him at 8:00 a.m. the day before when she initiated the hunger strike protocol. As noted, RN (b)(6); (b)(7)(C) documented he refused vital signs, but she did not document that he refused a shower or labs.<sup>156</sup>

At 12:22 p.m., LPN (b)(6); (b)(7)(C) notified ERO via e-mail that HERNANDEZ was on hunger strike.<sup>157</sup> SDDO (b)(6); (b)(7)(C) acknowledged receiving notification of the hunger strike, commenting that there was confusion as to when HERNANDEZ missed his last meal.<sup>158</sup> He asked Deportation Deputy (DO) (b)(6); (b)(7)(C) to see HERNANDEZ because he was on hunger strike and refused lab work.<sup>159</sup> DO (b)(6); (b)(7)(C) stated he planned to see HERNANDEZ to discuss the hunger strike and serve notice his parole was denied, but did not have the opportunity prior to the detainee's suicide.<sup>160</sup>

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<sup>151</sup> See Nurse's Notes, dated October 14, 2019.

<sup>152</sup> See untitled form, dated October 14, 2019.

<sup>153</sup> See second untitled form, dated October 14, 2019.

<sup>154</sup> See Nurse's Notes, dated October 15, 2019. As noted, RN (b)(6); (b)(7)(C) documented at 8:00 a.m. on October 14, 2019 that HERNANDEZ had missed his ninth meal. By 12:00 p.m. this date, HERNANDEZ would have missed three additional meals.

<sup>155</sup> ERAU interview with RN (b)(6); (b)(7)(C), dated November 26, 2019.

<sup>156</sup> See untitled form, dated October 14, 2019.

<sup>157</sup> *Id.*

<sup>158</sup> ERAU interview with SDDO (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>159</sup> See email dated October 15, 2019, timed 9:38 a.m. ERAU cannot explain the time of the email vis-à-vis the time LPN (b)(6); (b)(7)(C) documented the email notification to ERO in her nurse's note.

<sup>160</sup> ERAU interview with DO (b)(6); (b)(7)(C) dated November 20, 2019.

At approximately 2:05 p.m., security staff discovered HERNANDEZ hanging by the neck from a bed sheet tied to the railing of the top bunk. Based on ERAU's analysis of video surveillance footage starting at 7:00 a.m., staff last communicated with him at approximately 10:04 a.m. and last completed a security round that involved looking in the cell at 11:28 a.m.<sup>161</sup> The chronology of events leading up to and following discovery of the suicide, based on video evidence, incident statements, and interviews, is as follows.<sup>162</sup>

At 10:04 a.m., Lieutenant (b)(6); (b)(7)(C) approached LD 3, lifted the window flap and peered in.<sup>163</sup> He opened the cell door and spoke with HERNANDEZ for approximately 11 seconds, then secured the door and made a notation in the log. Lieutenant (b)(6); (b)(7)(C) stated to ERAU that HERNANDEZ told him he did not want to eat and waved him off.<sup>164</sup>

At 10:17 a.m., Sergeant (b)(6); (b)(7)(C) approached LD 3, lifted the window flap and peered in.<sup>165</sup> He logged his round, then departed. He stated to ERAU that HERNANDEZ was either on the floor or on his bunk when he made this and next security check.<sup>166</sup>

At 10:50 a.m., Sergeant (b)(6); (b)(7)(C) lifted the window flap on LD 3 and peered into the cell.<sup>167</sup> He logged his round and departed the area.

At 11:28 a.m., Deputy (b)(6); (b)(7)(C) lifted the window flap and peered into the cell. She logged the round and departed the area.<sup>168</sup>

At 11:53 a.m., 12:34 p.m., 1:19 p.m., and 1:24 p.m., and 1:54 p.m., Deputy (b)(6); (b)(7)(C) removed the log from the wall pocket outside LD 3 and made notations.<sup>169</sup> She did not lift the window flap but logged security rounds.<sup>170</sup> She made notations in the logs at cells LD 2 and LD 1 as well, without lifting the window flaps.<sup>171</sup>

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<sup>161</sup> The time stamp on the video is one hour before the actual time. ERAU adjusted the times in this report to reflect the correct times.

<sup>162</sup> ERAU notes there is considerable inconsistency between staff accounts of events, inconsistency that cannot be reconciled. For that reason, and because the video provides only timeline evidence, precise determination of the role each staff responding staff member played is not possible.

<sup>163</sup> Video surveillance footage, dated October 15, 2019.

<sup>164</sup> ERAU interview with Lieutenant (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>165</sup> Video surveillance footage, dated October 15, 2019.

<sup>166</sup> ERAU interview with Sergeant (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>167</sup> Video surveillance footage, dated October 15, 2019.

<sup>168</sup> *Id.* ERAU did not interview Deputy (b)(6); (b)(7)(C) because her employment at RCC ended before the site visit. According to Sergeant (b)(6); (b)(7)(C) he assigned Deputy (b)(6); (b)(7)(C) to take over conducting security checks so that he could perform other duties.

<sup>169</sup> *Id.*

<sup>170</sup> See I-888, dated October 15, 2019.

<sup>171</sup> Video surveillance footage, dated October 15, 2019.



At 1:26 p.m., Deputies (b)(6); (b)(7)(C) approached LD 3.<sup>172</sup> Deputy (b)(6); (b)(7)(C) lifted the window flap, twice peering into the cell while Deputy (b)(6); (b)(7)(C) looked on. Deputy (b)(6); (b)(7)(C) informed ERAU he had arrived early for the next shift and while walking down (b)(6); (b)(7)(C) with Deputy (b)(6); (b)(7)(C), noticed a classification tag suggesting the cell was not occupied.<sup>173</sup> When he looked in the cell, he did not see HERNANDEZ, following which Deputy (b)(6); (b)(7)(C) informed him HERNANDEZ was in medical.<sup>174</sup> During interview, Deputy A (b)(6); (b)(7)(C) explained that he checked the cell because his duties for the next shift included offering detainees in segregation cells showers, phone calls, hygiene items and laundry services. He looked in the cell in the interest of determining which cells he had to cover.

At 2:04 p.m., Captain (b)(6); (b)(7)(C) approached LD 3 with Lieutenant (b)(6); (b)(7)(C). Captain (b)(6); (b)(7)(C) lifted the window flap and peered into the cell for approximately ten seconds, then knocked on the door three times before walking away. He returned within a minute with Captain (b)(6); (b)(7)(C) following, and again lifted the window flap to peer into the cell. He unlocked and slightly opened the cell door, then pushed it open further and looked to the right. Captain (b)(6); (b)(7)(C) quickly backed out, secured the door, lunged backward covering his mouth with his hand, and bolted from camera view. During interview, he elaborated on what is shown on video, stating to ERAU that he first approached the cell after smelling a very strong, foul odor.<sup>176</sup> He noticed sheets on the bed were positioned in a fashion that suggested the detainee was on the bunk. When he opened the door, he saw HERNANDEZ hanging from the top bunk, in the right corner of the cell. He ran out because he had never seen anything like that before and felt ill.

Immediately after Captain (b)(6); (b)(7)(C) left camera view, Lieutenant (b)(6); (b)(7)(C) approached the cell, lifted the window flap and peered in for approximately four seconds before opening the cell door.<sup>177</sup> He backed away and raised his radio. Deputy (b)(6); (b)(7)(C) who was in the immediate area when Captain (b)(6); (b)(7)(C) first approached the cell, looked in and immediately turned and left. Lieutenant (b)(6); (b)(7)(C) re-entered LD 3 and stood in the doorway for approximately six seconds, then backed out and raised his hands to his head.

Asked about his training in responding to a suicide attempt by hanging, Lieutenant (b)(6); (b)(7)(C) stated the requirement is to first lift the detainee upward, then cut him down and start cardio pulmonary resuscitation (CPR).<sup>178</sup> His intention was cut HERNANDEZ down once medical

<sup>172</sup> *Id.*

<sup>173</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 20, 2019. ERAU cannot explain why a classification tag was on the cell. Documentation and staff reports indicate HERNANDEZ was in the cell.

<sup>174</sup> Deputy May did not recall telling Deputy Arnold HERNANDEZ was in medical. ERAU interview with Deputy May, dated November 20, 2019.

<sup>175</sup> *Id.*

<sup>176</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>177</sup> Video surveillance footage, dated October 15, 2019.

<sup>178</sup> ERAU interview with Lieutenant (b)(6); (b)(7)(C) dated November 20, 2019. Captain (b)(6); (b)(7)(C) RCC training coordinator at the time, confirmed staff are trained to respond to a suicide attempt by hanging in the manner described by Lieutenant (b)(6); (b)(7)(C). ERAU interview with Captain (b)(6); (b)(7)(C) dated November 19, 2019.



staff arrived with the cut down tool but in the meantime, his superiors directed that that not happen (see below). During interview of Deputy (b)(6); (b)(7)(C) he stated that after seeing HERNANDEZ, he did not consider entering the cell to lift and cut him down because it was clear he was already dead.<sup>179</sup> He also stated he does not know where a cut down tool is located.

Lieutenant (b)(6); (b)(7)(C) confirmed that as observed on video, he used his radio to call 10-19, RCC's radio code for an emergency of any type.<sup>180</sup> He stated that Captain (b)(6); (b)(7)(C) had also called 10-19 when he moved away from the cell and out of camera view. According to Captain (b)(6); (b)(7)(C), his 10-19 radio call was for Major (b)(6); (b)(7)(C) and Acting Warden (AW) (b)(6); (b)(7)(C) to respond to the area.<sup>181</sup>

At 2:06 p.m., Major (b)(6); (b)(7)(C) arrived in camera view, immediately followed by multiple nurses.<sup>182</sup> Reports as to what transpired in the following minutes vary considerably; however, all responding staff stated that upon his arrival (b)(6); (b)(7)(C) was in command. The video shows (b)(6); (b)(7)(C) did not approach the cell and although nurses looked in, they did not enter. Major (b)(6); (b)(7)(C) informed ERAU and documented in a post-incident statement that he learned from a nurse, (b)(6); (b)(7)(C)<sup>183</sup> that a detainee hanged himself and had no pulse.<sup>184</sup> However, video evidence does not support that she ever entered the cell. There is no record of who informed Major (b)(6); (b)(7)(C) of the situation inside the cell.

(b)(6); (b)(7)(C) arrived within two minutes, describing the scene as chaotic.<sup>185</sup> He said staff were everywhere but no one was doing anything. The cell door was open and when he entered, he observed HERNANDEZ hanging from the top bunk, obviously dead. He then exited the cell and spoke with Major (b)(6); (b)(7)(C) whom he presumed had looked in the cell himself. They made the decision to declare the cell a crime scene and directed staff not to cut HERNANDEZ down. AW (b)(6); (b)(7)(C) stated the decision was a judgment call, not based on policy or protocol. He was not aware HERNANDEZ was on hunger strike and although he was in a lockdown cell, AW (b)(6); (b)(7)(C) could not be certain he was housed alone. For that reason, he said he could not be certain he had taken his own life. Asked about the decision, (b)(6); (b)(7)(C) informed ERAU he advocated declaring the cell a crime scene based on his 28 years in law enforcement. He said that in his experience, the scene of an apparent suicide is a crime scene until determined otherwise by law

<sup>179</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>180</sup> ERAU interview with Lieutenant (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>181</sup> See Captain (b)(6); (b)(7)(C) Unusual Occurrence Report, dated October 15, 2019.

<sup>182</sup> Video surveillance footage, dated October 15, 2019.

<sup>183</sup> (b)(6); (b)(7)(C) did not provide her last name during interview but referenced (b)(6); (b)(7)(C) in his October 15, 2019 written statement. Presumably, he was referring to LPN (b)(6); (b)(7)(C) who was leaving (b)(6); (b)(7)(C) following pill call when the 10-19 was called.

<sup>184</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019, and memorandum, dated October 15, 2019. When interviewed, (b)(6); (b)(7)(C) was on administrative leave pending finalization of LaSalle Corrections' investigation into the incident.

<sup>185</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019. When interviewed, (b)(6); (b)(7)(C) was on administrative leave pending finalization of LaSalle Corrections' investigation into the incident.



enforcement.<sup>186</sup> According to Regional Director (b)(6); (b)(7)(C) there is no policy basis or precedent for (b)(6); (b)(7)(C) decision to declare the cell a crime scene.<sup>187</sup>

Among the responding nursing staff were (b)(6); (b)(7)(C) RN (b)(6); (b)(7)(C) as first to arrive followed closely by others, and although RN (b)(6); (b)(7)(C) stated she immediately entered the cell<sup>189</sup>, video evidence shows she entered approximately six minutes later after speaking with (b)(6); (b)(7)(C) (see below).<sup>190</sup> As noted, (b)(6); (b)(7)(C) and other nurses looked in the cell when they arrived on scene (b)(6); (b)(7)(C) reporting to ERAU that she did not expect to encounter a suicide and that she was surprised no one had cut HERNANDEZ down.<sup>191</sup> She stated she was even more surprised when (b)(6); (b)(7)(C) prohibited entry into the cell on grounds it was a crime scene. (b)(6); (b)(7)(C) reported she and (b)(6); (b)(7)(C) adamantly expressed their objections,<sup>192</sup> information supported by (b)(6); (b)(7)(C) who observed the interactions.<sup>193</sup>

In the meantime, upon discovering the emergency was a suicide, (b)(6); (b)(7)(C) went to retrieve a cut down tool from medical; (b)(6); (b)(7)(C) retrieved one from the control center.<sup>194</sup> Both stated that when they returned to scene with the tools, (b)(6); (b)(7)(C) stated they could not enter because it was a crime scene. (b)(6); (b)(7)(C) confirmed that nurses made repeated requests to cut HERNANDEZ down.<sup>195</sup>

At 2:11 p.m., (b)(6); (b)(7)(C) arrived at the scene.<sup>196</sup> He conversed with (b)(6); (b)(7)(C) before looking into the cell. He left the cell and walked halfway down the hall, then stopped to briefly speak with (b)(6); (b)(7)(C) before departing. SDDO (b)(6); (b)(7)(C) informed ERAU that he could not recall what they discussed, beyond his stating that he would notify the Deputy Field Office Director.<sup>197</sup> He also informed ERAU it was obvious HERNANDEZ had been dead for quite some time and for that reason, it did not occur to him to direct that the detainee be cut down. He said that even if it had, he would have left the decision to the facility.

<sup>186</sup> When interviewed, (b)(6); (b)(7)(C) was on administrative leave pending finalization of LaSalle Corrections' investigation into the incident.

<sup>187</sup> ERAU discussion with Regional Director (b)(6); (b)(7)(C)

<sup>188</sup> RN Welch was charge nurse this date and therefore, was lead medical responder.

<sup>189</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 19, 2019. Also, see her Unusual Occurrence Report, dated October 15, 2019.

<sup>190</sup> Video surveillance footage, dated October 15, 2019.

<sup>191</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>192</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 18, 2019.

<sup>193</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>194</sup> ERAU interviews with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>195</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>196</sup> See Video surveillance footage, dated October 15, 2019.

<sup>197</sup> ERAU interviews with SDDO (b)(6); (b)(7)(C) dated November 26, 2019.

Immediately after SDDC (b)(6); (b)(7)(C) came back to the area near LD 3 and spoke to the nurses.<sup>198</sup> (b)(6); (b)(7)(C) then donned gloves and at 2:12 p.m., entered the cell. (b)(6); (b)(7)(C) stated that although they did not recall exactly what (b)(6); (b)(7)(C) he allowed them into the cell to confirm HERNANDEZ had no pulse.<sup>199</sup> Upon entry, the nurses could not find a radial or carotid pulse, and did not see or hear respirations.<sup>200</sup> HERNANDEZ was pale in color and nurses noted red mottling in both arms and hands. They exited approximately 26 seconds later<sup>201</sup> and numerous times, told security personnel HERNANDEZ must be cut down.<sup>202</sup> (b)(6); (b)(7)(C) repeated that was not to happen because the cell was crime scene.

At approximately 2:14 p.m., (b)(6); (b)(7)(C) to have Main Control call for emergency medical services (EMS).<sup>203</sup> (b)(6); (b)(7)(C) the deputy assigned to Main Control, stated she made the call at Captain (b)(6); (b)(7)(C) direction, but did not document the direction or the time of the call in the control log.<sup>204</sup> She explained she was new to the Main Control post and at the time, was not aware of her responsibility to log events surrounding an emergency, including EMS notification and the time of ambulance and law enforcement arrival.<sup>205</sup> The Prehospital Care Report Summary from the Quachita County Acadian Ambulance Services documents the 911 call was received at 2:14 p.m.<sup>206</sup>

At 2:17 p.m., (b)(6); (b)(7)(C) appeared to prepare his phone to take a picture, and then gave it to (b)(6); (b)(7)(C).<sup>207</sup> (b)(6); (b)(7)(C) stood in the cell doorway and appeared to take a picture, then he entered the cell where he remained for 23 seconds. Upon his exit from the cell, Captain (b)(6); (b)(7)(C) returned the phone to (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) confirmed he took pictures at (b)(6); (b)(7)(C) direction and using his phone.<sup>208</sup> (b)(6); (b)(7)(C) did not recall giving Captain (b)(6); (b)(7)(C) his phone and commented that he did not know why he would have.<sup>209</sup> He did recall that someone sent him a picture of the scene but said he deleted it.

<sup>198</sup> Video surveillance footage, dated October 15, 2019.

<sup>199</sup> ERAU interviews with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>200</sup> See Unusual Occurrence Report (b)(6); (b)(7)(C) dated October 15, 2019. See also, written statement (b)(6); (b)(7)(C) dated October 15, 2019 and (b)(6); (b)(7)(C) nurse's note, dated October 15, 2019.

<sup>201</sup> Video surveillance footage, dated October 15, 2019.

<sup>202</sup> See (b)(6); (b)(7)(C) Unusual Occurrence Report, dated October 15, 2019 and written statement of (b)(6); (b)(7)(C) dated October 15, 2019.

<sup>203</sup> See Captain (b)(6); (b)(7)(C) Unusual Occurrence Report, dated October 15, 2019.

<sup>204</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>205</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>206</sup> See Prehospital Care Report Summary, Quachita County Acadian Ambulance Services, dated October 15, 2019.

<sup>207</sup> Video surveillance footage, dated October 15, 2019.

<sup>208</sup> ERAU interview with Captain (b)(6); (b)(7)(C), dated November 20, 2019.

<sup>209</sup> ERAU interview with Major (b)(6); (b)(7)(C) dated November 18, 2019.



At 2:19 p.m., three EMS responders arrived on scene and entered the cell.<sup>210</sup> The responders documented the following<sup>211</sup>:

- HERNANDEZ's pupils were fixed and dilated.
- HERNANDEZ exhibited no respiration effort.
- HERNANDEZ's skin was pale, mottled and cool to touch at his core. Lividity<sup>212</sup> was noted in the lower extremities.
- HERNANDEZ's vital signs were absent, and an electro cardiogram (EKG) was flat-lined.<sup>213</sup>
- HERNANDEZ was not bleeding.
- HERNANDEZ had to have had the ability to stand based on the height of the hanging and the fact his feet were on the ground.

The EMS responders did not document whether they cut HERNANDEZ from his hanging position. According to (b)(6); (b)(7)(C) they did not.<sup>214</sup> The EMS team exited the cell at 2:21 p.m. and departed the area.

At 2:30 p.m., Chief Cleveland (first name unknown) of the Richwood Police Department arrived and called the Ouachita Parish Sheriff's Office to ask that they handle the investigation.<sup>216</sup>

Starting at 3:07 p.m., uniformed and civilian-attired Ouachita Parish personnel arrived on scene and entered the cell, including Sheriff's Office crime scene investigators.<sup>217</sup> According to (b)(6); (b)(7)(C) the Sheriff's Office notified the Ouachita Parish Coroner's Office after completing its investigation.<sup>218</sup> The coroner arrived and pronounced HERNANDEZ deceased, then called Mulhearn Funeral Home. (b)(6); (b)(7)(C) informed ERAU that the coroner cut HERNANDEZ down.<sup>219</sup> ERAU estimates that more than an hour elapsed between discovery of HERNANDEZ hanging and the time he was cut down by the coroner.

At 3:49 p.m., two persons from the Mulhearn Funeral Home arrived on scene, entered the cell, and departed within a minute with HERNANDEZ on the gurney.<sup>220</sup> All other external personnel followed.

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<sup>210</sup> Video surveillance footage, dated October 15, 2019.

<sup>211</sup> See Prehospital Care Report Summary from the Ouachita County Acadian Ambulance Services, dated October 15, 2019.

<sup>212</sup> Lividity is the process in which the body's blood supply stops moving.

<sup>213</sup> An EKG records the electrical activity of the heart. A flat line means there is no electrical activity.

<sup>214</sup> ERAU interview with Major (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>215</sup> Video surveillance footage, dated October 15, 2019.

<sup>216</sup> See Major (b)(6); (b)(7)(C) memorandum, dated October 15, 2019. The video does not show Chief Cleveland at the scene.

<sup>217</sup> Video surveillance footage, dated October 15, 2019.

<sup>218</sup> See Major (b)(6); (b)(7)(C)'s memorandum, dated October 15, 2019.

<sup>219</sup> ERAU interview with Major (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>220</sup> Video surveillance footage, dated October 15, 2019.

## Post-Incident Actions

- (b)(6); (b)(7)(C) summarized the emergency response in a lengthy Nurse's Note timed 2:14 p.m.<sup>221</sup> Based on ERAU's analysis of events, her account is largely accurate except for her statement that EMS cut HERNANDEZ down. Given the timing of her note, ERAU concludes she may have been unaware that EMS left without cutting him down.
- All staff involved in the response submitted written statements. According to Regional Director (b)(6); (b)(7)(C) LaSalle Corrections did not conduct a security de-briefing or an after-action review.<sup>222</sup> (b)(6); (b)(7)(C) stated she conducted a de-briefing with nurses and participated in an internal morbidity review for LaSalle Corrections leadership.<sup>223</sup>
- According to Deputy (b)(6); (b)(7)(C) he retrieved HERNANDEZ's stored property from the property room and took it to (b)(6); (b)(7)(C) office.<sup>224</sup> He was not involved in collection of any property from HERNANDEZ's cell. RCC did not provide documentation of release of his personal property.
- HERNANDEZ's remaining funds balance of \$51.18 was released by money order dated October 17, 2019 to (b)(6); (b)(7)(C).
- All staff interviewed stated LaSalle Corrections offered employee assistance services, some sharing that they were also offered and took administrative leave. ERAU observed both security and nursing staff still struggled to process the events of October 15, 2019. Many became very emotional during interview. Staff, particularly nurses, expressed that not being allowed to cut HERNANDEZ down and attempt CPR exacerbated the shocking nature of what they observed when they looked in the cell.

## CONCLUSIONS

### MEDICAL

ERAU cites the following deficiencies in the ICE PBNDS 2011 governing healthcare:

1. ICE PBNDS 2011, Medical Care, Section (V)(A)(2), which states, "Every facility shall directly or contractually provide its detainee population with the following: Medically

<sup>221</sup> See Nurse's Note, dated October 15, 2019.

<sup>222</sup> ERAU discussion with Regional Director (b)(6); (b)(7)(C)

<sup>223</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 18, 2019. She stated that if not proprietary, she would provide the morbidity review to ERAU.

<sup>224</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>225</sup> See receipt, dated xxx.



necessary and appropriate medical, dental, and mental health care and pharmaceutical services.”

- Special diet orders on June 21, 2019 and June 24, 2019 were not processed; consequently, HERNANDEZ continued to receive the standard diet.
  - Nurses did not recheck HERNANDEZ’s blood pressure on June 24, 2019 as ordered by the provider.
  - Occult blood tests ordered by a provider on July 5, 2019 were not completed until reordered by another provider on August 8, 2019.
2. ICE PBNDS 2011, Medical Care, Section (V)(E), which states, “Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services.”
- The form presented to HERNANDEZ on October 14, 2019 requesting consent for treatment while on hunger strike and providing education on symptoms was in English.
3. ICE PBNDS 2011, Medical Care, Section (V)(M), which states, “The CMA shall be responsible for review of all comprehensive health assessments to assess the priority for treatment.”
- The CMA did not sign the health assessment conducted by (b)(6); (b)(7)(C) following intake screening on June 13, 2019. The CMA did not produce designation of authority for providers to conduct initial health assessments without review by the CMA or other designated provider.
  - A midlevel provider reviewed the health appraisal conducted by (b)(6); (b)(7)(C) on June 20, 2019 six weeks later, on August 6, 2019. Although (b)(6); (b)(7)(C) had conducted an examination on June 13, 2019, the appraisal conducted by RN (b)(6); (b)(7)(C) was scheduled as the initial, requiring review by the CMA. As noted, the CMA has not designated authority to review health appraisals to other providers. The standard does not specify a review timeframe; however, six weeks does not assure timely determination of treatment priority.
4. ICE PBNDS 2011, Medical Care, Section (V)(O)(1)(b)(4), which states, “Each facility shall have an in-house or contractual mental health program, approved by the appropriate medical authority that provides: referral as needed for evaluation, diagnosis, treatment and monitoring of mental illness by a competent mental health professional. Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.”
- On September 4, 2019, RN (b)(6); (b)(7)(C) referred HERNANDEZ to mental health. The scheduled appointment was ten days later, September 14, 2019.

5. ICE PBNDS 2011, Medical Care, Section (V)(U), which 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 medications given to or refused by detainees shall be maintained.”
- Nurses left 126 boxes on the MAR blank. (b)(6); (b)(7)(C) entries included the periods of time HERNANDEZ was on segregation.
  - Nurses did not consistently enter their initials on MARs to document administration. Instead, they entered checkmarks or indistinguishable symbols.
  - A nurse incorrectly transcribed the provider’s order for psyllium fiber on June 24, 2019. The provider ordered one scoop of fiber; the nurse wrote two scoops on the MAR.
  - Nurses continued to administer dicyclomine three days after a provider ordered its discontinuation on July 5, 2019.
  - Although Pinaverium was not available, nurses documented two doses were given on August 30, 2019.
  - A nurse incorrectly transcribed Levsin onto the MAR by recording 0.12 mg instead of 0.125 mg.
  - Nurses first administered Levsin four days after the August 26, 2019 order date.
  - Nurses administered Levsin two days beyond expiration of the 30-day prescription.
6. ICE PBNDS 2011, Medical Care, Sections (V)(AA)(7,8,9), which state, “If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment. Medical staff shall ensure that the detainee’s questions regarding the treatment are answered by appropriate medical personnel. Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee’s medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatment.”
- For the 126 scheduled doses nurses left MARs blank, ERAU cannot determine whether HERNANDEZ refused medications or if nurses did not offer them. The only medication-related refusal form in the medical record is dated June 23, 2019. RN Ainsworth stated that standing practice at the time was for deputies, not nurses, to take refusal forms to detainees for signature; therefore, nurses did not provide education on the risks of refusing medication treatment.
7. ICE PBNDS 2011, Hunger Strike, Sections (V)(C)(1)(c) and (d), which state, “During the initial evaluation of a detainee on a hunger strike, medical staff shall: c) perform urinalysis; d) conduct psychological/psychiatric evaluation.”



- On October 14, 2019, RN (b)(6); (b)(7)(C) did not attempt to conduct urinalysis and did not refer HERNANDEZ for mental health evaluation.
8. ICE PBNDS 2011, Hunger Strike, Sections (V)(C)(2), which states, “Medical staff shall measure and record weight and vital signs at least once every 24 hours during the hunger strike and repeat other procedures as medically indicated.
    - Nurses did not attempt to take HERNANDEZ’s weight and vital signs within the 24 hours following initiation of the hunger strike protocol at 8:00 a.m. on October 14, 2019.
  9. ICE PBNDS 2011, Hunger Strike, Section (V)(C)(5), which states, “If the detainee refuses the initial medical evaluation or any treatment or other medical procedures, medical staff must attempt to secure the detainee’s signature on a ‘Refusal of Treatment’ form. If the detainee will not cooperate by signing, staff shall note this on the ‘Refusal of Treatment’ form.”
    - (b)(6); (b)(7)(C) did not complete a Refusal of Treatment form on October 14, 2019 when HERNANDEZ refused to cooperate with the initial hunger strike evaluation.
  10. ICE PBNDS 2011, Significant Self-harm and Suicide Prevention and Intervention, Section (V)(H), which states, “Following a suicide attempt, security staff shall initiate and continue appropriate life-saving measures until relieved by arriving medical personnel.”
    - Security staff did not initiate life-saving measures and security command staff did not allow medical staff to do so.

## DEVIATIONS FROM RCC POLICY

1. RCC policy HC 4.2, *Hunger Strikes*, Section (D)(2), which states, “Detainee will be provided education regarding risks to health, as well as, an educational pamphlet will be available in preferred language.”
  - On October 14, 2019, (b)(6); (b)(7)(C) did not provide LaSalle Corrections Patient Handout: Hunger Strike Fact Sheet, outlining the expected sequence of hunger strike symptoms.
2. RCC policy HC 4.2, *Hunger Strikes*, Section (D)(5), which states, “CMA, or designee, shall review and document in the medical record initial hunger strike placement evaluation orders, and plan of care.”
  - There is no documentation nurses referred HERNANDEZ to a provider for baseline review of his hunger strike status as of October 14, 2019.

## AREAS OF CONCERN

1. RCC has not yet pursued NCCHC accreditation.
2. RCC has not yet implemented a system of internal review and quality assurance.
3. As noted in above deficiencies, ERAU identified multiple issues with nurses' documentation of medication administration. ERAU also identified the following concerns related to documentation in the medical record:
  - Nurses documented sick call encounters on HERNANDEZ's sick call requests and not in nurse's notes.
  - Nurse's notes did not follow the SOAPE format.
  - Although (b)(6); (b)(7)(C) stated LaSalle Corrections has a comprehensive set of nursing protocols, only one was used during a sick call encounter.
  - Nurses' and providers' signatures were often illegible, and name stamps were seldom used.
  - Nurses did not consistently record pain levels when HERNANDEZ reported pain.
  - On two occasions, a provider did not document an in-person encounter with HERNANDEZ. She stated was confident she had seen him, but documented orders, only.
  - Multiple forms did not have titles identifying their purpose.
4. (b)(6); (b)(7)(C) health appraisal on June 20, 2019 did not reflect HERNANDEZ's known history of IBS and current medications, and did not note that by request dated the day before, he complained the medications were ineffective.
5. Cells used for medical observation are not within sight and sound proximity of medical staff.
6. Documentation addressing HERNANDEZ's placement in segregation on June 20, 2019 and October 10, 2019 is ambiguous. Available records do not clearly document whether his placement was for monitoring meal consumption, or whether he met criteria for initiation of the hunger strike protocol. If the former, there is no record of meal consumption during the first period of segregation. If the latter, the record of meal consumption by security staff was incomplete and not verified by nurses. Also, as noted in the above deficiency, on October 14, 2019 when (b)(6); (b)(7)(C) initiated the hunger strike protocol, she did not attempt to conduct urinalysis or refer HERNANDEZ to mental health or a medical provider.
7. Upon discovering HERNANDEZ hanging, Captain (b)(6); (b)(7)(C) Lieutenant C (b)(6); (b)(7)(C) or Deputy (b)(6); (b)(7)(C) did not enter the cell to lift him to relieve pressure to the neck until he could be cut down. None of the three retrieved the cut down tool from control, Lieutenant



(b)(6); (b)(7)(C) stating that medical is responsible for bringing the tool and Deputy (b)(6); (b)(7)(C) stating he did not know where cut down tools are located. When nurses arrived on scene, they did not bring a cut down tool because the radio code 10-19 is not specific to the type of emergency. Two nurses did, however, leave the scene to retrieve cut down tools.

8. Although HERNANDEZ appeared dead when discovered, (b)(6); (b)(7)(C) (b)(6); interfered with performance of emergency medical care by denying nurses' entry to the cell to cut the detainee down and attempt CPR.

## SECURITY

ERAU cites the following deficiencies in the ICE PBNDS 2011 governing security operations.

1. ICE PBNDS 2011, Special Management Units, Section (V)(A)(2)(a), which states, "Prior to a detainee's placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing a detainee in administrative segregation."
  - On June 20, 2019, HERNANDEZ was placed in segregation cell SM2 for hunger strike monitoring. (b)(6); (b)(7)(C) initiated the Administrative Segregation Order, which was signed the next day by (b)(6); (b)(7)(C). A security supervisor did not sign the order.
2. ICE PBNDS 2011, Special Management Units, Section (V)(A)(2)(e), which states, "The administrative segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility."
  - There is no documentation staff provided HERNANDEZ the Administrative Segregation Orders dated June 20, 2019 and October 10, 2019.
3. ICE PBNDS 2011, Special Management Units, Section (V)(M), which states, "Detainees in SMU shall be personally observed at least every 30 minutes on an irregular schedule."
  - On October 15, 2019, security staff did not observe HERNANDEZ between 11:28 a.m. and 2:04 p.m. when Captain (b)(6); looked in the cell after noticing a foul odor. Deputy (b)(6); (b)(7)(C) who was responsible for security rounds after 10:50 a.m., documented five that video evidence shows she did not make, at 11:53 a.m., 12:34 p.m., 1:19 p.m., 1:24 p.m., and 1:54 p.m.
4. ICE PBNDS 2011, Terminal Illness, Advance Directives and Death, Section (V)(F), which 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."

- (b)(6); (b)(7)(C) stated he placed HERNANDEZ's property in Maj (b)(6); (b)(7)(C) officer; however, there is no documentation of its disposition, including release to ERO and ERO's return of the property to next of kin.
5. ICE PBNDS 2011, Funds and Personal Property, Section (V)(G)(1), which states, "For recordkeeping and accounting purposes, use of the G-589 Property Receipt form or its equivalent is mandatory to inventory any funds removed from a detainee's possession, and a separate G-589 form or its equivalent is required for each kind of currency and negotiable instrument. Removal and inventory of detainee funds shall be conducted by at least two officers and in the presence of the detainee. Separate documentation should be made for each kind of currency and negotiable instrument, and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried. Officers should then deposit the funds with a copy of the documentation in the drop safe or similarly secured depository."
    - Admission records do not include documentation supporting compliance with the standard. The records include only a detainee funds report showing HERNANDEZ's account history.
  6. ICE PBNDS 2011, Funds and Personal Property, Section (V)(I), which states, "An itemized inventory of all detainee baggage and property (separate from funds and valuables) shall be completed during admissions processing using the personal property inventory form. Each facility shall inventory all property, even in the event the property was previously inventoried by another facility and is contained in a sealed bag."
    - Admission documentation does not include an itemized inventory of HERNANDEZ's property.

## DEVIATION FROM RCC POLICY

1. RCC Post Orders, Main Control Room Officer, Section 2, (5), which states, "The Main Control Room Officer shall be responsible for maintaining an accurate account of all activities occurring during assignment at this duty post and shall document the following:
  - f) Document all unusual occurrences or incidents reported through the control room; and
  - h) Document any other information relevant to activities during assignment."
  - The Main Control officer did not document EMS notification, arrival, and departure, the arrival and departure of personnel from external agencies following HERNANDEZ's death.



## AREAS OF CONCERN

1. RCC does not have a special management unit; therefore, detainees assigned to segregation are placed in cells which open onto a high traffic corridor through which general population detainees regularly traverse. RCC does not have procedures prohibiting staff from routinely opening the segregation cells when general population detainees are in the area, procedures which would approximate the purpose sally ports serve in special management units.
2. Following HERNANDEZ's death, RCC took steps to improve visibility into cells used for segregation, including removing the window flaps and repositioning the bunk beds. However, small bars running vertically on the security windows remain, obscuring the view of the cell side to side.
3. The security reviewer endorses medical concerns related to security staff's failure to immediately enter the cell to lift HERNANDEZ to relieve pressure on his neck and retrieve a cut down tool themselves. The reviewer also endorses the concern related to (b)(6); (b)(7)(C) decision to declare the cell a crime scene.

## AUTOPSY REPORT

**Case No:** LA459-19

**Date of Examination:** October 17, 2019

**Name:** DIAZ, Roylan

**Age:** 43 years

**Race:** Hispanic

**Sex:** Male

**Investigating Agency:** Ouachita Parish Coroner's Office

### FINDINGS:

- I. Hanging.
  - A. Ligature consisting of sheet wrapped tightly around neck.
  - B. Petechial hemorrhages of epiglottic and laryngeal mucosa.
- II. Contusion, left hand.



**CAUSE OF DEATH:** Hanging.

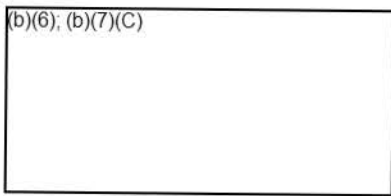
**OPINION:**

This 43-year-old Hispanic male, Roylan Diaz, died of hanging.

Investigation of the circumstances of death revealed that the decedent was an inmate at the Richwood Correctional Center when he was found hanging on the bedrail of his bunk with a white sheet wrapped around his neck. Reportedly, he was the lone occupant of the cell and had been participating in his second documented "hunger strike" since his detention in June of 2019. There was no evidence of foul play reported at the scene.

Autopsy demonstrated a ligature consisting of a sheet wrapped tightly around the neck. Other injuries included a small bruise of the left hand. There was no evidence of disease present. Toxicology detected no drugs or alcohol in the blood. Vitreous chemistries detected a markedly elevated urea nitrogen level.

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



11-18-19/mkh

**EXTERNAL EXAMINATION**

Received for examination was the body of a well-developed, well-nourished, Hispanic male clad in a prison uniform consisting of a green shirt and pants, a white t-shirt, boxers which were markedly soiled with feces and disposed of and white socks. Two pieces of a cut white sheet were present on top of the body. A ligature was present around the neck and will be described further below in detail. The body weighed 180 pounds, measured 68 inches in length and appeared compatible with the age of 43 years. The body was cold. Rigor mortis was present and fixed to an equal degree in all extremities. Livor mortis was present and fixed on the posterior surface of the body and the legs except for the areas exposed to pressure. The scalp hair was brown gray. The deceased wore a mustache and beard. The irides were hazel. The corneas were clear. The sclerae and conjunctivae showed no petechial hemorrhages. The external nares and oral cavity contained a slight amount of serosanguinous fluid. The teeth were natural and in good condition. The neck will be described further below in detail. The chest was unremarkable with no evidence of injury to the ribs or sternum externally. The abdomen was flat with no scars or injuries noted. On the shaft of the penis was a 1-inch surgical scar. Below this scar was a ½ x ¼ inch raised prosthetic implant consisting of a piece of clear plastic. The external genitalia were free of injury. The lower extremities showed a few old, irregular scars along with slight bilateral loss of hair growth. On the posterior surface of the left thigh was a nevus. The ankles and feet were clean. No tattoos, needle tracks or wrist scars were noted. A vaccination scar was present on the left deltoid region. The posterior torso was unremarkable.

**EVIDENCE OF MEDICAL ATTENTION:**

EKG electrodes were present on the front of the chest and the lower extremities.

**EVIDENCE OF INJURY:****EVIDENCE OF HANGING:**

Situated tightly and wrapped multiple times around the neck was a white bedsheet situated respectively 3 inches inferior to the right external auditory meatus and 3 ¾ inches to the left external auditory meatus. The ligature was situated on and above the thyroid



eminence and completely encircled the neck tightly. The knot was present on the right side of the neck.

Upon removal of the ligature, there was a tan brown ligature furrow measuring 1 – 1 ½ inches in width with approximately ¼ - ½ indentation into the neck. The furrow canted up on the left side of the neck and faded into the hairline. Underlying ligature on the posterior neck was a band of pallor.

Subsequent layer wise dissection of the neck demonstrated no sternocleidomastoid or strap muscle hemorrhages. The hyoid bone and laryngeal cartilages were intact. A few scattered petechial hemorrhages were present on the epiglottic and laryngeal mucosa.

#### OTHER INJURIES:

On the back of the left hand at the thumb was a 1 ½ x 1 inch blue contusion.

#### INTERNAL EXAMINATION

The subcutaneous fat layer measured up to 2 inches. No adhesions or abnormal collections of fluid were present in the body cavities. Petechiae were not present on the thoracic organs. All body organs were present in normal anatomic position and were diffusely congested. There was no internal evidence of blunt force or penetrating injury to the thoraco-abdominal region.

#### CARDIOVASCULAR SYSTEM:

The pericardial surfaces were smooth and glistening. The pericardial sac contained a few milliliters of fluid. The heart was normal in size, shape and configuration. The coronary arteries arose normally, followed the usual distribution and were widely patent, without evidence of luminal stenosis or acute thrombosis. The chambers and valves exhibited the usual size-position relationship and were unremarkable. The myocardium was dark red brown and firm with no focal lesions. The atrial and ventricular septa were intact. The aorta and its major branches arose normally, followed the usual course and were widely patent. The vena cava and its major tributaries returned to the heart in the usual distribution and were free of thrombi. The heart weighed 260 grams.

**RESPIRATORY SYSTEM:**

The pleural surfaces were smooth and glistening. The pulmonary arteries were normally developed, patent and without thrombus or embolus. The mucosal surfaces were unremarkable. The upper and lower airways contained bloody, frothy mucoid secretions. The pulmonary parenchyma was grayish purple and diffusely congested. The right lung weighed 500 grams; the left 400 grams.

**NECK:**

Injuries to the neck have been previously described. No other abnormalities were noted.

**ALIMENTARY TRACT:**

The tongue, esophagus, small and large bowels, rectum and anus showed no lesions or abnormalities. The stomach contained a scant amount of mucus. The appendix was present.

**LIVER AND BILIARY SYSTEM:**

The hepatic parenchyma was maroon with no focal lesions. The gallbladder contained a few milliliters of bile. The liver weighed 1200 grams.

**GENITOURINARY SYSTEM:**

The cortical surfaces were red-brown and smooth. The cortex was unremarkable. The urinary bladder contained 50 ml of dark yellow urine. The prostate and testes were unremarkable. The right kidney weighed 120 grams; the left 130 grams.

**RETICULOENDOTHELIAL SYSTEM:**

The spleen had a smooth, intact capsule covering a red purple, firm parenchyma. The regional lymph nodes were not enlarged and appeared normal. The spleen weighed 140 grams.



Name: DIAZ, Roylan

Parish: Ouachita

Case No.: LA459-19

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**ENDOCRINE AND EXOCRINE SYSTEMS:**

The pituitary gland, thyroid gland, adrenal glands and pancreas were unremarkable.

**MUSCULOSKELETAL SYSTEM:**

Muscles were red brown and within normal development. No bone or joint abnormalities were noted. The cervical, thoracic and lumbar spine showed no obvious old fractures or other abnormalities.

**CENTRAL NERVOUS SYSTEM:**

The scalp showed no edema or hemorrhage. The calvarium and base of the skull showed no fractures. The dura and falx cerebri were intact. There was no epidural, subdural or subarachnoid hemorrhage present. The leptomeninges were clear. The cerebral hemispheres were symmetric and diffusely congested. The circle of Willis and related blood vessels were normal in caliber and distribution. Sections through the cerebral hemispheres, cerebellum and brain stem showed no lesions or hemorrhage. The spinal cord was not examined. The brain weighed 1450 grams.



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## Toxicology Report

Report Issued 10/27/2019 15:08

To: 10005  
(b)(6); (b)(7)(C)

North Little Rock, AR 72117

Patient Name DIAZ, ROYLAN  
Patient ID (b)(6); (b)(7)(C)  
Chain 30243374  
Age 43 Y DOB Not Given  
Gender Male  
Workorder 19319915

Page 1 of 3

### Positive Findings:

| Compound                       | Result | Units  | Matrix Source        |
|--------------------------------|--------|--------|----------------------|
| Creatinine (Vitreous Fluid)    | 0.79   | mg/dL  | 003 - Vitreous Fluid |
| Sodium (Vitreous Fluid)        | 143    | mmol/L | 003 - Vitreous Fluid |
| Potassium (Vitreous Fluid)     | 14     | mmol/L | 003 - Vitreous Fluid |
| Chloride (Vitreous Fluid)      | 128    | mmol/L | 003 - Vitreous Fluid |
| Urea Nitrogen (Vitreous Fluid) | 52     | mg/dL  | 003 - Vitreous Fluid |

See Detailed Findings section for additional information

### Testing Requested:

| Analysis Code | Description                                                            |
|---------------|------------------------------------------------------------------------|
| 8042B         | Postmortem, Expanded w/Vitreous Alcohol Confirmation, Blood (Forensic) |
| 1919FL        | Electrolytes and Glucose Panel (Vitreous), Fluid (Forensic)            |

### Specimens Received:

| ID  | Tube/Container          | Volume/<br>Mass | Collection<br>Date/Time | Matrix Source  | Miscellaneous<br>Information |
|-----|-------------------------|-----------------|-------------------------|----------------|------------------------------|
| 001 | Gray Top Tube           | 8.75 mL         | 10/17/2019              | Cardiac Blood  |                              |
| 002 | Gray Top Tube           | 8.75 mL         | 10/17/2019              | Cardiac Blood  |                              |
| 003 | Red Top Tube            | 4 mL            | 10/17/2019              | Vitreous Fluid |                              |
| 004 | White Plastic Container | 30 mL           | 10/17/2019              | Urine          |                              |

All sample volumes/weights are approximations.

Specimens received on 10/18/2019.

NMS v.18.0





CONFIDENTIAL

Workorder 19319915  
Chain 30243374  
Patient ID LA459-19 OUACHITA

Page 2 of 3

**Detailed Findings:**

| Analysis and Comments          | Result        | Units  | Rpt. Limit | Specimen Source      | Analysis By        |
|--------------------------------|---------------|--------|------------|----------------------|--------------------|
| Creatinine (Vitreous Fluid)    | 0.79          | mg/dL  | 0.050      | 003 - Vitreous Fluid | Colorimetry        |
| Sodium (Vitreous Fluid)        | 143           | mmol/L | 80         | 003 - Vitreous Fluid | Chemistry Analyzer |
| Potassium (Vitreous Fluid)     | 14            | mmol/L | 1.0        | 003 - Vitreous Fluid | Chemistry Analyzer |
| Chloride (Vitreous Fluid)      | 128           | mmol/L | 70         | 003 - Vitreous Fluid | Chemistry Analyzer |
| Glucose (Vitreous Fluid)       | None Detected | mg/dL  | 35         | 003 - Vitreous Fluid | Chemistry Analyzer |
| Urea Nitrogen (Vitreous Fluid) | 52            | mg/dL  | 3.0        | 003 - Vitreous Fluid | Chemistry Analyzer |

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded one (1) year from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Workorder 19319915 was electronically

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

Forensic Toxicologist

**Analysis Summary and Reporting Limits:**

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acocde 1919FL - Electrolytes and Glucose Panel (Vitreous), Fluid (Forensic) - Vitreous Fluid

-Analysis by Chemistry Analyzer for:

| Compound                   | Rpt. Limit | Compound                       | Rpt. Limit |
|----------------------------|------------|--------------------------------|------------|
| Chloride (Vitreous Fluid)  | 70 mmol/L  | Sodium (Vitreous Fluid)        | 80 mmol/L  |
| Glucose (Vitreous Fluid)   | 35 mg/dL   | Urea Nitrogen (Vitreous Fluid) | 3.0 mg/dL  |
| Potassium (Vitreous Fluid) | 1.0 mmol/L |                                |            |

-Analysis by Colorimetry (C) for:

| Compound                    | Rpt. Limit  | Compound | Rpt. Limit |
|-----------------------------|-------------|----------|------------|
| Creatinine (Vitreous Fluid) | 0.050 mg/dL |          |            |

Acocde 8042B - Postmortem, Expanded w/Vitreous Alcohol Confirmation, Blood (Forensic) - Cardiac Blood

-Analysis by Enzyme-Linked Immunosorbent Assay (ELISA) for:

NMS v.18.0



CONFIDENTIAL

Workorder 19319915  
Chain 30243374  
Patient ID LA459-19 OUACHITA

Page 3 of 3

**Analysis Summary and Reporting Limits:**

| <u>Compound</u> | <u>Rpt. Limit</u> | <u>Compound</u> | <u>Rpt. Limit</u> |
|-----------------|-------------------|-----------------|-------------------|
| Barbiturates    | 0.040 mcg/mL      | Gabapentin      | 5.0 mcg/mL        |
| Cannabinoids    | 10 ng/mL          | Salicylates     | 120 mcg/mL        |

-Analysis by Headspace Gas Chromatography (GC) for:

| <u>Compound</u> | <u>Rpt. Limit</u> | <u>Compound</u> | <u>Rpt. Limit</u> |
|-----------------|-------------------|-----------------|-------------------|
| Acetone         | 5.0 mg/dL         | Isopropanol     | 5.0 mg/dL         |
| Ethanol         | 10 mg/dL          | Methanol        | 5.0 mg/dL         |

-Analysis by High Performance Liquid Chromatography/Time of Flight-Mass Spectrometry (LC/TOF-MS) for: The following is a general list of compound classes included in this screen. The detection of any specific analyte is concentration-dependent. Note, not all known analytes in each specified compound class are included. Some specific analytes outside these classes are also included. For a detailed list of all analytes and reporting limits, please contact NMS Labs.

Amphetamines, Anticonvulsants, Antidepressants, Antihistamines, Antipsychotic Agents, Benzodiazepines, CNS Stimulants, Cocaine and Metabolites, Hallucinogens, Hypnotosedatives, Hypoglycemics, Muscle Relaxants, Non-Steroidal Anti-Inflammatory Agents, Opiates and Opioids.

NMS v.18.0





## Detainee Death Review Report

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# Roylan HERNANDEZ-Diaz

Date of Death: October 15, 2019

Alien File Number: 203 637 060

Joint Integrity Case Management System (JICMS) Number:

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

June 4, 2020

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

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## **DETAILS OF REVIEW**

From November 18 to 21, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Richwood Correctional Center (RCC) in Richwood, Louisiana (LA), to review the circumstances surrounding Roylan HERNANDEZ-Diaz's (HERNANDEZ) 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.<sup>1</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to HERNANDEZ, in addition to conducting in-person interviews of individuals employed by RCC and the local ICE Enforcement and Removal Operations (ERO) field office.

On June 13, 2019, ICE transferred HERNANDEZ from Tallahatchie County Correctional Facility (TCCF) to RCC, where he remained until his death. The Ouachita Parish Coroner documented the official cause of death as hanging.<sup>2</sup>

## **FACILITY PROFILE**

RCC is owned and operated by La Salle Corrections under an Intergovernmental Service Agreement (IGSA), which requires the facility to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. La Salle Corrections provides both security and medical care. ICE ERO began housing detainees at RCC in April of 2019, under the oversight of the ERO Field Office Director (FOD) in New Orleans, LA. The RCC houses male detainees for periods longer than 72 hours, and at the time of HERNANDEZ's death, RCC housed approximately 988 ICE male detainees with an average ICE detainee population is 998.<sup>3</sup>

## **IMMIGRATION AND CRIMINAL HISTORY**

On May 18, 2019, at approximately 12:56 p.m., HERNANDEZ applied for admission to the United States at the Paso Del Norte Port of Entry in El Paso, Texas (TX).<sup>4</sup> During the inspection, HERNANDEZ claimed fear of returning to his home country; therefore, a U.S. Customs and Border Protection (CBP) officer referred HERNANDEZ for secondary inspection as a possible asylum and credible fear case.<sup>5</sup> CBP determined HERNANDEZ was inadmissible pursuant to section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act, as an alien who is not in possession of a valid unexpired immigrant visa or other entry document at the time of admission. CBP processed HERNANDEZ for expedited removal pending a credible fear determination.

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<sup>1</sup> See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis.

<sup>2</sup> See Exhibit 2: Ouachita Parish Coroner's Office, dated November 18, 2019.

<sup>3</sup> See ERO Facility List Report, dated October 28, 2019; see also ERO Records Request, dated October 18, 2019.

<sup>4</sup> See Record of Deportable/Inadmissible Alien (DHS Form I-213), dated May 20, 2019. ERAU notes there are conflicting dates of arrival on CBP and ICE documents.

<sup>5</sup> *Id.*

On May 20, 2019, HERNANDEZ provided a sworn statement and expressed fear of returning to Cuba.<sup>6</sup> CBP served HERNANDEZ with an Information about Credible Fear Interview form (DHS Form M-444).<sup>7</sup>

While in CBP custody, HERNANDEZ complained of right-side abdominal pain, right flank pain, nausea, vomiting and diarrhea.<sup>8</sup> At an unknown time, CBP transported HERNANDEZ to The Hospitals of Providence Memorial Campus.<sup>9</sup> At 2:09 a.m., HERNANDEZ arrived at the hospital.<sup>10</sup> The emergency department physician diagnosed HERNANDEZ with abdominal pain in the right lower quadrant, nausea, and vomiting. The hospital conducted radiology and laboratory testing, both of which produced negative results. The physician prescribed HERNANDEZ with acetaminophen (500 mg),<sup>11</sup> one tablet three times a day, Bifidobacterium-lactobacillus,<sup>12</sup> one capsule daily, and ondansetron (4 mg),<sup>13</sup> one tablet every six hours as needed.

At an unknown time, CBP transferred HERNANDEZ to ERO El Paso's custody. At approximately 1:00 p.m.,<sup>14</sup> ERO transferred HERNANDEZ to the El Paso Service Processing Center (SPC) for housing and asylum hearing arrangements. At approximately 8:20 p.m., ERO El Paso transferred HERNANDEZ to the West Texas Detention Center in Sierra Blanca, TX.<sup>15</sup>

On May 21, 2019, at approximately 2:04 p.m., HERNANDEZ arrived at the West Texas Detention Center.<sup>16</sup>

On May 23, 2019, ERO El Paso transferred HERNANDEZ into the custody of ERO New Orleans for a credible fear referral.<sup>17</sup> ERO New Orleans transferred him to TCCF in Tutwiler, Mississippi.

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

<sup>6</sup> See Record of Sworn Statement in Proceedings under Section 235(b)(1) of the Act (DHS Form I-867A), dated May 20, 2019.

<sup>7</sup> See DHS Form M-444, dated May 20, 2019.

<sup>8</sup> See Order to Detail or Release Alien remarks field (DHS Form I-203), dated May 20, 2019. Documentation from the Hospitals of Providence Memorial Campus clarified that HERNANDEZ experienced these symptoms for four days.

<sup>9</sup> See DHS CBP Medical Care/Medpas Tracking, dated May 20, 2019.

<sup>10</sup> See Hospitals of Providence Memorial Campus, Patient Education & Visit Summary, dated May 20, 2019.

<sup>11</sup> Acetaminophen, brand name Tylenol Extra Strength, is a medication used to treat minor aches and pains.

<sup>12</sup> Bifidobacterium-Lactobacillus is a medical food used as a probiotic, or friendly bacteria, to maintain a healthy digestive tract.

<sup>13</sup> Ondansetron, brand name Zofran, is a medication used to prevent nausea and vomiting.

<sup>14</sup> ERAU notes CBP and the Providence Memorial Campus documents in HERNANDEZ's Alien File do not note a discharge time. See ENFORCE Alien Removals Module (EARM) database Detention History, entry dated May 20, 2019.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> See EARM Comments, entry dated May 23, 2019.

<sup>18</sup> See Record of Determination/Credible Fear Worksheet (USCIS Form I-870), dated May 31, 2019.



On June 5, 2019, HERNANDEZ was served with a Notice to Appear (DHS Form I-862).<sup>19</sup> Deportation Officer (DO) (b)(6); (b)(7)(C) notified HERNANDEZ of his parole case review set for June 8, 2019.<sup>20</sup> HERNANDEZ signed the notification.

On June 8, 2019, ERO New Orleans Acting FOD (b)(6); (b)(7)(C) signed a Notification Declining to Grant Parole, as HERNANDEZ had not established that he was not a flight risk.<sup>21</sup>

On June 13, 2019, ERO New Orleans transferred HERNANDEZ to RCC.<sup>22</sup>

On June 24, 2019, Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) scheduled a review of HERNANDEZ's case for August 20, 2019.<sup>23</sup> HERNANDEZ signed the notification.

On August 8, 2019, HERNANDEZ submitted an ICE Detainee Request form regarding his parole.<sup>24</sup> ICE did not respond or sign the form.

On August 21, 2019, ERO New Orleans Acting FOD (b)(6); (b)(7)(C) signed a Notification Declining to Grant Parole.<sup>25</sup> It was documented that HERNANDEZ was considered a flight risk.

On September 14, 2019, HERNANDEZ submitted an ICE Detainee Request form regarding his parole.<sup>26</sup> (b)(6); (b)(7)(C) ERO's facility liaison, responded two days later documenting that the request was forwarded to the case agent, D (b)(6); (b)(7)(C)

On September 17, 2019 (b)(6); (b)(7)(C) notified HERNANDEZ of his parole case review set for October 7, 2019.<sup>27</sup> HERNANDEZ signed the notification.

On October 8, 2019, ERO New Orleans Acting FOD (b)(6); (b)(7)(C) signed a Notification Declining to Grant Parole as HERNANDEZ was considered a flight risk.<sup>28</sup> DO (b)(6); (b)(7)(C) stated he had a copy of this notification to give to HERNANDEZ prior to his suicide on October 15, 2019, but did not deliver it to him.<sup>29</sup>

<sup>19</sup> See DHS Form I-862, dated June 5, 2019.

<sup>20</sup> See Parole Advisal and Scheduling Notification (ICE Form 71-012), dated June 5, 2019.

<sup>21</sup> See ICE Notification Declining to Grant Parole, dated June 8, 2019.

<sup>22</sup> See EARM Detention History, entry dated June 13, 2019.

<sup>23</sup> See EARM Comments, entry dated June 24, 2019.; see also ICE Form 71-012, undated.

<sup>24</sup> See ICE RCC Detainee Request to ICE Staff Member form, dated August 8, 2019.

<sup>25</sup> See ICE Notification Declining to Grant Parole, dated August 21, 2019.

<sup>26</sup> See ICE RCC Detainee Request to ICE Staff Member form, dated September 14, 2019.

<sup>27</sup> See ICE Form 71-012, dated September 17, 2019.

<sup>28</sup> See ICE Notification Declining to Grant Parole, dated October 8, 2019.

<sup>29</sup> ERAU Interview with DO (b)(6); (b)(7)(C) dated November 21, 2019.

On October 9, 2019, the Executive Office for Immigration Review (EOIR) sent a Notice of Hearing in Removal Proceedings, for a hearing scheduled January 30, 2020.<sup>30</sup>

## **CHRONOLOGY OF EVENTS**

### **May 23, 2019**

At approximately 5:31 p.m., HERNANDEZ arrived at TCCF.<sup>31</sup>

### **May 24, 2019**

At 3:13 a.m., (b)(6); (b)(7)(C) Registered Nurse (RN), completed HERNANDEZ's intake using interpretation services.<sup>32</sup> (b)(6); (b)(7)(C) documented<sup>33</sup> the following:

- HERNANDEZ's vital signs were within normal limits and his mental health screening was normal.<sup>34</sup>
- HERNANDEZ reported stomach problems to include colon problems and acid reflux,<sup>35</sup> and about being careful with what he ate to avoid symptoms.
- HERNANDEZ reported pain located bilaterally in the lower abdomen and back pain at a level of eight.<sup>36</sup>
- HERNANDEZ reported taking medication; however, he refused to take them stating they did not help.<sup>37</sup>
- HERNANDEZ reported no history of tuberculosis (TB),<sup>38</sup> and his TB symptom check was negative.<sup>39</sup>
- RN (b)(6); (b)(7)(C) gave HERNANDEZ sick call information in Spanish and approved him for housing in general population.

<sup>30</sup> See EOIR Notice of Hearing in Removal Proceedings, dated October 9, 2019.

<sup>31</sup> See EARM Detention History, entry dated May 23, 2019.

<sup>32</sup> Throughout the remainder of the report, only instances in which interpretation services were not used will be noted.

<sup>33</sup> See Initial Intake Screening, dated May 24, 2019.

<sup>34</sup> 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 less than 120/80.

<sup>35</sup> Acid reflux, commonly referred to as heart burn, is a digestive disease in which stomach acid or bile flows into the esophagus and irritates the lining.

<sup>36</sup> 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.

<sup>37</sup> The initial intake document does not specify what medication HERNANDEZ was taking, only "See MAR." TCCF did not provide a MAR in the medical record.

<sup>38</sup> TB is a potentially serious infectious bacterial disease that mainly affects the lungs; symptoms include a prolonged cough, fever, chills, night sweats, unexplained weight loss and fatigue, and chest pain.

<sup>39</sup> See TB Intake/TB Annual Symptom Screening form, dated May 24, 2019.



**May 29, 2019**

At approximately 10:38 a.m., (b)(6); (b)(7)(C) Licensed Professional Counselor (LPC), completed HERNANDEZ's comprehensive mental health screening.<sup>40</sup> LP (b)(6); (b)(7)(C) documented all normal findings and included a note that HERNANDEZ reported being threatened in his home country. HERNANDEZ denied thoughts of self-harm or the need for mental health services. LPC (b)(6); (b)(7)(C) documented that she informed HERNANDEZ on how to access mental health and health services.

At 3:36 p.m., (b)(6); (b)(7)(C) Nurse Practitioner (NP), signed off on HERNANDEZ's physical examination, documenting<sup>41</sup> the following:

- HERNANDEZ's vital signs were within normal limits.
- HERNANDEZ reported a history of irritable bowel syndrome (IBS)<sup>42</sup> and constipation.<sup>43</sup>
- HERNANDEZ reported a history of foot surgery in 2002 and an endoscopy of the colon in 2003.
- HERNANDEZ arrived with the medications Senosidos A-B,<sup>44</sup> (8.6 mg), and Nesajar,<sup>45</sup> (100/300 mg).

(b)(6); (b)(7)(C) documented that she replaced Nesajar with Benyt<sup>46</sup> at the instruction of Dr. (b)(6); (b)(7)(C) first name unknown) because Nesajar was unavailable to order. N (b)(6); (b)(7)(C) also ordered dicyclomine HCL, (10 mg), every 12 hours, and Senokot, (8.6 mg), two tablets at bedtime. (b)(6); (b)(7)(C) also referred HERNANDEZ for a chronic care appointment.

**June 12, 2019**

(b)(6); (b)(7)(C) Licensed Practical Nurse (LPN), completed HERNANDEZ's transfer summary documenting<sup>47</sup> HERNANDEZ had a history of IBS, his medications were dispensed with him for transport, and his chest x-ray was negative for tuberculosis.<sup>48</sup> Furthermore, although LPN (b)(6); (b)(7)(C) documented HERNANDEZ was quarantined for mumps and would remain in cohort<sup>49</sup> until June 26, 2019, she cleared him for transfer. ERAU confirmed in HERNANDEZ's case, he was not diagnosed with mumps but rather quarantined with other detainees who potentially had contact

<sup>40</sup> See Comprehensive Mental Health Evaluation, dated May 29, 2019.

<sup>41</sup> See Inmate/Resident Health Appraisal, dated May 29, 2019.

<sup>42</sup> IBS, also referred to as spastic colon, is a common intestinal disorder causing belly pain, gas, diarrhea, and constipation.

<sup>43</sup> Constipation is having fewer than three bowel movements a week.

<sup>44</sup> Senosidos A-B, an alternative brand of Senokot, is a natural medicine derived from the senna plant that is used as a laxative and to treat constipation.

<sup>45</sup> Nesajar is a medication used to treat IBS.

<sup>46</sup> Bentyl, brand name for dicyclomine, is an antispasmodic drug used to treat spasms of the colon.

<sup>47</sup> See Prisoner Transit Medical Summary, dated June 12, 2019.

<sup>48</sup> See Express Mobile Radiology Interpretation, dated June 12, 2019. TCCF medical staff documented they performed the chest x-ray due to a nonspecific reaction to a PPD skin test. Because of an apparent system outage, (b)(6); (b)(7)(C) RN, documented that (b)(6); (b)(7)(C) RN, (first name unknown) planted a PPD skin test on HERNANDEZ on an unspecified date; records do not further indicate when the test was read.

<sup>49</sup> Cohorts are utilized to decrease the spread of infectious diseases.

with a positive case of mumps. The cohort group was not housed with the actively infected detainee. Creative Corrections advised medical professionals with infectious disease training can use their clinical judgement to determine when a cohort group or member of that group can be safely removed at any given time.

### June 13, 2019

At approximately 9:15 a.m., ERO New Orleans transferred HERNANDEZ to RCC.<sup>50</sup>

At 11:07 a.m., HERNANDEZ arrived at RCC.<sup>51</sup> (b)(6); (b)(7)(C) noted HERNANDEZ was cleared for TB at RCC by way of chest X-ray.

At 2:05 p.m., (b)(6); (b)(7)(C) NP, completed HERNANDEZ's medical and mental health intake assessment and documented<sup>52</sup> the following:

- HERNANDEZ's vital signs were within normal limits.
- HERNANDEZ reported a history of IBS, constipation, and daily lower abdomen pain.
- HERNANDEZ reported a colonoscopy<sup>53</sup> in Peru in 2018.
- HERNANDEZ reported currently taking Bentyl and Senakote<sup>54</sup> although he had not taken his medication in several weeks due to a misunderstanding.<sup>55</sup> (b)(6); (b)(7)(C) administered these medications during the encounter.
- HERNANDEZ reported being a victim of physical assault while in Cuba but declined a referral to mental health.

(b)(6); (b)(7)(C) documented a diagnosis of IBS, and a plan to continue HERNANDEZ's current medication with follow-up in three months.<sup>56</sup>

At an unknown time, HERNANDEZ signed consent for treatment and healthcare information release forms.<sup>57</sup>

During intake,<sup>58</sup> Deputy I (b)(6); (b)(7)(C) appropriately classified HERNANDEZ as low custody; Sergeant (Sgt. (b)(6); (b)(7)(C)) approved the rating the same day.<sup>59</sup> HERNANDEZ arrived with \$19.58 in funds, and RCC staff deposited those funds into his account.<sup>60</sup> Deputy I (b)(6); (b)(7)(C)

<sup>50</sup> See EARM Detention History, entry dated June 13, 2019.

<sup>51</sup> See TB Screening and Testing form, dated June 13, 2019.

<sup>52</sup> *Id.*

<sup>53</sup> A colonoscopy is an exam used to detect changes or abnormalities in the large intestine (colon) and rectum.

<sup>54</sup> NP Boothe noted Senakote which is believed to be a misspelling error for Senokot.

<sup>55</sup> NP Boothe did not further note context regarding the misunderstanding.

<sup>56</sup> See Doctor's Orders, dated June 13, 2019.

<sup>57</sup> See RCC Medical Consent form, dated June 13, 2019; *see also* RCC Authorization to Release Healthcare Information form, dated June 13, 2019.

<sup>58</sup> See EARM Detention History, entry dated June 13, 2019.

<sup>59</sup> See ICE Custody Classification Worksheet, dated June 13, 2019.

<sup>60</sup> See Inmate Financial History, dated October 18, 2019.



was noted as the property officer at intake;<sup>61</sup> however, there was no property inventory form located within HERNANDEZ's detention file.

Security staff assigned HERNANDEZ to general population unit C, upper bunk 88, in F building.<sup>62</sup>

### June 14, 2019

At an unknown time, (b)(6); (b)(7)(C) RN, documented an order for dicyclomine (20 mg), twice a day for six months, and Senakot<sup>63</sup> (8.6 mg), every evening for three months.<sup>64</sup> (b)(6); (b)(7)(C) medical doctor (MD), as the ordering physician; however, as noted previously, (b)(6); (b)(7)(C) ordered the medication during the intake assessment. A provider did not sign the Medication Order Form as required.

ERAU notes review of the Medication Administration Record (MAR) for dicyclomine, Senokot, and subsequent medications found that nurses did not clearly document administration. They often did not enter their initials, made checks or indistinguishable marks, circled the boxes, or left them blank, such that it remained unclear whether the medications were given, offered, and refused, or not offered. In addition, two pages of the MAR did not show the month and year, and three remaining pages were labeled with the wrong month. Additional administration issues identified from the review of the MAR are further addressed in the findings section of this report.

### June 19, 2019

At approximately 10:41 a.m., (b)(6); (b)(7)(C) RN, attempted to evaluate HERNANDEZ pursuant to a sick call request submitted the day prior for abdominal pain, to include that his medication was not helping.<sup>65</sup> (b)(6); (b)(7)(C) documented that HERNANDEZ refused to be seen or sign the refusal line on the sick call request form, and that HERNANDEZ stated he was not going to eat.<sup>67</sup>

During interview, (b)(6); (b)(7)(C) stated that when a detainee says they will not eat, their consumption is monitored by security and medical staff, but the detainee is not necessarily moved to a cell for initiation of hunger strike protocol.<sup>68</sup>

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<sup>61</sup> See Intake Booking, dated June 13, 2019.

<sup>62</sup> See Activity Sheet, dated June 13, 2019.

(b)(6); (b)(7)(C) noted Senakot which is believed to be a misspelling error for Senokot.

<sup>64</sup> See Medication Order Form, dated June 14, 2019. RCC's Medication Order Form is an internal form that provides secondary documentation of provider orders. Primary documentation consists of the doctor's orders themselves, which must be signed by the provider and noted by nurses, and MARs, onto which nurses must transcribe the orders. ERAU addresses Medication Order Forms in this report because although not necessary, they are part of the medical record.

<sup>65</sup> At the time of HERNANDEZ's detention, (b)(6); (b)(7)(C) as the corporate Clinical Director and designated RCC Clinical Director.

<sup>66</sup> See RCC Sick Call Request Form, dated June 19, 2019. (b)(6); (b)(7)(C) did not document use of interpretation services during this encounter.

<sup>67</sup> See Nurse's Notes, (b)(6); (b)(7)(C) dated June 19, 2019.

<sup>68</sup> ERAU's interview with (b)(6); (b)(7)(C) dated November 19, 2019.

At approximately 7:10 p.m., Lieutenant (b)(6); (b)(7)(C) responded to HERNANDEZ's housing unit after he stated he was not going to eat or take his medication.<sup>69</sup> (b)(6); (b)(7)(C) documented that HERNANDEZ asked to speak with ICE. (b)(6); (b)(7)(C) advised HERNANDEZ to submit an ICE request rather than refuse food and medication, to which HERNANDEZ replied that ICE was not responding. (b)(6); (b)(7)(C) further documented HERNANDEZ had missed six consecutive meals and two days of medication.<sup>70</sup> (b)(6); (b)(7)(C) also documented that he notified his immediate supervisor.

ERAU notes that according to RCC policy HC 4.2, *Hunger Strikes*, if a detainee has missed meals for 72-hours or declares a hunger strike, certain actions are required, including referral to mental health, notification to the Health Services Administrator (HSA), and placement in a single-occupancy cell. Furthermore, the policy states that security and medical staff will monitor, measure, and document all food intake, water intake, and total output.

### June 20, 2019

At approximately 10:00 a.m., (b)(6); (b)(7)(C) RN, completed an initial health assessment documenting<sup>71</sup> the following:

- HERNANDEZ's vital signs were within normal limits except for an elevated blood pressure of 129/74.<sup>72</sup>
- HERNANDEZ was missing teeth but did not notate which teeth.
- HERNANDEZ reported being physically assaulted in Cuba in 1994 and 2000.
- HERNANDEZ was instructed on how to access medical care.

(b)(6); (b)(7)(C) did not document HERNANDEZ's IBS history, current medications, complaint from the day prior of ineffective medication, or his refusal to take medication or eat. During her interview, (b)(6); (b)(7)(C) did not have an explanation for why she did not notate the information, she stated she did not recall the assessment.<sup>73</sup>

At approximately 3:55 p.m., (b)(6); (b)(7)(C) initiated a pre-segregation health evaluation, documenting<sup>74</sup> the following:

<sup>69</sup> See RCC Unusual Occurrence Report (UOR) (b)(6); (b)(7)(C) dated June 20, 2019. (b)(6); (b)(7)(C) documented he used (b)(6); (b)(7)(C) to interpret; however, he did not document who informed him of HERNANDEZ's refusals.

<sup>70</sup> (b)(6); (b)(7)(C) did not note who or where he obtained this information from. ERAU notes there was no other documentation provided from RCC detailing HERNANDEZ had missed six consecutive meals and two days of medication.

<sup>71</sup> See Physical/Health Assessment, dated June 20, 2019. (b)(6); (b)(7)(C) did not document use of interpretation services.

<sup>72</sup> 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 in this report, it is defined; this blood pressure falls within the AHA parameters for elevated blood pressure. Elevated blood pressure is categorized by a systolic reading of 120 to 129 and a diastolic reading less than 80. Mildly elevated blood pressure can be the result of dehydration, stress, salty food intake, smoking, some medications, or activity prior to testing.

<sup>73</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>74</sup> See Pre-Segregation Health Evaluation, dated June 20, 2019.



- HERNANDEZ appeared disheveled, listless,<sup>75</sup> and had a disorganized and illogical thought processes.
- HERNANDEZ had limited range of motion in his upper and lower extremities.

(b)(6); (b)(7)(C) approved HERNANDEZ for administrative housing placement due to his hunger strike for a period of three days.<sup>76</sup> (b)(6); (b)(7)(C) created an Administrative Segregation Order, which was signed by (b)(6); (b)(7)(C), the following day.<sup>77</sup> ERAU notes (b)(6); (b)(7)(C) did not (i) document when HERNANDEZ stopped eating or his declaration to refuse to eat; (ii) obtain his vitals; or (iii) refer him to mental health, despite her observations.<sup>78</sup>

At 4:04 p.m., security staff noted HERNANDEZ was placed in SM-2, a single occupancy cell.<sup>79</sup> Although requested, RCC could not produce a copy of the Administrative Segregation Form (Form I-888).<sup>80</sup>

### June 21, 2019

At an unknown time, (b)(6); (b)(7)(C) evaluated HERNANDEZ, documenting the following:<sup>81</sup>

- HERNANDEZ's blood pressure was elevated at 138/98.<sup>82</sup>
- HERNANDEZ drank two cups of juice and was provided a bottle of Ensure<sup>83</sup> for later.
- HERNANDEZ was not in acute distress.
- (b)(6); (b)(7)(C) documented plans to continue monitoring HERNANDEZ for signs and symptoms of dehydration.

At approximately 7:50 a.m. (b)(6); (b)(7)(C) evaluated HERNANDEZ and documented<sup>84</sup> the following:

- HERNANDEZ's blood pressure was elevated at 124/86.<sup>85</sup>
- HERNANDEZ drank an 8-ounce bottle of Ensure and 16 ounces of juice at 9:00 p.m. the night before.
- HERNANDEZ weighed 160.6 pounds.

<sup>75</sup> A person may be listless when s/he is lacking energy or enthusiasm.

<sup>76</sup> See Segregation Placement Checklist, dated June 20, 2019; *see also* Nurse's Note, dated June 20, 2019.

<sup>77</sup> See Administrative Segregation Order, dated June 20, 2019.

<sup>78</sup> ERAU could not confirm the amount of meals missed or how many additional meals HERNANDEZ refused as of his placement in segregation, as the records provided do not document this information.

<sup>79</sup> See Activity Log, dated June 20, 2019.

<sup>80</sup> The Form I-888 is used to document all activities in segregation to include meals and security checks.

<sup>81</sup> See Nurse's Notes, dated June 21, 2019. (b)(6); (b)(7)(C) did not document the use of interpretation services.

<sup>82</sup> According to the AHA, this blood pressure reading indicated stage two hypertension. Stage two hypertension is characterized by a systolic reading of at least 140 or diastolic reading of at least 90.

<sup>83</sup> Ensure is a liquid nutritional supplement.

<sup>84</sup> See Nurse's Notes, dated June 21, 2019.

<sup>85</sup> According to the AHA, this blood pressure reading indicated stage one hypertension. Stage one hypertension is characterized by a systolic reading of 130 to 139 or diastolic reading of 80 to 89.

- HERNANDEZ provided a urinalysis urine sample and used the restroom twice that morning.<sup>86</sup>

At approximately 9:00 a.m., (b)(6); (b)(7)(C) documented HERNANDEZ was resting and drank 8 ounces of Ensure.<sup>87</sup>

At approximately 11:45 a.m., (b)(6); (b)(7)(C) documented HERNANDEZ ate 25-30 percent of his lunch.<sup>88</sup> HERNANDEZ requested to return to general population; however, (b)(6); (b)(7)(C) instructed him to continue eating and drinking. (b)(6); (b)(7)(C) informed ERAU that she personally observed the amount of the lunch meal HERNANDEZ consumed, as nurses are responsible for looking at each tray.<sup>89</sup>

At approximately 12:10 p.m., (b)(6); (b)(7)(C) documented a verbal order from (b)(6); (b)(7)(C) to continue monitoring HERNANDEZ in isolation through the weekend.<sup>90</sup> According to (b)(6); (b)(7)(C) the verbal order resulted after she shared her concerns with (b)(6); (b)(7)(C) that HERNANDEZ might start refusing meals again.<sup>91</sup> Although the verbal order was documented in the nurse's notes, there was no accompanying Doctor's Order included in the medical record.

At approximately 4:35 p.m., (b)(6); (b)(7)(C) evaluated HERNANDEZ. (b)(6); (b)(7)(C) ordered HERNANDEZ a bland diet with no spices and extra vegetables.<sup>93</sup> During the interview, (b)(6); (b)(7)(C) recalled HERNANDEZ was refusing to eat, not as a protest but because he could not tolerate the food; for that reason, she discontinued hunger strike monitoring and ordered him a bland diet.<sup>94</sup> However, RCC did not provide documentation to confirm that the order was forwarded to Food Service or that HERNANDEZ ever received the special diet while detained at RCC.<sup>95</sup> Furthermore, (b)(6); (b)(7)(C) did not document this encounter within a progress note or the use of interpretation services; she stated she evaluated HERNANDEZ in person before issuing her orders and typically uses deputies for interpretation.<sup>96</sup>

<sup>86</sup> Results of a urinalysis were not included in the RCC medical record provided to ERAU. (b)(6); (b)(7)(C) stated to ERAU on November 18, 2019, that she could not recall if the urine sample was sent for laboratory testing or if it was tested in-house by way of dipstick.

<sup>87</sup> See Nurse's Notes, dated June 21, 2019.

<sup>88</sup> *Id.*

<sup>89</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019. This is the only occasion during this stay in administrative segregation that a nurse documented the percentage of food items HERNANDEZ consumed within a nurse's note. As noted below, security personnel did not initiate Meal Intake Logs until the time of HERNANDEZ's second placement in segregation for hunger strike monitoring on October 10, 2019.

<sup>90</sup> See Nurse's Notes, dated June 21, 2019.

<sup>91</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>92</sup> See Doctor's Order, dated June 21, 2019.

<sup>93</sup> See Medical Diet Order, dated June 21, 2019.

<sup>94</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>95</sup> During interview, (b)(6); (b)(7)(C) stated that at the time, orders were not always provided to Food Service because high turnover among nursing staff often left them unfilled. Furthermore, (b)(6); (b)(7)(C) the case manager responsible for managing food service in September and October of 2019, stated she discovered her predecessor did not have a system for documenting receipt of special diet orders. ERAU interviews with (b)(6); (b)(7)(C) and Case Manager (b)(6); (b)(7)(C) both dated November 19, 2019.

<sup>96</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.



(b)(6); (b)(7)(C) discharged HERNANDEZ to general population, noting he was not on hunger strike or suicidal.<sup>97</sup> At 5:16 p.m., security staff documented HERNANDEZ was transferred out of the single occupancy cell SM-2.<sup>98</sup>

### June 23, 2019

At 12:00 p.m., LPN (b)(6); (b)(7)(C) (first name unknown) documented that HERNANDEZ refused to report for pill call.<sup>99</sup> (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) both signed the form noting HERNANDEZ refused to sign. (b)(6); (b)(7)(C) explained that at the time, if a detainee did not report for pill call, the nurse initiated a refusal form and the unit deputy obtained the detainee's signature; the process did not necessarily involve communication between the detainee and nurse, including inquiry into the reason for the refusal and counseling the detainee on the risks.<sup>100</sup>

### June 24, 2019

At an unknown time, (b)(6); (b)(7)(C) evaluated HERNANDEZ, documenting<sup>101</sup> the following:

- HERNANDEZ's blood pressure was elevated at 160/85.
- HERNANDEZ's physical exam was normal except for hypoactive bowel sounds.<sup>102</sup>
- HERNANDEZ requested a diet change, as standard meals consisted of low fiber and spicy foods.

(b)(6); (b)(7)(C) ordered a bland diet, Psyllium fiber powder,<sup>103</sup> one scoop daily for three months, and for HERNANDEZ's blood pressure to be re-checked in 30 minutes. RCC did not provide evidence that the second bland diet order was either submitted to or fulfilled by Food Service or that HERNANDEZ received it. Furthermore, there was no documentation within the medical record to confirm medical staff re-checked HERNANDEZ's blood pressure. Although (b)(6); (b)(7)(C) noted the order for Psyllium fiber powder, medical staff did not complete the Medication Order Form, and incorrectly transcribed the order to the MAR by noting HERNANDEZ was to receive two scoops once daily.<sup>104</sup>

<sup>97</sup> See Doctor's Order, dated June 21, 2019; *see also* Administrative Segregation Order, dated June 20, 2019.

<sup>98</sup> See Activity Log, dated June 21, 2019. RCC did not provide documentation detailing HERNANDEZ's new general population assignment.

<sup>99</sup> See Refusal Form, dated June 23, 2019.

<sup>100</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>101</sup> See RCC Untitled Document, dated June 24, 2019. (b)(6); (b)(7)(C) did not document the use of interpretation services.

<sup>102</sup> Hypoactive bowel sounds indicate a reduction in intestinal activity and possible constipation.

<sup>103</sup> Psyllium fiber powder is an over the counter dietary supplement used to reduce constipation. Fiber is typically ordered on an open-ended basis with periodic review.

<sup>104</sup> See MAR, dated June 2019.

**June 30, 2019**

At an unknown time, (b)(6); (b)(7)(C) PN, administered a measles, mumps, and rubella (MMR) vaccination.<sup>105</sup>

**July 5, 2019**

At approximately 8:30 a.m., (b)(6); (b)(7)(C) assessed HERNANDEZ pursuant to a sick call request.<sup>106</sup> (b)(6); (b)(7)(C) documented HERNANDEZ's vital signs were all within normal limits. HERNANDEZ stated dicyclomine was causing side effects such as dizziness and weakness, and he continued to experience stomach pain. HERNANDEZ reported taking fiber every morning and having regular bowel movements. HERNANDEZ requested and was referred to a provider by RN (b)(6); (b)(7)(C)

At approximately 5:13 p.m., (b)(6); (b)(7)(C) ordered three occult cards<sup>108</sup> for hemoccult tests and the discontinuation of dicyclomine.<sup>109</sup> Although an LPN signed under (b)(6); (b)(7)(C) order, there was no corresponding medication order form and discontinuation of dicyclomine was not transcribed on the MAR until three days later; as a result, nurses continued to administer dicyclomine for three days following the discontinuation order.<sup>110</sup> Furthermore, the occult blood tests were not completed for over a month, and only after (b)(6); (b)(7)(C) reordered the test as noted on August 8, 2019.<sup>111</sup> (b)(6); (b)(7)(C) stated she was unaware the tests were not completed per her order.<sup>112</sup>

**July 13, 2019**

At approximately 11:00 a.m., (b)(6); (b)(7)(C) assessed HERNANDEZ pursuant to his sick call request submitted the day prior, documenting<sup>113</sup> the following:

- HERNANDEZ's vital signs were within normal limits except for an elevated blood pressure of 133/82.

<sup>105</sup> See Consentimiento para la vacuna MMR, dated June 30, 2019. MMR is a vaccination which combines protection for the communicable diseases of measles, mumps, and rubella.

<sup>106</sup> See RCC Sick Call Request Form, dated July 5, 2019. The submission date of this request (and others discussed in this report) is unknown as HERNANDEZ input his birth date instead. Furthermore, (b)(6); (b)(7)(C) documented her encounter on the sick call request rather than in a nursing note following standard practice for documenting patient encounters, which requires recording subjective history (S), objective findings (O), nursing assessment (A), plan (P), and patient education (E).

<sup>107</sup> See Referral Slip, dated July 5, 2019.

<sup>108</sup> Patients are given blood occult cards for placement of fecal samples for laboratory testing and detection of hidden blood, which might indicate cancer or polyps.

<sup>109</sup> See Doctor's Order, dated July 5, 2019. ERAU notes there was no assessment filled out showing (b)(6); (b)(7)(C) saw HERNANDEZ in person. During her interview with ERAU on November 19, 2019, (b)(6); (b)(7)(C) stated it would be unusual for her to write orders without seeing a patient.

<sup>110</sup> See MAR.

<sup>111</sup> See Untitled Form, dated August 8, 2019.

<sup>112</sup> ERAU Interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>113</sup> See RCC Sick Call Request Form, dated July 13, 2019. (b)(6); (b)(7)(C) did not document the use of interpretation services.



- HERNANDEZ complained of pain in his toe and requested the toenail be cut and lifted to prevent infection.
- HERNANDEZ showed no signs of an ingrown toenail and there was no redness or swelling.

(b)(6); (b)(7)(C) directed HERNANDEZ to return to his dorm and submit a sick call request, if necessary.

### July 30, 2019

At an unknown time, (b)(6); (b)(7)(C) evaluated HERNANDEZ pursuant to his sick call request submitted the day prior for itchy skin.<sup>114</sup> (b)(6); (b)(7)(C) documented that HERNANDEZ's vital signs were within normal limits, and his skin was negative for any rash, bumps, fungal areas, or other symptoms of rash. (b)(6); (b)(7)(C) advised HERNANDEZ to apply the lotion available in the housing unit every morning, evening and after showering, and submit a sick call request if the condition worsened.

### August 6, 2019

At an unknown time, (b)(6); (b)(7)(C) evaluated HERNANDEZ pursuant to his sick call request submitted the day prior for colon pain.<sup>115</sup> (b)(6); (b)(7)(C) noted HERNANDEZ's vital signs were within normal limits, and that HERNANDEZ stated he voluntarily stopped taking dicyclomine because of the side effects, and wanted to try a different medication. (b)(6); (b)(7)(C) completed an ASAP Provider Referral Slip noting HERNANDEZ's complaints.<sup>116</sup>

### August 8, 2019

At approximately 9:55 a.m., (b)(6); (b)(7)(C) evaluated HERNANDEZ pursuant to RN (b)(6); (b)(7)(C) referral, documenting HERNANDEZ's vital signs were normal except for an elevated blood pressure at 123/78 and a normal physical assessment with no abdominal tenderness and active bowel sounds.<sup>117</sup> (b)(6); (b)(7)(C) re-ordered the hemoccult test, as the July 5, 2019 order was never completed. (b)(6); (b)(7)(C) LPN, confirmed HERNANDEZ was given the hemoccult cards.<sup>118</sup> The results for the hemoccult tests were normal.<sup>119</sup>

<sup>114</sup> See RCC Sick Call Request Form, dated July 30, 2019. (b)(6); (b)(7)(C) documented the assessment on the sick call request form rather than a nursing note. (b)(6); (b)(7)(C) did not document the use of interpretation services.

<sup>115</sup> See RCC Sick Call Request Form, dated August 6, 2019. (b)(6); (b)(7)(C) documented her assessment on the sick call request rather than a nursing note. RN (b)(6); (b)(7)(C) did not document the use of interpretation services.

<sup>116</sup> See ASAP Provider Referral Slip, dated August 6, 2019. During her interview with ERAU on November 19, 2019, RN Reed stated she used the only form available and that she meant for it to be a routine referral.

<sup>117</sup> See RCC Untitled Form, dated August 8, 2019.

<sup>118</sup> See Doctors Orders, dated August 8, 2019.

<sup>119</sup> See Nurses Notes, dated August 8, 2019. The results of one of the hemoccult tests came back same day and the other two on August 9, 2019.

**August 26, 2019**

At approximately 8:50 a.m., NP (b)(6); (b)(7)(C) evaluated HERNANDEZ for an abdominal pain follow-up appointment. NP (b)(6); (b)(7)(C) documented<sup>120</sup> the following:

- HERNANDEZ's vital signs were normal except for an elevated blood pressure of 125/74.
- HERNANDEZ stated the pain in his abdomen was stress-induced and that he had a reaction to dicyclomine.
- HERNANDEZ had bloating and pain in the lower left quadrant of the abdomen on palpation.<sup>121</sup>

(b)(6); (b)(7)(C) assessment conclusion was chronic IBS and documented to discontinue senna and prescribe Pinaverium bromide,<sup>122</sup> noting if the medication was unavailable, to order Levsin<sup>123</sup> (0.125 mg), twice a day for one month, and continue fiber.<sup>124</sup> Furthermore, (b)(6); (b)(7)(C) recommended a mental health referral but HERNANDEZ refused. (b)(6); (b)(7)(C) documented discussing stress relieving techniques, encouraging medication compliance, and to schedule follow-up with a provider as needed.

(b)(6); (b)(7)(C) did not accurately document the orders as written by (b)(6); (b)(7)(C) as she did not address the continuation of fiber and added both Pinaverium bromide and Levsin to the MAR.<sup>125</sup> Although (b)(6); (b)(7)(C) completed a Medication Order Form, she dated it for two days prior to the order date, and (b)(6); (b)(7)(C) did not sign the form.<sup>126</sup> Also, though Pinaverium bromide was unavailable, nurses documented administering the medication on the morning and evening of August 30, 2019. The medication Levsin was ultimately ordered, but (b)(6); (b)(7)(C) erroneously transcribed it as 0.12 mg instead of 0.125 mg, and medical staff did not administer it until four days later. During the 30-day prescription period, nurses documented they gave HERNANDEZ 38 of 60 doses; available records indicate that he refused two; 20 were unaccounted for. Furthermore, nurses administered two doses of the medication after the prescription expired.

**September 4, 2019**

At approximately 1:15 p.m., (b)(6); (b)(7)(C) triaged HERNANDEZ's undated sick call request for a mental health consult for stress.<sup>127</sup> (b)(6); (b)(7)(C) submitted a mental health referral to the provider documenting HERNANDEZ stated he was unable to sleep and had increased levels of stress and anxiety since being housed in Unit C.<sup>128</sup>

<sup>120</sup> See RCC Untitled Form, dated August 26, 2019. (b)(6); (b)(7)(C) used interpretation services during this encounter.

<sup>121</sup> Palpation is an examination method, using one's hands to press or feel areas of the patient's body to determine presence, size, shape, firmness, or location.

<sup>122</sup> Pinaverium bromide is a medication used to restore normal contractions of the bowel.

<sup>123</sup> Levsin is used to relieve spasms caused by lower abdominal disorders.

<sup>124</sup> See Doctor's Order, dated August 26, 2019.

<sup>125</sup> See MAR.

<sup>126</sup> See Medication Order form, dated August 24, 2019.

<sup>127</sup> See RCC Sick Call Request Form, dated September 4, 2019.

<sup>128</sup> See Mental Health Referral Slip, dated September 4, 2019. (b)(6); (b)(7)(C) did not document the use of interpretation services.



## September 10, 2019

An LPN evaluated HERNANDEZ pursuant to an undated sick call request<sup>129</sup> for abdominal pain due to not receiving his medication and documented<sup>130</sup> the following:

- HERNANDEZ's documented vital signs were normal, but the LPN omitted a diastolic blood pressure finding, noting only an elevated systolic blood pressure of 129.
- HERNANDEZ's last bowel movement was four days ago.
- HERNANDEZ's abdomen was soft and non-distended, with bowel sounds present but sluggish in all four quadrants.

The LPN referred HERNANDEZ to a provider for evaluation of constipation, noting on the referral that HERNANDEZ also requested senna be restarted, as it was the one medication that worked for him.<sup>131</sup>

## September 13, 2019

At approximately 2:50 p.m., (b)(6); (b)(7)(C) evaluated HERNANDEZ for abdominal pain and reviewed his current medication (b)(6); (b)(7)(C) documented<sup>132</sup> the following:

- HERNANDEZ's vital signs were within normal limits except an elevated blood pressure of 132/90.
- HERNANDEZ was tender in the right lower quadrants of the abdomen and complained of right-side back pain.
- HERNANDEZ stated he did not like fiber but felt Senokot worked.

(b)(6); (b)(7)(C) diagnosed HERNANDEZ with chronic constipation and abdominal pain, and ordered Pinaverium bromide to be discontinued, but re-prescribed Senokot (8.6 mg), two tablets at nighttime for six months.<sup>133</sup>

(b)(6); (b)(7)(C) completed a Medication Order Form noting (b)(6); (b)(7)(C) orders, but (b)(6); (b)(7)(C) did not sign the form.<sup>134</sup> Furthermore, nurses maintained compliance with Senokot administration throughout the month of September but only accounted for seven doses during the month of October.<sup>135</sup>

## September 14, 2019

<sup>129</sup> See RCC Sick Call Request Form, dated September 10, 2019. The LPN's name is illegible and could not be determined by medical staff. The LPN did not document the use of interpretation services.

<sup>130</sup> See Constipation Protocol Form, dated September 10, 2019.

<sup>131</sup> See Chronic Provider Referral Slip, undated.

<sup>132</sup> See Doctor's Notes, dated September 13, 2019. (b)(6); (b)(7)(C) did not document the use of interpretation services.

<sup>133</sup> See Doctor's Order, dated September 13, 2019. As noted earlier, Pinaverium bromide was not available; therefore, Levsin was given instead. Levsin was not discontinued on this date.

<sup>134</sup> See Medication Order Form, dated September 13, 2019.

<sup>135</sup> See MAR.

LPN (b)(6); (b)(7)(C) documented HERNANDEZ refused a follow-up mental health appointment with J. (b)(6); (b)(7)(C) (first name unknown).<sup>136</sup> HERNANDEZ signed the refusal form.<sup>137</sup>

## October 10, 2019

At approximately 10:00 a.m., security staff placed HERNANDEZ in SM-2 after he threatened hunger strike.<sup>138</sup> (b)(6); (b)(7)(C) completed HERNANDEZ's pre-segregation health evaluation, documenting that HERNANDEZ appeared fully oriented with no signs of distress but refused vital signs and a weight assessment.<sup>139</sup>

(b)(6); (b)(7)(C) cared HERNANDEZ for segregation, initiated and signed the Administrative Segregation Order, and documented the reason as medical observation.<sup>140</sup> (b)(6); (b)(7)(C) signed the order, further noting the placement was for threatening hunger strike. Available security and medical documentation does not clarify when or to whom HERNANDEZ threatened or declared hunger strike, or if he missed meals. Consequently, ERAU cannot determine whether (b)(6); (b)(7)(C) should have initiated hunger strike protocol, or whether HERNANDEZ was placed in segregation for monitoring of meal consumption before declaring a hunger strike or missing consecutive meals.

At approximately 2:31 p.m., security staff moved HERNANDEZ to lockdown cell 3 (LD-3), where he remained until his death on October 15, 2019.<sup>141</sup> LD-3 is one of five cells on A Hall used for segregation and medical observation.<sup>142</sup>

Nurses did not conduct any additional rounds on this date following HERNANDEZ's assignment to segregation.<sup>143</sup> Deputies documented<sup>144</sup> irregular 30-minute security checks and created the first Meal Intake Log,<sup>145</sup> detailing that HERNANDEZ consumed zero percent of his supper meal.

<sup>136</sup> See Nurse's Notes, dated September 14, 2019; see also Mental Health Referral Slip, dated September 4, 2019.

<sup>137</sup> See Medication Refusal form, dated September 14, 2019.

<sup>138</sup> See Administrative Segregation Order, dated October 10, 2019.

<sup>139</sup> See Pre-Segregation Health Evaluation, dated October 10, 2019.

<sup>140</sup> See Administrative Segregation Order, dated October 10, 2019.

<sup>141</sup> See Activity Sheet, dated October 10, 2019.

<sup>142</sup> The cell has a combination toilet/sink fixture in the corner to the left of the door. At the time of HERNANDEZ's detention, there was a heavy rubberized window flap covering the window, and a bunk bed positioned along the right-side wall with one end up against the back wall opposite the door. Without opening the cell door, observation of the space between the other end of the bunk and adjoining wall required careful effort. Following HERNANDEZ's death, RCC removed the flaps.

<sup>143</sup> The materials provided by RCC did not include policy addressing nursing requirements for detainees placed on medical observation, including frequency and expectations during the rounds.

<sup>144</sup> See Form I-888, dated October 10, 2019.

<sup>145</sup> See RCC Meal Intake Log, dated October 10, 2019. Deputies utilize Meal Intake Logs to record items on meal trays and the percentage consumed by the detainee. The log also includes instruction stating trays are not to be removed before inspected by medical staff; however, there is no signature line for medical to confirm an inspection of the tray.



RCC provided Meal Intake Logs starting with the October 10, 2019, supper meal through the lunch meal on October 14, 2019, the day before HERNANDEZ's death.<sup>146</sup> ERAU notes entries on the Meal Intake Logs were incomplete and do not notate who reviewed HERNANDEZ's consumption, making it impossible to determine if the instruction for medical inspection of trays was followed by either deputies or nurses.

### October 11, 2019

At approximately 4:00 a.m., an unknown nurse documented observing HERNANDEZ resting in bed and that he showed no signs or symptoms of distress.<sup>147</sup>

At approximately 7:00 a.m., (b)(6); (b)(7)(C) documented that HERNANDEZ refused vital signs, but was fully oriented with no apparent distress, and voiced no complaints or sick call needs.<sup>148</sup>

At approximately 9:20 p.m., (b)(6); (b)(7)(C) documented HERNANDEZ did not eat dinner, denied needs, and was not in distress.<sup>149</sup>

On this date, deputies documented irregular 30-minute security checks, and that HERNANDEZ accepted only the supper meal.<sup>150</sup> However, security staff did not document acceptance or refusal or the amount of consumption of the supper meal on the Meal Intake Log.<sup>151</sup>

### October 12, 2019

At approximately 10:50 a.m., (b)(6); (b)(7)(C) noted HERNANDEZ had no complaints or requests.

At 12:30 p.m., (b)(6); (b)(7)(C) documented checking Main Control records and the segregation chart, noting HERNANDEZ ate supper the previous night and breakfast on this date.<sup>152</sup> However, ERAU notes R (b)(6); (b)(7)(C) record of meals consumed is not consistent with security records or (b)(6); (b)(7)(C) nursing note from the night before.

At 8:30 p.m., (b)(6); (b)(7)(C) noted HERNANDEZ had no complaints.<sup>153</sup>

On this date, deputies documented irregular 30-minute security checks.<sup>154</sup> HERNANDEZ accepted his breakfast tray and refused his lunch and supper meals. The deputy recorded on the Meal Intake Log that HERNANDEZ consumed nothing from the breakfast tray.<sup>155</sup>

<sup>146</sup> See RCC Meal Intake Logs, dated October 10 – 14, 2019.

<sup>147</sup> See Nurses Notes, dated October 11, 2019. The nurse's signature is illegible.

<sup>148</sup> *Id.*

<sup>149</sup> *Id.*

<sup>150</sup> See Form I-888, dated October 11, 2019.

<sup>151</sup> See RCC Meal Intake Log, dated October 10 – 13, 2019.

<sup>152</sup> See Nurse's Notes, dated October 12, 2019.

<sup>153</sup> *Id.*

<sup>154</sup> See Form I-888, dated October 12, 2019.

<sup>155</sup> See RCC Meal Intake Log, dated October 10 – 13, 2019.

## October 13, 2019

At 9:05 a.m., (b)(6); (b)(7)(C) noted HERNANDEZ was resting, displayed no signs or symptoms of distress, and responded when addressed but refused to talk otherwise.<sup>156</sup>

At 11:05 p.m., (b)(6); (b)(7)(C) noted HERNANDEZ had refused lunch and supper on the previous day and all three meals on this date.<sup>157</sup> HERNANDEZ was resting and calm, with even and unlabored respirations, and voiced no concerns.

Deputies documented irregular 30-minute security checks.<sup>158</sup> HERNANDEZ accepted the breakfast tray but refused the lunch and supper meals. The deputy documented HERNANDEZ consumed nothing from the breakfast tray.<sup>159</sup>

## October 14, 2019

At 8:00 a.m., (b)(6); (b)(7)(C) documented the only encounter with HERNANDEZ on this date.<sup>160</sup> RN (b)(6); (b)(7)(C) noted HERNANDEZ was fully oriented and was not in acute distress but refused to have his vital signs taken or sign a Hunger-Strike Consent and Expected/Possible Medical Sequence of Symptoms form.<sup>161</sup> (b)(6); (b)(7)(C) completed another form documenting HERNANDEZ refused initial vital signs after missing his ninth meal.<sup>162</sup> (b)(6); (b)(7)(C) documented that she provided water to and educated HERNANDEZ on the risks and possible symptoms of hunger strike, encouraged him to consume approximately two liters of water daily, and explained he would be given three meals a day and a daily supply of water.<sup>163</sup> (b)(6); (b)(7)(C) did not contact a provider to receive orders after she initiated the hunger strike protocol and did not submit a referral to mental health.

Deputies documented irregular 30-minute security checks.<sup>164</sup> HERNANDEZ refused his breakfast and lunch trays but accepted his supper tray. A deputy documented on the Meal Intake Log that HERNANDEZ consumed nothing from his supper tray.<sup>165</sup>

<sup>156</sup> See Nurse's Note, dated October 13, 2019.

<sup>157</sup> *Id.*

<sup>158</sup> See Form I-888, dated October 13, 2019.

<sup>159</sup> See Meal Intake Log, dated October 10 – 13, 2019.

<sup>160</sup> See Nurse's Note, dated October 14, 2019.

<sup>161</sup> *Id.*; see also RCC Hunger-Strike Consent and the Expected/Possible Medical Sequence of Symptoms, dated October 14, 2019. The consent form is specific to treatment while on hunger strike and lists the possible sequence of symptoms. ERAU notes the form given to HERNANDEZ was in English and (b)(6); (b)(7)(C) did not document if she used interpretation services.

<sup>162</sup> See RCC Untitled Form, October 14, 2019.

<sup>163</sup> *Id.*

<sup>164</sup> See Form I-888, dated October 14, 2019.

<sup>165</sup> See Meal Intake Log, dated October 14, 2019.



October 15, 2019<sup>166</sup>

At 8:35 a.m., (b)(6); (b)(7)(C) notified ERO via e-mail that HERNANDEZ was on hunger strike.<sup>167</sup> SDDO (b)(6); (b)(7)(C) acknowledged receiving notification of the hunger strike, commenting that there was confusion as to when HERNANDEZ missed his last meal.<sup>168</sup> He then asked DO (b)(6); (b)(7)(C) to see HERNANDEZ because he was on hunger strike and refused lab work.<sup>169</sup> DO (b)(6); (b)(7)(C) stated he planned to see HERNANDEZ to discuss the hunger strike and serve notice that his parole was denied but did not have the opportunity prior to the detainee's death.<sup>170</sup>

At 10:04 a.m., (b)(6); (b)(7)(C) approached LD-3, lifted the window flap, and peered in.<sup>171</sup> He opened the cell door and spoke with HERNANDEZ for approximately 11 seconds, then secured the door and made a notation in the log. (b)(6); (b)(7)(C) stated to ERAU that HERNANDEZ told him he did not want to eat and waved him off.<sup>172</sup>

At 10:17 a.m. and 10:50 a.m., (b)(6); (b)(7)(C) approached LD-3, lifted the window flap and peered in.<sup>173</sup> He logged his round, then departed. He stated to ERAU that HERNANDEZ was either on the floor or on his bunk when he made these security checks.<sup>174</sup>

At 11:28 a.m., Deputy (b)(6); (b)(7)(C) lifted the window flap on LD-3 and peered into the cell. She logged the round and departed the area.<sup>175</sup>

At 11:53 a.m., (b)(6); (b)(7)(C) removed the log from the wall pocket outside LD-3 and made notations but did not lift the window flap for any of the rounds.<sup>176</sup>

At 12:00 p.m. (b)(6); (b)(7)(C) documented that HERNANDEZ missed breakfast and lunch, making it the tenth meal missed.<sup>177</sup> She further noted that per (b)(6); (b)(7)(C) he refused vital signs, a shower, and labs. During her interview, (b)(6); (b)(7)(C) stated she did not conduct an encounter with HERNANDEZ on this date and that no nurse made a round to attempt taking his vital signs or

<sup>166</sup> ERAU notes there is considerable inconsistency between staff accounts of events on this date; consequently, reference to facility video footage was the most reliable way to account for certain events hereafter.

<sup>167</sup> See LPN (b)(6); (b)(7)(C) email 'Hunger Strike,' dated October 15, 2019.

<sup>168</sup> ERAU interview with SDDO (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>169</sup> See SDDO Reaves email 'FW: Hunger Strike,' dated October 15, 2019.

<sup>170</sup> ERAU interview with DO (b)(6); (b)(7)(C), dated November 20, 2019.

<sup>171</sup> See Video surveillance footage, dated October 15, 2019.

<sup>172</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 20, 2019.

<sup>173</sup> See Video surveillance footage, dated October 15, 2019.

<sup>174</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 20, 2019.

<sup>175</sup> See Video surveillance footage, dated October 15, 2019. According to (b)(6); (b)(7)(C) he assigned Deputy (b)(6); (b)(7)(C) to take over conducting security checks so that he could perform other duties.

<sup>176</sup> See Form I-888, dated October 15, 2019; see also Video surveillance footage, dated October 15, 2019. Deputy (b)(6); (b)(7)(C) conducted four additional rounds at 12:34 p.m., 1:19 p.m., 1:24 p.m., and 1:54 p.m. in the same manner as her 11:53 a.m. round. ERAU did not interview Deputy (b)(6); (b)(7)(C) because her employment at RCC ended prior to the on-site visit.

<sup>177</sup> See Nurse's Notes, dated October 15, 2019. As previously noted, RN (b)(6); (b)(7)(C) documented that HERNANDEZ had missed his ninth meal at 8:00 a.m. the preceding day. By 12:00 p.m. this date, HERNANDEZ would have missed three additional meals.

weight.<sup>178</sup> As previously discussed, HERNANDEZ refused a vital sign assessment during RN (b)(6); (b)(7)(C)'s October 14, 2019 morning encounter, but there is no other mention in the medical record concerning refusal of a shower or labs between the time of R (b)(6); (b)(7)(C)'s encounter and (b)(6); (b)(7)(C)'s nursing note.

At 1:26 p.m., Deputies (b)(6); (b)(7)(C) approached LD-3.<sup>179</sup> Deputy (b)(6); (b)(7)(C) lifted the window flap, twice peering into the cell. Deputy A (b)(6); (b)(7)(C) informed ERAU he had arrived early for the next shift and decided to begin checking the cells as his duties included offering detainees in segregation cells showers, phone calls, hygiene items and laundry services. While walking down A Hall with Deputy (b)(6); (b)(7)(C) noticed there was a classification tag suggesting the cell was not occupied but saw the logbook in the wall pocket suggesting otherwise.<sup>180</sup> When he looked in the cell, he did not see HERNANDEZ; Deputy (b)(6); (b)(7)(C) then informed him HERNANDEZ was in medical.<sup>181</sup>

At 2:04 p.m., Captain (Capt. (b)(6); (b)(7)(C)) approached LD-3 with (b)(6); (b)(7)(C). During his interview, (b)(6); (b)(7)(C) elaborated on what is shown on video by stating he first approached the cell after smelling a very strong, foul odor.<sup>183</sup> (b)(6); (b)(7)(C) lifted the window flap and peered into the cell for approximately ten seconds, then knocked on the door three times before walking away.<sup>184</sup> He returned within a minute with (b)(6); (b)(7)(C) following, and again lifted the window flap to peer into the cell. (b)(6); (b)(7)(C) stated he noticed sheets on the bed positioned in a fashion that suggested the detainee was on the bunk.<sup>185</sup> He unlocked and slightly opened the cell door, then pushed it open further and looked to the right. (b)(6); (b)(7)(C) quickly backed out, secured the door, lunged backward covering his mouth with his hand, and left from camera view. Capt. (b)(6); (b)(7)(C) explained that when he opened the door, he saw HERNANDEZ hanging from the top bunk, in the right corner of the cell.

Immediately after (b)(6); (b)(7)(C) left camera view, (b)(6); (b)(7)(C) approached the cell, lifted the window flap, and peered in for approximately four seconds before opening the cell door.<sup>186</sup> He then backed away and raised his radio, which he confirmed was to call a 10-19, RCC's radio code for an emergency of any type.<sup>187</sup> He added that (b)(6); (b)(7)(C) also called 10-19 when he moved away from the cell and out of camera view. According to (b)(6); (b)(7)(C), his 10-19 radio call was for Major (b)(6); (b)(7)(C) and Acting Warden (AW) (b)(6); (b)(7)(C) to respond to the area.<sup>188</sup> Deputy (b)(6); (b)(7)(C) who was in the immediate area when (b)(6); (b)(7)(C) first approached the cell, also looked in and then immediately left from camera view. At 2:05 p.m., Lt.

<sup>178</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>179</sup> *Id.*

<sup>180</sup> ERAU interview with Deputy Arnold, dated November 20, 2019. See Deputy (b)(6); (b)(7)(C)'s Unusual Occurrence Report, dated October 15, 2019. ERAU cannot explain why a classification tag was on the cell.

<sup>181</sup> During interview with Deputy (b)(6); (b)(7)(C) in November 20, 2019, he did not recall telling Deputy (b)(6); (b)(7)(C) HERNANDEZ was in medical.

<sup>182</sup> See Video surveillance footage, dated October 15, 2019.

<sup>183</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 20, 2019.

<sup>184</sup> See Video surveillance footage, dated October 15, 2019.

<sup>185</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>186</sup> See Video surveillance footage, dated October 15, 2019.

<sup>187</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>188</sup> See (b)(6); (b)(7)(C)'s Unusual Occurrence Report, dated October 15, 2019.



(b)(6); (b)(7)(C) e-entered LD-3 and stood in the doorway for approximately six seconds, then backed out and raised his hands to his head.

When asked about his training in responding to a suicide attempt by hanging (b)(6); (b)(7)(C) stated that the training required the responder to first lift the detainee upward, then cut him down and start cardio pulmonary resuscitation (CPR).<sup>189</sup> He communicated that his intention was to cut HERNANDEZ down once medical staff arrived with the cut-down tool, but his superiors directed otherwise. During interview, Deputy (b)(6); (b)(7)(C) stated that after seeing HERNANDEZ, he did not consider entering the cell to lift and cut him down because it was clear he was already dead; he also stated he did not know where a cut-down tool was located.<sup>190</sup>

At 2:06 p.m., (b)(6); (b)(7)(C) arrived at A Hall.<sup>191</sup> Reports as to what transpired in the following minutes vary; however, all responding staff stated that upon his arrival (b)(6); (b)(7)(C) was in command. Major (b)(6); (b)(7)(C) informed ERAU and documented in a post-incident statement that he learned from a nurse<sup>192</sup> that a detainee hanged himself and had no pulse.<sup>193</sup> The video shows Major (b)(6); (b)(7)(C) not approach the cell and although nurses looked in, they did not enter.

(b)(6); (b)(7)(C) arrived within two minutes of the 10-19 call.<sup>194</sup> (b)(6); (b)(7)(C) described the scene as chaotic, with staff everywhere but no one was doing anything.<sup>195</sup> (b)(6); (b)(7)(C) entered LD-3 and observed HERNANDEZ hanging from the top bunk.<sup>196</sup> He exited the cell and spoke with Major (b)(6); (b)(7)(C), whom he presumed had looked in the cell himself.<sup>197</sup> (b)(6); (b)(7)(C) made the decision to declare the cell a crime scene and directed staff not to cut HERNANDEZ down.<sup>198</sup>

(b)(6); (b)(7)(C) stated the decision was a judgement call, not based on policy or protocol. At the time of the incident, (b)(6); (b)(7)(C) was not aware why HERNANDEZ was in LD-3, and although it is a lockdown cell, (b)(6); (b)(7)(C) could not be certain he was housed alone. For that reason, he said he could not be certain he had taken his own life. (b)(6); (b)(7)(C) stated he declared the cell a crime

<sup>189</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 20, 2019. During interview with ERAU on November 19, 2019, Capt. (b)(6); (b)(7)(C) RCC Training Coordinator at the time, confirmed staff are trained to respond to a suicide attempt by hanging in the manner described by (b)(6); (b)(7)(C).

<sup>190</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>191</sup> See Video surveillance footage, dated October 15, 2019.

<sup>192</sup> (b)(6); (b)(7)(C) did not provide her last name during interview but reference (b)(6); (b)(7)(C) in his October 15, 2019 written statement. There is no (b)(6); (b)(7)(C) on staff, but LPN (b)(6); (b)(7)(C) was on-site this date, specifically leaving A Hall following pill call around the time of the emergency call. Video evidence does not support that she ever entered the cell.

<sup>193</sup> See Re: Detainee Roylan Hernandez Diaz A# A203637060/Cuba Memorandum, dated October 15, 2019; ERAU interview with Major (b)(6); (b)(7)(C) dated November 18, 2019. When interviewed, (b)(6); (b)(7)(C) was on administrative leave pending completion of LaSalle Corrections' investigation into the incident. As of November 20, 2019, Major (b)(6); (b)(7)(C) is no longer employed by LaSalle Corrections.

<sup>194</sup> See Video surveillance footage, dated October 15, 2019.

<sup>195</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019. When interviewed, (b)(6); (b)(7)(C) was on administrative leave pending completion of LaSalle Corrections' investigation into the incident. As of November 20, 2019, (b)(6); (b)(7)(C) is no longer employed by LaSalle Corrections.

<sup>196</sup> See Video surveillance footage, dated October 15, 2019.

<sup>197</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>198</sup> ERAU interviews with (b)(6); (b)(7)(C) and Major (b)(6); (b)(7)(C) both dated November 18, 2019.

scene based on his 28 years in law enforcement, and that in his experience the scene of an apparent suicide is a crime scene until determined otherwise by law enforcement.<sup>199</sup> However, LaSalle Corrections Regional Director (b)(6); (b)(7)(C) stated there is no policy basis or precedent for (b)(6); (b)(7)(C) decision to declare the cell a crime scene.<sup>200</sup>

Shortly after (b)(6); (b)(7)(C) arrival, (b)(6); (b)(7)(C) arrived, followed closely by (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C). Medical staff looked into LD-3, but did not enter.<sup>202</sup> (b)(6); (b)(7)(C) stated she did not expect to encounter a suicide and that she was surprised no one had cut HERNANDEZ down.<sup>203</sup> (b)(6); (b)(7)(C) stated she was also surprised when (b)(6); (b)(7)(C) prohibited entry into the cell stating it was a crime scene. (b)(6); (b)(7)(C) reported she and (b)(6); (b)(7)(C) amantly expressed their objections,<sup>204</sup> and those representations were supported by (b)(6); (b)(7)(C) who observed the interactions.<sup>205</sup>

Upon discovering the emergency was a suicide, (b)(6); (b)(7)(C) went to retrieve a cut down tool from medical, while (b)(6); (b)(7)(C) retrieved one from the control center.<sup>206</sup> Both stated when they returned to the scene with the tools, (b)(6); (b)(7)(C) stated they could not enter because it was a crime scene. (b)(6); (b)(7)(C) confirmed that nurses made repeated requests to cut HERNANDEZ down.<sup>207</sup>

At 2:11 p.m., (b)(6); (b)(7)(C) arrived on scene.<sup>208</sup> (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) then looked into LD-3, then spoke to (b)(6); (b)(7)(C) again before departing. (b)(6); (b)(7)(C) stated he could not recall what they discussed, beyond stating he would notify the Deputy Field Office Director.<sup>209</sup> (b)(6); (b)(7)(C) recalled that HERNANDEZ appeared to have been dead for quite some time, and for that reason, it did not occur to him to direct the facility to cut him down; he further added he would have left the decision to the facility.

After SDD (b)(6); (b)(7)(C) left the scene, (b)(6); (b)(7)(C) turned and spoke to the nurses.<sup>210</sup> At 2:12 p.m., (b)(6); (b)(7)(C) entered the cell. (b)(6); (b)(7)(C) stated that although they did not recall exactly what (b)(6); (b)(7)(C) said, he allowed them into the cell to confirm HERNANDEZ had no pulse.<sup>211</sup> Upon entry, the nurses could not find a radial<sup>212</sup>

<sup>199</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>200</sup> ERAU discussion with Regional Director (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>201</sup> On this date, (b)(6); (b)(7)(C) was the charge nurse and therefore, was the lead medical responder.

<sup>202</sup> See Video surveillance footage, dated October 15, 2019.

<sup>203</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 19, 2019. See Unusual Occurrence Report, dated October 15, 2019. Although (b)(6); (b)(7)(C) stated in her Unusual Occurrence Report that she immediately entered the cell, video evidence shows she entered approximately six minutes later after speaking with (b)(6); (b)(7)(C).

<sup>204</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>205</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>206</sup> ERAU interviews with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>207</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>208</sup> See Video surveillance footage, dated October 15, 2019.

<sup>209</sup> ERAU interview with SDD (b)(6); (b)(7)(C) dated November 26, 2019.

<sup>210</sup> See Video surveillance footage, dated October 15, 2019.

<sup>211</sup> ERAU interviews with (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>212</sup> A radial pulse is felt at the wrist.



or carotid pulse,<sup>213</sup> and did not see or hear respirations.<sup>214</sup> The nurses further noted HERNANDEZ was pale in color and had red mottling<sup>215</sup> in both arms and hands. Approximately 26 seconds later, the nurses exited the cell.<sup>216</sup> The nurses documented that on numerous occasions, they told security personnel HERNANDEZ must be cut down, to which (b)(6); (b)(7)(C) repeated the cell was a crime scene.<sup>217</sup>

At 2:14 p.m., (b)(6); (b)(7)(C) to have Main Control<sup>218</sup> call for emergency medical services (EMS).<sup>219</sup>

At 2:17 p.m., (b)(6); (b)(7)(C) gave his cell phone (b)(6); (b)(7)(C) to (b)(6); (b)(7)(C) who stood in the cell doorway and appeared to take a picture, then he entered the cell where he remained for 23 seconds. Upon his exit from the cell, (b)(6); (b)(7)(C) returned the phone to (b)(6); (b)(7)(C) Capt. (b)(6); (b)(7)(C) confirmed he took pictures at (b)(6); (b)(7)(C) direction and using (b)(6); (b)(7)(C) cell phone.<sup>221</sup> (b)(6); (b)(7)(C) did not recall giving (b)(6); (b)(7)(C) s phone and commented that he did not know why he would have; however, he did recall that someone sent him a picture of the scene, but said he deleted it.<sup>222</sup>

At 2:19 p.m., three EMS responders arrived on scene and entered the cell.<sup>223</sup> The responders documented the following:<sup>224</sup>

- HERNANDEZ's pupils were fixed and dilated. He exhibited no respiration effort and was not bleeding.
- HERNANDEZ's skin was pale, mottled, and cool to touch at his core. Lividity<sup>225</sup> was noted in the lower extremities.

<sup>213</sup> A carotid pulse is felt in the neck.

<sup>214</sup> See (b)(6); (b)(7)(C) Unusual Occurrence Report, dated October 15, 2019; see also written statement of (b)(6); (b)(7)(C) dated October 15, 2019; see also (b)(6); (b)(7)(C) nurse's note, dated October 15, 2019.

<sup>215</sup> Mottling refers to red or purple blotching of the skin, occurring when the heart is no longer able to pump blood effectively, causing blood flow to slow or stop.

<sup>216</sup> See Video surveillance footage, dated October 15, 2019.

<sup>217</sup> See (b)(6); (b)(7)(C) Unusual Occurrence Report, dated October 15, 2019 and written statement of (b)(6); (b)(7)(C) dated October 15, 2019.

<sup>218</sup> During her interview with ERAU on November 20, 2019, Deputy (b)(6); (b)(7)(C) signed to Main Control on this date, stated she made the call to EMS at (b)(6); (b)(7)(C) direction but did not document the direction or the time of the call in the control log. She explained she was new to the Main Control post, and at the time, was unaware of her responsibility to log events surrounding an emergency, including EMS notification and the time of ambulance and law enforcement arrival. ERAU notes the Quachita County Acadian Ambulance Service documented receipt of the 911 call at 2:14 p.m. See Prehospital Care Report Summary, Quachita County Acadian Ambulance Services, dated October 15, 2019.

<sup>219</sup> See Capt. (b)(6); (b)(7)(C) Unusual Occurrence Report, dated October 15, 2019.

<sup>220</sup> See Video surveillance footage, dated October 15, 2019.

<sup>221</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>222</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>223</sup> See Video surveillance footage, dated October 15, 2019.

<sup>224</sup> See Prehospital Care Report Summary from the Quachita County Acadian Ambulance Services, dated October 15, 2019.

<sup>225</sup> Lividity is the process in which the body's blood supply stops moving.

- HERNANDEZ's vital signs were absent and an electrocardiogram (EKG) was flat-lined.<sup>226</sup>
- HERNANDEZ had to have had the ability to stand based on the height of the hanging and the fact his feet were on the ground.

At 2:21 a.m., the EMS team exited the cell and departed the area without HERNANDEZ.<sup>227</sup>

At 2:30 p.m., Richwood Police Department arrived and Chief Cleveland (first name unknown) called the Ouachita Parish Sheriff's Office to ask that they handle the investigation.<sup>228</sup>

Starting at 3:07 p.m., Ouachita Parish personnel arrived on scene and entered the cell, including the sheriff's office crime scene investigators.<sup>229</sup> According to (b)(6); (b)(7)(C) the sheriff's office notified the Ouachita Parish Coroner's Office after completing its investigation and that the Coroner cut HERNANDEZ down.<sup>230</sup> ERAU estimates that more than an hour elapsed between discovery of HERNANDEZ hanging and the time he was cut down.

At 3:49 p.m., Mulhearn Funeral Home employees arrived on scene, entered the cell, and departed within a minute with HERNANDEZ on the gurney.<sup>231</sup> All other external personnel followed.

### Post-Death Actions

All staff involved in the response submitted written statements. According to Regional Director McCormick, LaSalle Corrections did not conduct a security de-briefing or an after-action review.<sup>232</sup> Immediately following the incident, HS (b)(6); (b)(7)(C) conducted a debrief with nursing staff.<sup>233</sup> Furthermore, (b)(6); (b)(7)(C) stated that on October 17 and 18, 2019, she participated in an internal mortality review with LaSalle Corrections leadership.<sup>234</sup>

(b)(6); (b)(7)(C) stated he retrieved HERNANDEZ's stored property from the property room and took it to (b)(6); (b)(7)(C) office and that he was not involved in collection of any property from HERNANDEZ's cell.<sup>235</sup> With the exception of a money order documenting a remaining funds balance of \$51.18 directed to HERNANDEZ's next of kin, RCC did not provide documentation of the release of HERNANDEZ's personal property.<sup>236</sup>

<sup>226</sup> An EKG records the electrical activity of the heart. A flat line means there is no electrical activity.

<sup>227</sup> See Video surveillance footage, dated October 15, 2019.

<sup>228</sup> See (b)(6); (b)(7)(C) memorandum, dated October 15, 2019. ERAU notes video footage provided does not show Chief Cleveland at the scene.

<sup>229</sup> See Video surveillance footage, dated October 15, 2019.

<sup>230</sup> See (b)(6); (b)(7)(C) memorandum, dated October 15, 2019. ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019.

<sup>231</sup> See Video surveillance footage, dated October 15, 2019.

<sup>232</sup> ERAU discussion with Regional Director (b)(6); (b)(7)(C) dated November 20, 2019.

<sup>233</sup> See Debrief, dated October 15, 2019.

<sup>234</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 18, 2019. See Mortality Review A208637060, dated October 21, 2019.

<sup>235</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 19, 2019.

<sup>236</sup> See ICE Detainee Released Funds Receipt, dated October 18, 2019.



Interviews with staff members confirmed LaSalle Corrections offered employee assistance services to all, some further sharing that they were also offered and took administrative leave. ERAU observed both security and nursing staff still struggling to process the events of October 15, 2019. Many became very emotional during their interviews, and staff, particularly nurses, expressed that not being allowed to cut HERNANDEZ down and attempt CPR exacerbated the shocking nature of what they observed when they looked in the cell.

On October 15, 2019, Acting FOD Joyce signed a condolence letter to HERNANDEZ's next-of-kin.<sup>237</sup>

On October 17, 2019, Ouachita Parish Coroner's Office conducted HERNANDEZ's autopsy and documented the official cause of death as hanging.

On November 7, 2019, the State of Louisiana issued HERNANDEZ's death certificate documenting hanging as the cause of death.<sup>238</sup>

## **FINDINGS**

ERAU reviewed the medical care RCC provided HERNANDEZ, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found 19 deficiencies in RCC's compliance with the ICE PBNDS 2011. Additionally, ERAU has included other areas of concern that are not covered by the ICE PBNDS 2011. 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 (V)(A)(2)**, "Every facility shall directly or contractually provide its detainee population with the following: Medically necessary and appropriate medical, dental, and mental health care and pharmaceutical services."
  - RCC staff did not process special diet orders on June 21, 2019, and June 24, 2019; consequently, HERNANDEZ continued to receive the standard diet.
  - Nurses did not re-check HERNANDEZ's blood pressure on June 24, 2019, as ordered by the provider.
  - Occult blood tests ordered by a provider on July 5, 2019, were not completed until re-ordered by another provider on August 8, 2019.
2. **Medical Care, Section (V)(E)**, "Facilities shall provide appropriate interpretation and language services for LEP detainees related to medical and mental health care. Where appropriate staff interpretation is not available, facilities will make use of professional interpretation services."
  - On multiple occasions, medical staff did not document the use of interpretation services during appointments. (b)(6); (b)(7)(C) stated to ERAU that nurses document

<sup>237</sup> See Condolence Letter, dated October 15, 2019. The condolence letter was routed through the Assistant Attaché for Cuba the same day.

<sup>238</sup> See Exhibit 3: State of Louisiana – Certification of Death, dated November 7, 2019.

interpretation assistance only when they use the telephonic service, not when a deputy interprets. (b)(6); (b)(7)(C) concurred, stating there are designated deputies on every shift who provide interpretation assistance.

- On October 14, 2019, medical staff presented an English-version form to HERNANDEZ which requested consent for treatment while on hunger strike and provided education on symptoms related to hunger strike. If interpretation services were utilized, it was not documented on the form.
3. **Medical Care, Section (V)(F)(3)(a)(3)**, “If there is a specific area, separate from other housing areas, where detainees are admitted for health observation and care under the supervision and direction of health care personnel, consideration shall be given to the detainee’s age, gender, medical requirements and custody classification and the following minimum standards shall be met: ... Staff member within sight or sound of all patients.”
- Cells located in A-Hall used for medical observation are not within sight or sound proximity of medical staff.
4. **Medical Care, Section (V)(M)**, “The CMA [Clinical Medical Authority] shall be responsible for review of all comprehensive health assessments to assess the priority for treatment.”
- The CMA, (b)(6); (b)(7)(C) did not sign the health assessment conducted by (b)(6); (b)(7)(C) following intake screening on June 13, 2019. The CMA did not produce designation of authority for providers to conduct initial health assessments without review by the CMA or another designated provider.
  - (b)(6); (b)(7)(C) reviewed the June 20, 2019 health appraisal conducted by R (b)(6); (b)(7)(C) six weeks later, on August 6, 2019. Although (b)(6); (b)(7)(C) had conducted an examination on June 13, 2019, the appraisal conducted by R (b)(6); (b)(7)(C) was scheduled as the initial, requiring review by the CMA. As noted, the CMA has not designated authority to review health appraisals to other providers.
5. **Medical Care, Section (V)(O)(4)**, “Any detainee referred for mental health treatment shall receive an evaluation by a qualified health care provider no later than 72 hours after the referral, or sooner if necessary. If the practitioner is not a mental health provider and further referral is necessary, the detainee will be evaluated by a mental health provider within the next business day.”
- On September 4, 2019, (b)(6); (b)(7)(C) referred HERNANDEZ to mental health. Medical staff scheduled the related appointment for ten days later, September 14, 2019.
6. **Medical Care, Section (V)(U)**, “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 medications given to or refused by detainees shall be maintained.”



- On June 24, 2019, a nurse incorrectly transcribed the provider's order for psyllium fiber. The provider ordered one scoop of fiber, but the nurse wrote two scoops on the MAR.
  - Nurses continued to administer dicyclomine three days after a provider ordered its discontinuation on July 5, 2019.
  - Although Pinaverium bromide was not available, nurses documented two doses were given on August 30, 2019.
  - On August 24, 2019, a nurse incorrectly transcribed Levsin onto the MAR by recording 0.12 mg instead of 0.125 mg.
  - Nurses first administered Levsin four days after the August 26, 2019 order date.
  - Nurses administered Levsin two days beyond the 30-day prescription expiration date of September 26, 2019.
  - Nurses left 126 boxes on the MAR blank, to include periods of time that HERNANDEZ was in segregation.
  - Nurses did not consistently enter their initials on MARs to document administration. Instead, they entered checkmarks or indistinguishable symbols.
  - Nurses did not account for doses of the medications scheduled for June 18 – 22, 2019.
  - Nurses did not account for morning doses of dicyclomine scheduled for July 1 – 4, 2019, and evening doses scheduled for July 2, 6, and 7, 2019.
  - Nurses did not account for Senokot doses on July 2, August 4, 13, 19, and 20, 2019.
7. **Medical Care, Sections (V)(AA)(7), (8) and (9)**, “7.) If the detainee refuses to consent to treatment, medical staff shall make reasonable efforts to explain to the detainee the necessity for and propriety of the recommended treatment. 8.) Medical staff shall ensure that the detainee's questions regarding the treatment are answered by appropriate medical personnel. 9.) Medical staff shall explain the medical risks if treatment is declined and shall document their treatment efforts and refusal of treatment in the detainee's medical record. Detainees will be asked to sign a translated form that indicates that they have refused treatment.”
- The only medication-related refusal form in the medical record is dated June 23, 2019, although there are 126 blank doses on the MAR. ERAU could not determine whether HERNANDEZ refused, was not offered, or nursing staff did not document medication administration for these doses. Furthermore, refusal documentation was not obtained for known medication refusals during his hunger strike from October 10, 2019, until the date of his death.
8. **Hunger Strike, Sections (V)(C)(1)(c) and (d)**, “During the initial evaluation of a detainee on a hunger strike, medical staff shall: ... c) perform urinalysis; d) conduct psychological/psychiatric evaluation.”
- On October 10, 2019, (b)(6); (b)(7)(C) documented the reason for segregation placement as hunger strike, but she did not attempt to perform a urinalysis test, nor did she refer HERNANDEZ for a mental health evaluation.

9. **Hunger Strike, Section (V)(C)(5)**, “If the detainee refuses the initial medical evaluation or any treatment or other medical procedures, medical staff must attempt to secure the detainee’s signature on a “Refusal of Treatment” form. If the detainee will not cooperate by signing, staff shall note this on the “Refusal of Treatment” form.”
- On October 14, 2019, (b)(6); (b)(7)(C) did not complete a Refusal of Treatment form when HERNANDEZ refused to cooperate with the initial hunger strike evaluation.
10. **Hunger Strike, Sections (V)(C)(2)**, “Medical staff shall measure and record weight and vital signs at least once every 24 hours during the hunger strike and repeat other procedures as medically indicated.”
- Nurses did not attempt to take HERNANDEZ’s weight or vital signs within the 24 hours following initiation of the hunger strike protocol on October 14, 2019 at 8:00 a.m.
11. **Significant Self-harm and Suicide Prevention and Intervention, Section (V)(H)**, “Following a suicide attempt, security staff shall initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. Arriving medical personnel shall perform appropriate medical evaluation and intervention.”
- After initially finding HERNANDEZ hanging, security staff did not initiate life-saving measures.
  - (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) interfered with performance of emergency medical care by denying nurses’ entry to the cell to cut the detainee down and attempt CPR.
12. **Significant Self-harm and Suicide Prevention and Intervention, Section (V)(K)**, “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.”
- LaSalle Corrections did not conduct a security de-briefing or an after-action review.
13. **Special Management Units, Section (V)(A)(2)(a)**, “Prior to a detainee’s placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing a detainee in administrative segregation.”
- On June 20, 2019, HERNANDEZ was placed in segregation cell SM-2 for hunger strike monitoring. (b)(6); (b)(7)(C) initiated the Administrative Segregation Order, which was signed the next day by (b)(6); (b)(7)(C). A security supervisor did not sign the order.
14. **Special Management Units, Section (V)(A)(2)(e)**, “The administrative segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility.”



- There is no documentation that staff provided HERNANDEZ the June 20, 2019 or October 10, 2019 Administrative Segregation Orders.

15. ***Special Management Units, Section (V)(M)***, “Detainees in SMU shall be personally observed at least every 30 minutes on an irregular schedule.”

- On October 15, 2019, between 11:28 a.m. and 2:04 p.m., security staff did not observe HERNANDEZ, (b)(6); (b)(7)(C) who was responsible for security rounds after 10:50 a.m., documented five rounds that video evidence supports she did not make.

16. ***Terminal Illness, Advance Directives and Death, Section (V)(F)***, “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.”

- (b)(6); (b)(7)(C) stated he placed HERNANDEZ’s property in (b)(6); (b)(7)(C) office; however, there is no documentation of its disposition, including release to ERO or ERO’s return of the property to the next of kin.

17. ***Funds and Personal Property, Section (V)(G)(1)***, “For recordkeeping and accounting purposes, use of the G-589 Property Receipt form or its equivalent is mandatory to inventory any funds removed from a detainee’s possession, and a separate G-589 form or its equivalent is required for each kind of currency and negotiable instrument. Removal and inventory of detainee funds shall be conducted by at least two officers and in the presence of the detainee. Separate documentation should be made for each kind of currency and negotiable instrument and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried. Officers should then deposit the funds with a copy of the documentation in the drop safe or similarly secured depository.”

- RCC could not supply documentation that the staff complied with this standard. The records include only a detainee funds report showing HERNANDEZ’s account history.

18. ***Funds and Personal Property, Section (V)(I)***, “An itemized inventory of all detainee baggage and property (separate from funds and valuables) shall be completed during admissions processing using the personal property inventory form. Each facility shall inventory all property, even in the event the property was previously inventoried by another facility and is contained in a sealed bag.”

- RCC could not supply admission documentation inclusive of an itemized inventory of HERNANDEZ’s property.

19. *Staff-Detainee Communication, Section (V)(B)(1)(b)* “In facilities without ICE/ERO Onsite Presence, each detainee request shall be forwarded to the ICE/ERO office of jurisdiction within two business days and answered as soon as practicable, in person or in writing, but no later than within three business days of receipt. All dates shall be documented.”

- On August 8, 2019, HERNANDEZ submitted an ICE Detainee Request Form regarding his parole. There was no documented response from ICE present on the form.

## **AREAS OF CONCERN**

Although not violations of the ICE PBNDS 2011, ERAU noted the following concerns regarding HERNANDEZ’s medical care, safety, and security at RCC:

1. RCC policy HC 4.2, *Hunger Strikes*, Section (D)(2), “Detainee will be provided education regarding risks to health, as well as, an educational pamphlet will be available in preferred language.”
  - On October 14, 2019, although (b)(6); (b)(7)(C) documented HERNANDEZ was on hunger strike, she did not provide LaSalle Corrections Patient Handout: Hunger Strike Fact Sheet, outlining the expected sequence of hunger strike symptoms to HERNANDEZ.
2. RCC policy HC 4.2, *Hunger Strikes*, Section (D)(5), “CMA, or designee, shall review and document in the medical record initial hunger strike placement evaluation orders, and plan of care.”
  - There was no documentation that nurses referred HERNANDEZ to a provider for review of his hunger strike status as of October 14, 2019.
3. RCC Post Orders, Main Control Room Officer, Section (2)(5), “The Main Control Room Officer shall be responsible for maintaining an accurate account of all activities occurring during assignment at this duty post and shall document the following: ... f) Document all unusual occurrences or incidents reported through the control room; ... and h) Document any other information relevant to activities during assignment.”
  - The Main Control officer did not document EMS notification, arrival, and departure, or the arrival and departure of personnel from external agencies following HERNANDEZ’s death.
4. RCC has not yet implemented a system of internal review and quality assurance.
5. As of the date of ERAU’s site visit, RCC had not yet pursued National Commission on Correctional Health Care accreditation; per their contract with ICE, they have 18 months to receive the aforementioned accreditation.



6. As noted in above deficiencies, ERAU identified multiple issues with nurses' documentation of medication administration. ERAU also identified the following concerns related to documentation in the medical record:

- Nurses documented sick call encounters on HERNANDEZ's sick call requests but not in the nurse's notes.
- Nurse's notes did not follow the SOAPE format.
- Although (b)(6); (b)(7)(C) stated LaSalle Corrections has a comprehensive set of nursing protocols, September 10, 2019 was the only instance where a medical staff member used a protocol during a sick call encounter.
- Nurses' and providers' signatures were often illegible, and name stamps were seldom used.
- Nurses did not consistently record pain levels when HERNANDEZ reported pain.
- On June 21 and July 5, 2019, a provider did not document an in-person encounter with HERNANDEZ. The provider stated she was confident she had seen him but documented orders only.
- Multiple forms did not have titles identifying their purpose.
- RCC does not have an electronic medical record system. ERAU found the hard-copy system disorganized and set up in a way that made it difficult to chronologically track HERNANDEZ's care. During his interview, (b)(6); (b)(7)(C) stated locating files for patient encounters has been problematic. (b)(6); (b)(7)(C) advised LaSalle Corrections planned to consider converting to an electronic system within calendar year 2020.

7. (b)(6); (b)(7)(C) June 20, 2019 initial health appraisal did not reflect HERNANDEZ's known history of IBS and current medications, his complaint from the day prior of ineffective medication, or his refusal to take medication or eat.

8. Documentation addressing HERNANDEZ's placement in segregation on June 20, 2019 and October 10, 2019, is ambiguous. Available records do not clearly document whether his placement was for monitoring meal consumption or whether he met criteria for initiation of the hunger strike protocol. If the former, there is no record of meal consumption during the first period of segregation. If the latter, the record of meal consumption by security staff was incomplete and not verified by nurses. Additionally, documents were void of responses from either the medical or detention file due to the lack of communication between medical and security staff related to processes that required a coordinated effort.

9. Upon discovering HERNANDEZ hanging, neither (b)(6); (b)(7)(C) nor (b)(6); (b)(7)(C) entered the cell to lift him to relieve pressure to the neck until he could be cut down. For differing reasons, none of the three retrieved a cut-down tool: (b)(6); (b)(7)(C) stated that medical is responsible for bringing the tool, and (b)(6); (b)(7)(C) stated he did not know where cut-down tools are located. Although RCC has a policy on suicide prevention and intervention, it does not speak to the protocols security should take when finding a detainee attempting suicide. When nurses arrived on scene, they did not bring a cut down

tool because the radio code used (i.e. 10-19) is not specific to the type of emergency; however, two nurses did leave the scene to retrieve cut down tools.

10. RCC does not have a dedicated special management unit; therefore, detainees assigned to segregation are placed in cells which open onto a high traffic corridor through which general population detainees regularly traverse. RCC does not have procedures prohibiting staff from routinely opening the segregation cells when general population detainees are in the area.
11. Following HERNANDEZ's death, RCC took steps to improve visibility into cells used for segregation, including removing the window flaps and repositioning the bunk beds. However, small bars running vertically on the security windows remain, obscuring the view of the cell side-to-side.

## **EXHIBITS**

1. Creative Corrections Healthcare and Security Compliance Analysis
2. Ouachita Parish Coroner's Autopsy Report, dated November 18, 2019
3. State of Louisiana – Certification of Death, dated November 7, 2019





**U.S. Immigration  
and Customs  
Enforcement**

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

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

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

SUBJECT: Detainee Death Review Findings – Roylan HERNANDEZ-Diaz  
JICMS #202000483

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 Roylan HERNANDEZ-Diaz (HERNANDEZ), a 43-year-old citizen of Cuba, who died on October 15, 2019, while in ICE custody at the Richwood Correctional Center (RCC) in Richwood, Louisiana (LA). The Ouachita Parish Coroner's Office documented HERNANDEZ's official cause of death as hanging.<sup>1</sup>

**Abbreviated Chronology<sup>2</sup>**

On May 18, 2019, HERNANDEZ applied for admission to the United States at the Paso Del Norte Port of Entry in El Paso, Texas (TX). HERNANDEZ claimed credible fear. U.S. Customs and Border Protection (CBP) charged HERNANDEZ with inadmissibility pursuant to Section 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act, as an alien present in the United States who is not in possession of a valid unexpired immigrant visa or other entry document at the time of admission and subsequently processed him for expedited removal pending a credible fear determination.

On May 20, 2019, CBP released HERNANDEZ into the custody of the ICE Enforcement and Removal Operations (ERO) El Paso, and transferred him to the El Paso Service Processing Center in El Paso, TX. ERO El Paso subsequently transferred him to the West Texas Detention Center in Sierra Blanca, TX.

<sup>1</sup> See Ouachita Parish Coroner's Autopsy Report, dated November 18, 2019

<sup>2</sup> See accompanying Detainee Death Review for complete chronology.

On May 23, 2019, ERO El Paso transferred HERNANDEZ into the custody of ERO New Orleans, who transferred him to Tallahatchie County Correctional Facility (TCCF) in Tutwiler, Mississippi. While at TCCF, HERNANDEZ received an intake screening, a physical examination, and a comprehensive mental health screening, all of which resulted in normal findings.

On June 13, 2019, ERO New Orleans transferred HERNANDEZ to RCC. Upon arrival, a nurse practitioner (NP) completed HERNANDEZ's intake screening, noting a history of irritable bowel syndrome (IBS) and continued his current medication for that condition as prescribed.

On June 14, 2019, a licensed practical nurse (LPN) documented a medication order but listed the incorrect provider as the ordering physician. Furthermore, during HERNANDEZ's stay at RCC, nursing staff did not clearly or consistently document medication administration.

On June 19, 2019, a registered nurse (RN) attempted to evaluate HERNANDEZ pursuant to his sick call request on June 18, 2019 for abdominal pain and ineffective medication; however, he refused to be seen. Also, on this date, a security lieutenant completed an unusual occurrence report stating HERNANDEZ missed six consecutive meals and two days of medication, and that HERNANDEZ requested to speak with an ICE officer.

On June 20, 2019, an RN completed a health assessment which did not include his IBS history, current medications, complaint from his sick call, or his refusal to take medication or eat. On this same date, an RN initiated a pre-segregation health evaluation and approved HERNANDEZ for administrative segregation; however, the RN's documentation related to his placement was lacking pertinent information.

On June 21, 2019, an RN evaluated HERNANDEZ and observed him drinking two cups of juice and one bottle of Ensure. Later that day, an LPN also observed HERNANDEZ drink a bottle of Ensure and eat 25% of his lunch. A Medical Doctor (MD) evaluated HERNANDEZ, ordered a bland diet with extra vegetables, and discharged him from segregation to general population.

On June 23, 2019, an LPN documented HERNANDEZ refused to report to pill call. A refusal form was signed by the LPN and RN and noted that HERNANDEZ refused to sign.

On June 24, 2019, an NP evaluated HERNANDEZ for a complaint of not receiving a bland diet. The NP ordered a bland diet for a second time and added an additional medication to his regimen. The NP noted an abnormal blood pressure and ordered it to be rechecked; however, the order was never documented as being carried out. Furthermore, the additional medication was incorrectly transcribed on the medication administration record (MAR).

On July 5, 2019, an RN assessed HERNANDEZ pursuant to a sick call stating his current medication worsened his IBS symptoms and referred him to a provider. On the same day, the provider, discontinued the medication, and ordered a test to check for blood in the stool (hemoccult testing).

On August 6, 2019, an RN evaluated HERNANDEZ during a sick call for colon pain and a medication change request. The RN referred him to a provider for further evaluation.



On August 8, 2019, an NP evaluated HERNANDEZ pursuant to the above referral and documented normal findings. The NP reordered the hemoccult test as the July 5, 2019 order was never carried out, which resulted in normal findings. HERNANDEZ also submitted an ICE Detainee Request form regarding his parole, which was never responded to or signed.

On August 26, 2019, an NP evaluated HERNANDEZ for an IBS follow-up appointment. One medication was discontinued and, although another was prescribed, the medication was unavailable. A different version of the medication was ordered but not administered until four days later and the LPN erroneously transcribed the incorrect dose on the MAR. Furthermore, the medication was also continued for two doses after the medication prescription had expired. The NP recommended a mental health referral but HERNANDEZ refused. The NP documented discussing techniques for coping with stress with HERNANDEZ after his refusal.

On September 4, 2019, an RN triaged HERNANDEZ's sick call request for a mental health consult and submitted a referral to the provider.

On September 10, 2019, an LPN evaluated HERNANDEZ during a sick call for abdominal pain due to not receiving his medication. The LPN referred HERNANDEZ to a provider for evaluation.

On September 13, 2019, an MD evaluated HERNANDEZ for abdominal pain. The MD diagnosed HERNANDEZ with chronic constipation and abdominal pain. Medication was discontinued and a previous medication was re-prescribed.

On September 14, 2019, an RN documented HERNANDEZ's refusal for a mental health appointment.

On October 10, 2019, after HERNANDEZ threatened a hunger strike, an RN completed HERNANDEZ's pre-segregation health evaluation. HERNANDEZ refused vital signs and a weight assessment.

From October 10 until October 15, 2019, HERNANDEZ remained in administrative segregation for hunger strike monitoring. During this time, HERNANDEZ did not receive any medications and missed 10 consecutive meals. On October 15, 2019, an LPN notified ERO New Orleans and ICE Health Service Corps of HERNANDEZ's hunger strike.

On October 15, 2019 at 10:04 a.m., a lieutenant observed HERNANDEZ in his cell when he opened the door and spoke with him. From 11:53 a.m. until 1:54 p.m., although the deputy on duty documented four security checks, she conducted these rounds without looking into HERNANDEZ's cell. At 2:04 p.m., a security captain and lieutenant approached HERNANDEZ's cell. After smelling a strong odor, the captain looked into HERNANDEZ's cell window but could not see him; after stepping away briefly, the captain then entered the cell and observed HERNANDEZ hanging from the top bunk bed. The captain immediately called a medical emergency, and shortly after, two additional security staff personnel entered the cell.

Although multiple security staff were on-scene, none attempted to alleviate pressure from HERNANDEZ's neck or retrieve a cut down tool. The security major and medical staff arrived within one minute of the medical emergency call. Medical staff reported the major prevented them from cutting HERNANDEZ down because he perceived it to be a crime scene. Two minutes later, the acting warden arrived on-scene. At 2:12 p.m., medical staff were allowed to enter the cell to check for a pulse, which they were unable to find. The major and acting warden continued to instruct all staff not to cut HERNANDEZ down.

At 2:19 p.m., emergency medical services (EMS) arrived on scene and entered the cell. The EMS report documented cardiopulmonary resuscitation (CPR) was not initiated as there was no electrical activity in the heart, and vital signs were unobtainable. At 3:07 p.m., Ouachita Parish Sheriff's Department arrived on-scene. After the sheriff's office investigation was completed, the coroner cut HERNANDEZ down and declared him dead at an unknown time. At 3:49 p.m., the funeral home arrived on scene and departed within one minute with HERNANDEZ's body.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care RCC provided HERNANDEZ, as well as their efforts to ensure he was safe and secure while detained at the facility, during his time in ICE custody. In the attached report, ERAU assessed RCC's compliance with the ICE PBNDS 2011 standards and documented 19 findings.

1. **Medical Care, Section (V)(A)(2):** RCC staff did not process multiple special diet orders, re-check HERNANDEZ's blood pressure or timely complete hemocult tests as ordered by providers.
2. **Medical Care, Section (V)(E):** On multiple occasions, medical staff did not document the use of interpretation services during appointments. Furthermore, medical staff presented an English-version form to HERNANDEZ which requested consent for treatment while on hunger strike and provided education on symptoms related to hunger strike; if interpretation services were utilized, it was not documented on the form.
3. **Medical Care, Section (V)(F)(3)(a)(3):** Cells located in A-Hall used for medical observation are not within sight or sound proximity of medical staff.
4. **Medical Care, Section (V)(M):** The Clinical Medical Authority (CMA) did not sign comprehensive health assessments as required. The CMA did not produce designation of authority for providers to conduct initial health assessments without review by the CMA or another designated provider.
5. **Medical Care, Section (V)(O)(4):** Medical staff did not schedule HERNANDEZ for a mental health appointment until 10 days after the initial referral.
6. **Medical Care, Section (V)(U):** There were multiple issues identified with the distribution or refusal of medication, to include distributing in accordance with specific instructions



and procedures established by the Health Services Administrator or CMA and record keeping of the distribution or refusal of medication.

7. **Medical Care, Sections (V)(AA)(7), (8), and (9):** Although there are 126 blanks where medication administration should have been noted on the MAR (to include if medication was refused), there was only one medication-related refusal form in the medical record. Furthermore, refusal documentation was not obtained for known medication refusals during HERNANDEZ's hunger strike from October 10 until the date of his death.
8. **Hunger Strike, Sections (V)(C)(1)(c) and (d):** A nurse did not attempt to perform a urinalysis test or refer HERNANDEZ for a mental health evaluation during her initial hunger strike evaluation of HERNANDEZ.
9. **Hunger Strike, Section (V)(C)(5):** A nurse did not complete a Refusal of Treatment form when HERNANDEZ refused to cooperate with the initial hunger strike evaluation.
10. **Hunger Strike, Sections (V)(C)(2):** Nurses did not attempt to take HERNANDEZ's weight or vital signs within the 24 hours following initiation of the hunger strike protocol.
11. **Significant Self-harm and Suicide Prevention and Intervention, Section (V)(H):** After initially finding HERNANDEZ hanging, security staff did not initiate life-saving measures. Furthermore, the acting warden and major interfered with performance of emergency medical care by denying nurses' entry to the cell to cut the detainee down and attempt CPR.
12. **Significant Self-harm and Suicide Prevention and Intervention, Section (V)(K):** LaSalle Corrections did not conduct a security de-briefing or an after-action review.
13. **Special Management Units, Section (V)(A)(2)(a):** Although a nurse initiated the Administrative Segregation Order form, the facility administrator or designee did not complete the form prior to HERNANDEZ's placement in segregation.
14. **Special Management Units, Section (V)(A)(2)(e):** There is no documentation staff provided HERNANDEZ copies of the June 20, 2019 or October 10, 2019 Administrative Segregation Orders.
15. **Special Management Units, Section (V)(M):** Staff did not personally observe HERNANDEZ at least every 30 minutes on an irregular schedule. On October 15, 2019, between 11:28 a.m. and 2:04 p.m., security staff did not observe HERNANDEZ. The deputy responsible for security rounds after 10:50 a.m., documented five rounds that video evidence supports she did not make.
16. **Terminal Illness, Advance Directives and Death, Section (V)(F):** Although a deputy stated he placed HERNANDEZ's property in the major's office, there is no documentation of its disposition, including release to ERO or ERO's return of the property to the next of kin.

17. **Funds and Personal Property, Section (V)(G)(1):** RCC could not supply documentation that the staff complied with this standard. The records include only a detainee funds report showing HERNANDEZ's account history.
18. **Funds and Personal Property, Section (V)(I):** RCC could not supply admission documentation inclusive of an itemized inventory of HERNANDEZ's property.
19. **Staff-Detainee Communication, Section (V)(B)(1)(b):** ERO did not document a response to HERNANDEZ's request regarding his parole hearing; therefore, it is unknown if his request was ever answered.

Furthermore, although not violations of the ICE PBNDS 2011, ERAU noted 11 areas of concern regarding HERNANDEZ's medical care, safety, and security at RCC.

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) (202) 732 (b)(6); (b)(7)(C).

*Enclosure*

HERNANDEZ-Diaz Detainee Death Review Report



RELEASE TO:

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

19-03827  
SINGH, SIMRATPAL

MARICOPA COUNTY  
FORENSIC SCIENCE CENTER  
701 West Jefferson Street  
Phoenix, Arizona 85007

RECORD OF ADMISSION

Clothing

5/3/19 1314

Admission Date & Time

Weight: 210 Sealed By: USS Seal Number: 5607742  
Agency

Admitted to OME by: NN HM OME Representative F.S.C Body Location 1

Transported From Scene By: (b)(6); (b)(7)(C) For: USS Agency Transporting

Removal Address: 13677 W. McDowell Rd Body Pouch Exchange Required: Y N  
Location, Address or Name of Hospital Lightweight: Heavyweight: X

N.O.K INFORMATION

N.O.K. Name: Manjit Singh N.O.K. Relationship: Father  
N.O.K. Address: 10426 S. Donald Dr. CITY/STATE: Oak Creek, WI  
ZIP: 53154 Telephone #: 510-508-8486 Alt. #:

REQUEST FOR RELEASE

Release To: Whitney & Murphy Funeral Telephone #: 602-840-5600  
Funeral Home Funeral Home Phone #

Release Requested By: Al Asta Telephone #  
Phone Contact (Funeral Home Rep, family member, etc) Requestor's Phone #

Info taken by: M.S. Date/Time: 5/9/2019 10:51  
OME Representative

NOTIFICATION OF INTENT TO RELEASE

Date: 5/10 Time: 909 OME Representative: A Whom Spoke To: Verlinda  
Funeral Home Representative

Verify Decedent's Name for DC:

RECORD OF RELEASE

Released By: DM/LD Valuables Released: Yes: (see attached sheet) No: ✓  
OME Representative Clothing Released: Yes: (see attached sheet) ✓ No:

Exchange Body Pouch Received: Yes: ✓ No:

A mortuary representative of (b)(6); (b)(7)(C) has identified the remains above by the ankle  
band and certify that the name on the identifying label is the same.

NOTES:

5/14 WTS X-H

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

5-10-19

12:07

Release Date & Time Out

DHS-20-0638-C-000184

2020-ICLI-00057 762



**MARICOPA COUNTY  
OFFICE OF THE MEDICAL EXAMINER  
701 W. Jefferson Street  
Phoenix, AZ 85007**

**MEDICAL EXAMINER REPORT**

**DECEDENT:** Simratpal Singh

**CASE:** 19-03827

**DATE OF EXAMINATION:** 05/04/2019

**TIME:** 0854 Hours

---

**CAUSE OF DEATH:**  
HANGING

**MANNER OF DEATH:**  
SUICIDE

**HOW INJURY OCCURRED:**  
DECEDENT HANGED SELF

07/31/19  
**Date Signed**

(b)(6), (b)(7)(C)

**MEDICAL EXAMINER**



**FINDINGS**

- I. Hanging.
  - A. Found suspended by neck with clothing type ligature inside jail cell.
  - B. Ligature associated abrasion furrow present on neck.
  - C. Facial and bilateral conjunctival petechiae.

**SUMMARY AND OPINION**

The decedent, a 20 year old male, was incarcerated in a jail cell in Parker, Arizona when he was found suspended by the neck with a ligature made of clothing. The decedent was alone in the cell at that time, and following removal from this position he was taken to a local medical center in La Paz County, Arizona where a urine drug screen was negative upon arrival. He was subsequently diagnosed with neck trauma consistent with hanging, and no other significant traumatic injuries were diagnosed. He was then transferred to Abrazo West Campus in Goodyear, Arizona where he was pronounced dead in the emergency department on May 3, 2019.

Postmortem examination (external examination) demonstrated a ligature associated abrasion furrow of the neck with associated facial and conjunctival petechiae. There was no evidence of other significant traumatic injuries, and postmortem toxicology was positive only for a low level of naloxone in hospital-derived blood.

Based on the external examination findings and all other investigative information, including medical records, received to date and as available to me, it is my opinion that the decedent died of hanging.

It is further my opinion that the manner of death is suicide.

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

*The Maricopa 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.*

**POSTMORTEM EXAMINATION****CLOTHING AND PERSONAL EFFECTS**

The body is received unclad, and items of clothing received with the body include a cut

orange shirt consistent with jail apparel.

## EVIDENCE OF MEDICAL INTERVENTION

Two plastic medical tubes are in the oral cavity. A hard plastic and soft foam medical collar is on the neck. Defibrillator pads and electrocardiogram leads are scattered across the anterior torso and upper extremities. Gauze and medical tape cover a puncture wound on the left antecubital fossa. Medical bands on the wrists include the decedent's name and date of birth. A vascular access line is in the dorsal surface of the left hand. A pulse oximeter bandage covers the tip of the left first finger. A urinary catheter exiting the urethra is attached to a container that has a moderate amount of orange-yellow urine. Additional electrocardiogram leads are on the calves. Vascular access lines are in the right antecubital fossa and the right forearm. A medical bandage covers the tip of the right first finger. Gauze and medical tape cover a puncture wound on the right hand.

## EXTERNAL EXAMINATION

Received in a plastic body pouch secured by a seal bearing the number 0028305, the body is that of a 68 inch, 210 pound, well developed and well-nourished adult male who appears compatible with the reported age of 20 years. The scalp is covered by up to 2 inch dark brown hair that is cut shorter on the sides and back. Facial hair consists of a mustache, goatee, and multi-layered beard. The eyes have brown irides and equal size pupils. The bulbar and palpebral conjunctivae are congested with scattered faint petechiae. The nose has no acute injuries, and the nasal septum is free of perforation. The external ears have no acute injuries. The cheeks have faint petechiae of the skin. The oral cavity is free of non-medical foreign objects. The oral and palatal mucosa has no visible lesions. Native upper and lower dentition is in good repair.

The neck and chest are symmetric, and the breasts have no gynecomastia. The precordial region of the chest has a 1/4 inch cluster of abrasions. An accessory nipple is on the left lower aspect of the chest. The abdomen is flat. The back, buttocks, and anus are symmetric with no acute injuries. The atraumatic external genitalia are those of an adult male. Both testes are palpable within the scrotum.

The upper and lower extremities are symmetric with no visible bony abnormalities or palpable fractures. The dorsal surface of the left forearm has a less than 1 cm pigmented skin macule. Linear scars are scattered across the dorsal surfaces of the left second, third, and fourth fingers. The intact and clean fingernails, thumbnails, and toenails are otherwise unremarkable.

Rigor mortis is symmetric throughout the body and breaks with moderate difficulty. Livor mortis is fixed on the posterior surfaces of the body.

Postmortem whole body radiographs demonstrate no retained foreign bodies and no obvious skeletal injuries.



**EVIDENCE OF INJURY**

A ligature associated abrasion furrow is spread across the anterior and lateral aspects of the neck with sparing of the posterior aspect. This furrow consists of a 1/4 to 1/2 inch wide band of linear abrasions that are well circumscribed and that sweep upwards and towards the back of the neck. The adjacent skin above and below this furrow has no abrasions, contusions, lacerations, or other gross injuries. Anteriorly, the furrow is directly over the laryngeal prominence, and its distances below the right and left external auditory meati are 2-1/4 inches and 3 inches, respectively.

**TOXICOLOGY**

Samples that include hospital derived blood and serum, femoral blood, and vitreous fluid are collected and submitted for analysis (see also separate toxicology report).

WTS/Diskriter

D: 05/04/2019

T: 05/07/2019

WTS 07/31/19



## NMS Labs

CONFIDENTIAL

200 Welsh Road, Horsham, PA 19044-2208

Phone: (215) 657-4900 Fax: (215) 657-2972

e-mail: nms@nmslabs.com

Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

### Toxicology Report

Report Issued 05/19/2019 14:04

To: 10106

Maricopa County Office of the Medical Examiner  
Attn: Toxicology Lab  
701 W. Jefferson Street  
Phoenix, AZ 85007

Patient Name UNIDENTIFIED, MALE

Patient ID 19-03827

Chain NMSCP17806

Age Not Given DOB Not Given

Gender Not Given

Workorder 19138545

Page 1 of 3

### Positive Findings:

| <u>Compound</u> | <u>Result</u> | <u>Units</u> | <u>Matrix Source</u> |
|-----------------|---------------|--------------|----------------------|
| Naloxone        | Positive      | ng/mL        | 001 - Hospital Blood |

See Detailed Findings section for additional information

### Testing Requested:

| <u>Analysis Code</u> | <u>Description</u>                                                     |
|----------------------|------------------------------------------------------------------------|
| 8042B                | Postmortem, Expanded w/Vitreous Alcohol Confirmation, Blood (Forensic) |

### Specimens Received:

| <u>ID</u> | <u>Tube/Container</u>   | <u>Volume/<br/>Mass</u> | <u>Collection<br/>Date/Time</u> | <u>Matrix Source</u> | <u>Miscellaneous<br/>Information</u> |
|-----------|-------------------------|-------------------------|---------------------------------|----------------------|--------------------------------------|
| 001       | Green Vial              | 1.75 mL                 | 05/02/2019                      | Hospital Blood       |                                      |
| 002       | Yellow Vial             | 1.75 mL                 | 05/02/2019                      | Hospital Serum       |                                      |
| 003       | Blue Vial               | 1 mL                    | 05/02/2019 18:50                | Hospital Blood       |                                      |
| 004       | Lavender Vial           | 0.1 mL                  | 05/02/2019 18:50                | Hospital Blood       |                                      |
| 005       | Lavender Vial           | 0.1 mL                  | 05/02/2019 22:25                | Hospital Serum       |                                      |
| 006       | Gray Top Tube           | 9.25 mL                 | 05/04/2019 09:14                | Femoral Blood        |                                      |
| 007       | Gray Top Tube           | 7.5 mL                  | 05/04/2019 09:14                | Femoral Blood        |                                      |
| 008       | Red Top Tube            | 3.25 mL                 | 05/04/2019 09:14                | Vitreous Fluid       |                                      |
| 009       | White Plastic Container | 60 mL                   | 05/04/2019 09:04                | Urine                |                                      |

All sample volumes/weights are approximations.

Specimens received on 05/10/2019.



# Detailed Findings:

| Analysis and Comments | Result   | Units | Rpt. Limit | Specimen Source      | Analysis By |
|-----------------------|----------|-------|------------|----------------------|-------------|
| Naloxone              | Positive | ng/mL | 2.0        | 001 - Hospital Blood | LC/TOF-MS   |

Other than the above findings, examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

# Reference Comments:

1. Naloxone (Narcan®) - Hospital Blood:

Naloxone is a narcotic antagonist used to counter the central nervous system depression effects of opioids, including respiratory depression. It is also used for the diagnosis of suspected acute opioid overdose. Naloxone is available as a 0.4 mg/mL solution of the hydrochloride for parenteral injection.

Naloxone is also available in combination with buprenorphine (Suboxone®) for the treatment of opioid dependence. This combination is available in tablets of 2 mg buprenorphine with 0.5 mg naloxone or 8 mg buprenorphine with 2 mg of naloxone for sublingual administration.

The reported qualitative result for this substance was based upon a single analysis only. If confirmation testing is required please contact the laboratory.

# Sample Comments:

- 001 Physician/Pathologist Name (b)(6); (b)(7)(C)
- 001 Alternate Case ID: SINGH SIMRATPAL

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded one (1) year from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Workorder 19138545 was electronically signed on 05/19/2019 13:23 by:

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

Forensic Toxicologist

# Analysis Summary and Reporting Limits:

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acode 8042B - Postmortem, Expanded w/Vitreous Alcohol Confirmation, Blood (Forensic) - Hospital Blood

-Analysis by Enzyme-Linked Immunosorbent Assay (ELISA) for:

| Compound     | Rpt. Limit   | Compound    | Rpt. Limit |
|--------------|--------------|-------------|------------|
| Barbiturates | 0.040 mcg/mL | Salicylates | 120 mcg/mL |
| Cannabinoids | 10 ng/mL     |             |            |

-Analysis by Headspace Gas Chromatography (GC) for:

| Compound | Rpt. Limit | Compound | Rpt. Limit |
|----------|------------|----------|------------|
| Acetone  | 5.0 mg/dL  | Ethanol  | 10 mg/dL   |



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Workorder 19138545  
Chain NMSCP17806  
Patient ID 19-03827

Page 3 of 3

**Analysis Summary and Reporting Limits:**

| <u>Compound</u> | <u>Rpt. Limit</u> | <u>Compound</u> | <u>Rpt. Limit</u> |
|-----------------|-------------------|-----------------|-------------------|
| Isopropanol     | 5.0 mg/dL         | Methanol        | 5.0 mg/dL         |

-Analysis by High Performance Liquid Chromatography/Time of Flight-Mass Spectrometry (LC/TOF-MS) for: The following is a general list of compound classes included in this screen. The detection of any specific analyte is concentration-dependent. Note, not all known analytes in each specified compound class are included. Some specific analytes outside these classes are also included. For a detailed list of all analytes and reporting limits, please contact NMS Labs.

Amphetamines, Anticonvulsants, Antidepressants, Antihistamines, Antipsychotic Agents, Benzodiazepines, CNS Stimulants, Cocaine and Metabolites, Hallucinogens, Hypnosedatives, Hypoglycemics, Muscle Relaxants, Non-Steroidal Anti-Inflammatory Agents, Opiates and Opioids.



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



U.S. Immigration  
and Customs  
Enforcement

DATE: 13 September 2018

TO: Detention Standards Compliance Unit Chief  
ICE ERO Custody Management

FROM: (b)(6); (b)(7)(C)  
Detention Compliance Coordinator (DCC)  
Phoenix Field Office

SUBJECT: Operational Review Self-Assessment (ORSA) 2018  
Summary Letter

La Paz County Jail's designated Facility Compliance Coordinator, Commander Rico Suffle, performed the 2018 Operational Review Self-Assessment for compliance with the ICE National Detention Standards (NDS) of the La Paz County Jail Facility in Parker, AZ during the period of 1 September, 2018 through 11 September, 2018. This is an IGSA facility.

The annual inspection was performed under the guidance of the Field Office Detention Compliance Coordinator (DCC), (b)(6); (b)(7)(C)

#### Type of Review

This review is a scheduled ORSA inspection, which is performed to determine overall compliance with the ICE NDS for Under 72 hour facilities or eligible Over 72 hour facilities.

#### Standards Compliance

The following information is a summary of the standards that were reviewed and overall compliance that was determined as a result of the annual ORSA Inspection:

| <i>2018 ORSA Inspection</i>       |    |
|-----------------------------------|----|
| Meets Standards/Acceptable        | 29 |
| Does Not Meet Standards/Deficient | 0  |
| Not Applicable                    | 0  |

### **Facility Discussion of DNM Life Safety Standards and NA Ratings**

The following Standard components were identified as Life Safety Issues that were rated as Does Not Meet (DNM) Standards and or Not Applicable (NA) during the review: NONE.

### **Facility Discussion of DNM and NA Ratings**

The following Standard components were identified as that were rated as DNM Standards and or Not Applicable during the review. Please indicate any corrective action planned or pending for these standards and or components: NONE.

### **DCC Issues and Concerns**

There were no substantive issues or concerns during this inspection.

### **Significant Observations**

There were no significant observations noted during this inspection.

### **Recommended Rating and Justification**

The Detention Compliance Coordinator recommends that the facility receive a rating of "Meets Standards/Acceptable."

The facility complies with the ICE National Detention Standards (NDS). There were 0 standards found Does Not Meet/Deficient and 0 standards were listed as Not Applicable (N/A). All remaining 29 standards were found to be in compliance.

### **DCC Assurance Statement**

The findings of compliance and noncompliance are accurately and completely documented on the G-324B/O Inspection Form, 324 SIS and are supported by documentation retained in the inspection file.



|                                                                                                                                                             |                            |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| The facility ORSA has been reviewed and concurred with by the Detention Compliance Coordinator.                                                             |                            |
| Reviewer Name (Printed): (b)(6); (b)(7)(C)                                                                                                                  | *Reviewed Date: 09/13/2018 |
| Reviewer Title (Printed): DCC, COR (b)(6); (b)(7)(C)                                                                                                        |                            |
| Reviewer Signature (for printed form submission): (b)(6); (b)(7)(C)                                                                                         |                            |
| The facility ORSA has been reviewed and concurred with by the Field Office Director or designee (ERO field office official equivalent to an AFOD or above). |                            |
| Reviewer Name (Printed): Enrique M. Lucero                                                                                                                  | *Reviewed Date: 9-17-18    |
| Reviewer Title (Printed): (b)(6); (b)(7)(C) DD                                                                                                              |                            |
| Reviewer Signature (for printed form submission): (b)(6); (b)(7)(C)                                                                                         |                            |
| The facility ORSA has been reviewed by the Assistant Director of Custody Management or designee.                                                            |                            |
| Reviewer Name (Printed):                                                                                                                                    | *Reviewed Date:            |
| Reviewer Title (Printed):                                                                                                                                   |                            |
| Reviewer Signature (for printed form submission):                                                                                                           |                            |

**A. Type of Facility Reviewed**

- ☐ ICE Service Processing Center  
☐ ICE Contract Detention Facility  
☒ ICE Intergovernmental Service Agreement

**B. Current Inspection**

Type of Inspection  
☐ Field Office ☐ HQ Inspection ☒ ORSA  
Date[s] of Facility Review  
01 September 2018 – 11 September 2018

**C. Previous/Most Recent Facility Review**

Date[s] of Last Facility Review  
01 August 2017 – 04 August 2017  
Previous Rating  
☐ Superior ☐ Good ☒ Acceptable ☐ Deficient ☐ At-Risk

**D. Name and Location of Facility**

Name  
La Paz County Adult Detention Center  
Address (Street and Name)  
1109 Arizona Ave.  
City, State and Zip Code  
Parker, AZ 85344  
County  
La Paz  
Name and Title of Chief Executive Officer (Warden/OIC/Supt.)  
(b)(6), Sheriff  
Telephone # (Include Area Code)  
(928) 669-(b)(6)  
Field Office / Sub-Office (List Office with oversight responsibilities)  
Phoenix Field Office  
Distance from Field Office  
154 Miles

**E. ICE Information**

Name of Inspector (Last Name, Title and Duty Station)  
Name of Team Member / Title / Duty Location  
Name of Team Member / Title / Duty Location  
Name of Team Member / Title / Duty Location  
Name of Team Member / Title / Duty Location

**F. CDF/IGSA Information Only**

Contract Number  
08-02-0071  
Date of Contract or IGSA  
June 1, 2002  
Per Man-Day  
(b)(7)(E)  
Other Charges: (If None, Indicate N/A)  
Transportation: \$17.36/man-hour & \$0.535/mile

Estimated Man-days Per Year:  
1200

**G. Accreditation Certificates**

List all State or National Accreditation[s] received:

☒ Check box if facility has no accreditation[s]

**H. Problems / Complaints (Copies must be attached)**

The Facility is under Court Order or Class Action Finding  
☐ Court Order ☐ Class Action Order  
The Facility has Significant Litigation Pending  
☐ Major Litigation ☐ Life/Safety Issues  
☒ Check if None.

**I. Facility History**

Date Built  
1994  
Date Last Remodeled or Upgraded  
October 2007  
Date New Construction / Bed space Added  
N/A  
Future Construction Planned  
☐ Yes ☒ No Date:  
Current Bed space  
380  
Future Bed space (# New Beds only)  
Number: Date:

**J. Total Facility Population**

Total Facility Intake for previous 12 months  
21,343  
Total ICE Man-days for Previous 12 months  
394

**K. Classification Level (ICE SPCs and CDFs Only)**

|              | L-1 | L-2 | L-3 |
|--------------|-----|-----|-----|
| Adult Male   | N/A | N/A | N/A |
| Adult Female | N/A | N/A | N/A |

**L. Facility Capacity**

|              | Rated | Operational | Emergency |
|--------------|-------|-------------|-----------|
| Adult Male   | 261   | 261         | 350       |
| Adult Female | 30    | 30          | 44        |

☐ Facility holds Juveniles Offenders 16 and older as Adults

**M. Average Daily Population**

|              | ICE | USMS | Other |
|--------------|-----|------|-------|
| Adult Male   | 1   | 148  | 21    |
| Adult Female | 0   | 0    | 4     |

**N. Facility Staffing Level**

Security (b)(7)(E)

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**Significant Incident Summary Worksheet**

For ICE to complete its review of your facility, the following information must be completed prior to the scheduled review dates. The information on this form should contain data for the past twelve months in the boxes provided. The information on this form is used in conjunction with the ICE Detention Standards in assessing your Detention Operations against the needs of the ICE and its detained population. This form should be filled out by the facility prior to the start of any inspection. Failure to complete this section will result in a delay in processing this report and the possible reduction or removal of ICE detainees at your facility.

| <i>Incidents</i>                                                               | <i>Description</i>                                                           | Jan – Mar    | Apr – Jun  | Jul – Sept | Oct – Dec  |
|--------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------|------------|------------|------------|
| Assault:<br>Offenders on<br>Offenders <sup>1</sup>                             | Types (Sexual <sup>2</sup> , Physical, etc.)                                 | 0            | 0          | 1          | 0          |
|                                                                                | With Weapon                                                                  | 0            | 0          | 0          | 0          |
|                                                                                | Without Weapon                                                               | 0            | 0          | 1          | 0          |
| Assault:<br>Detainee on<br>Staff                                               | Types (Sexual Physical, etc.)                                                | 0            | 1          | 0          | 0          |
|                                                                                | With Weapon                                                                  |              |            |            |            |
|                                                                                | Without Weapon                                                               |              |            |            |            |
| Number of Forced Moves,<br>incl. Forced Cell moves <sup>3</sup>                |                                                                              | 0            | 0          | 2          | 4          |
| Disturbances <sup>4</sup>                                                      |                                                                              | 7            | 5          | 6          | 8          |
| Number of Times Chemical<br>Agents Used                                        |                                                                              | 0            | 0          | 1          | 0          |
| Number of Times Special<br>Reaction Team<br>Deployed/Used                      |                                                                              | 0            | 0          | 1          | 0          |
| # Times Four/Five Point<br>Restraints applied/used                             | Number/Reason (M=Medical,<br>V=Violent Behavior, O=Other)                    | 17 /15v / 2o | 10/ 7v/ 3o | 3 2v/ 1o   | 8 2v/3o/3m |
|                                                                                | Type (C=Chair, B=Bed,<br>BB=Board, O=Other)                                  | chair        | chair      | chair      | chair      |
| Offender / Detainee Medical<br>Referrals as a result of<br>injuries sustained. |                                                                              | 0            | 0          | 0          | 0          |
| Escapes                                                                        | Attempted                                                                    | 0            | 0          | 0          | 0          |
|                                                                                | Actual                                                                       | 0            | 0          | 0          | 0          |
| Grievances:                                                                    | # Received                                                                   |              |            |            |            |
|                                                                                | # Resolved in favor of<br>Offender/Detainee                                  |              |            |            |            |
| Deaths                                                                         | Reason (V=Violent, I=Illness,<br>S=Suicide, A=Attempted<br>Suicide, O=Other) | 0            | 0          | 0          | 0          |
|                                                                                | Number                                                                       | 0            | 0          | 0          | 0          |
| Psychiatric / Medical<br>Referrals                                             | # Medical Cases referred for<br>Outside Care                                 |              |            |            |            |

<sup>1</sup> Any attempted physical contact or physical contact that involves two or more offenders

<sup>2</sup> Oral, anal or vaginal penetration or attempted penetration involving at least 2 parties, whether it is consenting or non-consenting

<sup>3</sup> Routine transportation of detainees/offenders is not considered "forced"

<sup>4</sup> Any incident that involves four or more detainees/offenders, includes gang fights, organized multiple hunger strikes, work stoppages, hostage situations, major fires, or other large scale incidents.

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|  |                                                  |  |  |  |  |
|--|--------------------------------------------------|--|--|--|--|
|  | # Psychiatric Cases referred for<br>Outside Care |  |  |  |  |
|--|--------------------------------------------------|--|--|--|--|

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**Condition of Confinement Review Worksheet**

(This document must be attached to each G-324B Inspection Form)

**This Form to be used for Inspections of all Facilities Used Under 72 Hours with SAAP/****ICE Detention Standards Review Worksheet****REVIEW TEAM USE: (Edits Permitted, ALL FIELDS REQUIRED)**

|                                                                                                                                               |                      |                                 |   |
|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------|---|
| <b>Facility Information</b>                                                                                                                   |                      |                                 |   |
| Facility Name: LA PAZ COUNTY SHERIFF'S OFFICE                                                                                                 |                      | Review Purpose: Annual          |   |
| Facility Type: IGSA<br>Intergovernmental Service Agreement (IGSA), ICE Service Processing Center (SPC), ICE Contract Detention Facility (CDF) |                      |                                 |   |
| Address:                                                                                                                                      | 1109 Arizona Ave     |                                 |   |
| City: Parker                                                                                                                                  | State: AZ            | Zip Code: 85344                 |   |
| County:                                                                                                                                       | La Paz               |                                 |   |
| CEO Name:                                                                                                                                     | (b)(6); (b)(7)(C)    | CEO Title: Sheriff              |   |
| <b>Review Information</b> (Use following format for dates: mm/dd/yyyy)                                                                        |                      |                                 |   |
| Start Date: 09/01/2018                                                                                                                        | End Date: 09/11/2018 | Review Type: ORSA               |   |
| Lead Name:                                                                                                                                    | (b)(6); (b)(7)(C)    | Lead Title: Detention Commander |   |
| <b>Review Document Issue Summary</b> (See Document Check Section to Review/Update)                                                            |                      |                                 |   |
| Error(s) Found:                                                                                                                               | 0                    | Items Not Rated:                | 0 |

**ICE HQ USE ONLY: (DO NOT EDIT\*)**

|                      |                          |                                |
|----------------------|--------------------------|--------------------------------|
| Form Name: G324B_NDS | Form Key: 24             | Form Date: 10/5/2015           |
| Form Type: NDS       | Form Review Type: Annual | Form Over/Under 72 Status: U72 |

\*If Edits are required, contact ICE HQ for an updated form.

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G-324B (NDS) (Coded 10052015) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 - Form Key TBD

DHS-20-0638-C-000198

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**NOTE:** FOR EACH STANDARD RATED BELOW ACCEPTABLE, FACILITIES MUST ATTACH A PLAN OF ACTION FOR BRINGING OPERATIONS INTO COMPLIANCE. EACH FACILITY SHOULD EXAMINE THE ENTIRE WORKSHEET TO IDENTIFY AREAS OF IMPROVEMENT, INCLUDING THOSE STANDARDS WHERE AN OVERALL FINDING OF ACCEPTABLE WAS ACHIEVED.

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 - Form Key TBD



# ***Section I***

## **Detainee Service Standards**

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 - Form Key TBD

### ADMISSION AND RELEASE (Key: A)

**POLICY:** ALL DETAINEES WILL BE ADMITTED AND RELEASED IN A MANNER THAT ENSURES THEIR HEALTH, SAFETY, AND WELFARE. THE ADMISSIONS PROCEDURE WILL, AMONG OTHER THINGS INCLUDE: MEDICAL SCREENING; A FILE-BASED ASSESSMENT AND CLASSIFICATION PROCESS; A BODY SEARCH; AND A SEARCH OF PERSONAL BELONGINGS, WHICH WILL BE INVENTORIED, DOCUMENTED, AND SAFEGUARDED AS NECESSARY.

| COMPONENTS                                                                                                                                                                                                                          | RATING         | REMARKS (1000 CHAR MAX) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. In-processing includes an orientation of the facility.                                                                                                                                                                           | Meets Standard |                         |
| 2. Medical screenings are performed by medical staff <u>or</u> persons who have received specialized training for the purpose of conducting an initial health screening.                                                            | Meets Standard |                         |
| 3. All new arrivals are searched in accordance with the "Detainee Search" standard. An officer of the same sex as the detainee conducts the search and the search is conducted in an area that affords as much privacy as possible. | Meets Standard |                         |
| 4. Detainees are stripped searched only when cause has been established and not as routine policy. Non-criminal detainees are not strip-searched but are patted down, unless reasonable suspicion is established.                   | Meets Standard |                         |
| 5. The "Contraband" standard governs all personal property searches. IGSA/CDFs use or have a similar contraband standard. Staff prepares a complete inventory of each detainee's possessions. The detainee receives a copy.         | Meets Standard |                         |
| 6. Two officers are present during the processing of detainee funds and valuables during admissions processing to the facility. Both officers verify funds and valuables.                                                           | Meets Standard |                         |
| 7. Staff completes Form I-387 or similar form for CDFs and IGSA for every lost or missing property claim. Facilities forward all I-387 claims to ICE.                                                                               | Meets Standard |                         |
| 8. Detainees are issued appropriate and sufficient clothing and bedding for the climatic conditions.                                                                                                                                | Meets Standard |                         |
| 9. The facility provides and replenishes personal hygiene items as needed. Gender-specific items are available. ICE Detainees are not charged for these items.                                                                      | Meets Standard |                         |
| 10. All releases are properly coordinated with ICE using a Form I-203.                                                                                                                                                              | Meets Standard |                         |
| 11. Staff completes paperwork/forms for release as required.                                                                                                                                                                        | Meets Standard |                         |

### ADMISSION AND RELEASE – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

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| ADMISSION AND RELEASE – REVIEWER SUMMARY            |                   |                            |
|-----------------------------------------------------|-------------------|----------------------------|
| <i>(Use following format for dates: mm/dd/yyyy)</i> |                   |                            |
| Overall Rating: Meets Standard                      |                   |                            |
| Reviewer Name (Printed)                             | (b)(6); (b)(7)(C) | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form submission).   |                   |                            |

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

| CLASSIFICATION SYSTEM (Key: B)                                                                                                                                                                                                                                             |                |                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>POLICY:</b> ALL FACILITIES WILL DEVELOP AND IMPLEMENT A SYSTEM ACCORDING TO WHICH ICE DETAINEES ARE CLASSIFIED. THE CLASSIFICATION SYSTEM WILL ENSURE THAT EACH DETAINEE IS PLACED IN THE APPROPRIATE CATEGORY, PHYSICALLY SEPARATED FROM DETAINEES IN OTHER CATEGORIES |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                                 | RATING         | REMARKS (1000 CHAR MAX) |
| 1. The facility has a system for separating criminal and non-criminal ICE detainees. Violent offenders are separated from non-violent offenders.                                                                                                                           | Meets Standard |                         |
| 2. Housing assignments are based on threat level.                                                                                                                                                                                                                          | Meets Standard |                         |

| CLASSIFICATION SYSTEM – REVIEWER SUMMARY<br>(Use following format for dates: mm/dd/yyyy)                       |                                   |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------|
| <b>Overall Remarks:</b> (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                                   |
| <b>Overall Rating:</b> Meets Standard                                                                          |                                   |
| <b>Reviewer Name (Print)</b> (b)(6); (b)(7)(C)                                                                 | <b>Completion Date:</b> 9/11/2018 |
| <b>Reviewer Signature (for printed form submission):</b> (b)(6); (b)(7)(C)                                     |                                   |



### DETAINEE HANDBOOK (Key: C)

**POLICY:** EVERY OIC WILL DEVELOP A SITE-SPECIFIC DETAINEE HANDBOOK TO SERVE AS AN OVERVIEW OF, AND GUIDE TO, THE DETENTION POLICIES, RULES, AND PROCEDURES IN EFFECT AT THE FACILITY. THE HANDBOOK WILL ALSO DESCRIBE THE SERVICES, PROGRAMS, AND OPPORTUNITIES AVAILABLE THROUGH VARIOUS SOURCES, INCLUDING THE FACILITY, ICE, PRIVATE ORGANIZATIONS, ETC. EVERY DETAINEE WILL RECEIVE A COPY OF THIS HANDBOOK UPON ADMISSION TO THE FACILITY.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | RATING         | REMARKS (1000 CHAR MAX) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. The detainee handbook is written in English and translated into Spanish, or into the next most-prevalent Language(s).                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Meets Standard |                         |
| 2. The detainee handbook states in clear language the basic detainee responsibilities.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Meets Standard |                         |
| 3. The handbook identifies: <ul style="list-style-type: none"> <li>Initial issue of clothing and bedding, and personal hygiene items;</li> <li>When a medical examination will be conducted;</li> <li>The telephone policy, debit card procedures, direct and free calls, locations of telephones, policy when telephone demand is high, Policy and procedures for emergency phone calls, and the Detainee Message System;</li> <li>Facility search procedures and contraband policy; and</li> <li>Facility visiting hours and schedule, and visiting rules and regulations</li> </ul> | Meets Standard |                         |
| 4. The handbook describes the detainee disciplinary policy and procedures, to include: <ul style="list-style-type: none"> <li>Prohibited acts and severity scale sanctions;</li> <li>Time limits in the Disciplinary Process;</li> <li>Summary of Disciplinary Process;</li> <li>Sick call procedures for general population and segregation; and</li> <li>The rights and responsibilities of all detainees.</li> </ul>                                                                                                                                                                | Meets Standard |                         |

### DETAINEE HANDBOOK – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submission):** (b)(6); (b)(7)(C)

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

### FOOD SERVICE (Key: D)

**POLICY:** EVERY FACILITY WILL PROVIDE DETAINEES IN ITS CARE WITH NUTRITIOUS AND APPETIZING MEALS, PREPARED IN ACCORDANCE WITH THE HIGHEST SANITARY STANDARDS.

| COMPONENTS                                                                                                                                                                                                                 | RATING         | REMARKS (1000 CHAR MAX)          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------|
| 1. Trained staff supervises the food service program.                                                                                                                                                                      | Meets Standard |                                  |
| 2. Knife cabinets close with an approved locking device and the on-duty cook foreman maintains control of the key that locks the device.                                                                                   | Meets Standard |                                  |
| 3. All knives not in a secure cutting room are physically secured to the workstation and staff directly supervises detainees using knives at these workstations. Staff monitor the condition of knives and dining utensils | Meets Standard |                                  |
| 4. Detainees are served at least three meals daily. No more than 14 hours elapse between the last meal served and the first meal of the following day.                                                                     | Meets Standard | 3,000 calories a day             |
| 5. A registered dietitian conducts a complete nutritional analysis of every master-cycle menu planned.                                                                                                                     | Meets Standard | Kitchen contract company Trinity |
| 6. The food service program addresses medical diets.                                                                                                                                                                       | Meets Standard |                                  |
| 7. Satellite-feeding programs follow guidelines for proper sanitation.                                                                                                                                                     | N/A            |                                  |
| 8. Hot and cold foods are maintained at the prescribed, "safe" temperature(s) after two hours. (140 degrees for hot – 40 degrees for cold)                                                                                 | Meets Standard |                                  |
| 9. All meals are provided in nutritionally adequate portions.                                                                                                                                                              | Meets Standard |                                  |
| 10. Food is not used to punish or reward detainees based upon behavior.                                                                                                                                                    | Meets Standard |                                  |
| 11. Standard operating procedures include weekly inspections of all food service areas, including dining and food-preparation areas and equipment.                                                                         | Meets Standard |                                  |
| 12. Equipment is inspected daily.                                                                                                                                                                                          | Meets Standard |                                  |
| 13. Procedures include inspecting all incoming food shipments for damage, contamination, and pest infestation.                                                                                                             | Meets Standard |                                  |
| 14. Storage areas are locked.                                                                                                                                                                                              | Meets Standard |                                  |

### FOOD SERVICE – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed name):** (b)(6); (b)(7)(C)

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



**FUNDS AND PERSONAL PROPERTY (Key: E)**

**POLICY:** ALL FACILITIES WILL IMPLEMENT PROCEDURES TO CONTROL AND SAFEGUARD DETAINEES' PERSONAL PROPERTY. PROCEDURES WILL PROVIDE FOR THE SECURE STORAGE OF FUNDS, VALUABLES, BAGGAGE, AND OTHER PERSONAL PROPERTY; THE DOCUMENTATION AND RECEIPTING OF SURRENDERED PROPERTY; AND THE INITIAL AND REGULARLY SCHEDULED INVENTORYING OF ALL FUNDS, VALUABLES, AND OTHER PROPERTY.

**Standard N/A**

CLICK THE BUTTON ABOVE (IGSA ONLY) IF ALL ICE DETAINEE FUNDS, VALUABLES AND PROPERTY ARE HANDLED ONLY BY THE ICE FIELD OFFICE OR SUB-OFFICE IN CONTROL OF THE DETAINEE CASE. (ALL LINE ITEMS AND STANDARD WILL BE RATED "N/A").

| COMPONENTS                                                                                                                                                 | RATING         | REMARKS (1000 CHAR MAX) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Detainee funds and valuables are properly separated, stored, and are accessible only by designated supervisor(s).                                       | Meets Standard |                         |
| 2. Detainees' large valuables are secured in a location accessible to designated supervisor(s) or processing staff only.                                   | Meets Standard |                         |
| 3. (b)(7)(E) are present during the processing of detainee funds and valuables during in-processing to the facility. (b)(7)(E) verify funds and valuables. | Meets Standard |                         |
| 4. Staff forwards an arriving detainee's medicine to the medical staff.                                                                                    | Meets Standard |                         |
| 5. Staff searches arriving detainees and their personal property for contraband.                                                                           | Meets Standard |                         |
| 6. Staff procedures follow written policy for returning forgotten property to detainees.                                                                   | Meets Standard |                         |
| 7. Property discrepancies are immediately reported to the CDEO or Chief of Security.                                                                       | Meets Standard |                         |
| 8. CDF/IGSA facility procedures for handling detainee property claims are similar with the ICE standard.                                                   | Meets Standard |                         |

**FUNDS AND PERSONAL PROPERTY – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submission):** (b)(6); (b)(7)(C)

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

### DETAINEE GRIEVANCE PROCEDURES (Key: F)

**POLICY:** EVERY FACILITY WILL DEVELOP AND IMPLEMENT STANDARD OPERATING PROCEDURES (SOPs) FOR ADDRESSING DETAINEE GRIEVANCES IN TIMELY FASHION. EACH STEP IN THE PROCESS WILL OCCUR WITHIN THE PRESCRIBED TIME FRAME. AMONG OTHER THINGS, A GRIEVANCE WILL BE PROCESSED, INVESTIGATED, AND DECIDED (SUBJECT TO APPEAL) IN ACCORDANCE WITH THE SOPs; A GRIEVANCE COMMITTEE WILL CONVENE AS PROVIDED IN THE SOPs. STANDARD PROCEDURE WILL INCLUDE PROVIDING THE DETAINEE WITH A WRITTEN RESPONSE TO ANY FORMAL GRIEVANCE, WHICH WILL INCLUDE THE BASIS FOR THE DECISION. THE FACILITY WILL ALSO ESTABLISH STANDARD PROCEDURES FOR HANDLING EMERGENCY GRIEVANCES. ALL GRIEVANCES WILL RECEIVE SUPERVISORY REVIEW. REPRISAL AGAINST THE FILER OF A GRIEVANCE WILL NOT BE TOLERATED.

| COMPONENTS                                                                                                                                                                                                                                                                                      | RATING         | REMARKS (1000 CHAR MAX) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Every member of the staff knows how to identify emergency grievances, including the procedures for expediting them.                                                                                                                                                                          | Meets Standard |                         |
| 2. There are documented or substantiated cases of staff harassing, disciplining, penalizing, or otherwise retaliating against a detainee who lodged a complaint:<br>• If yes, explain.                                                                                                          | Meets Standard |                         |
| 3. Procedures include maintaining a Detainee Grievance Log.<br>• If not, an alternative acceptable record keeping system is maintained.<br>• "Nuisance complaints" are identified in the records.<br>• For quality control purposes, staff document nuisance complaints received but not filed. | Meets Standard |                         |
| 4. Staff is required to forward any grievance that includes officer misconduct to a higher official or, in a CDF/IGSA facility, to ICE.                                                                                                                                                         | Meets Standard |                         |

### DETAINEE GRIEVANCE PROCEDURES – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):**

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

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submission):**

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

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



**Issuance and Exchange of Clothing, Bedding, and Towels (Key: G)**

**POLICY:** ICE REQUIRES THAT ALL FACILITIES HOUSING ICE DETAINEES PROVIDE CLEAN CLOTHING, BEDDING, LINENS, AND TOWELS TO EVERY ICE DETAINEE UPON ARRIVAL. FURTHER, FACILITIES SHALL PROVIDE ICE DETAINEES WITH REGULAR EXCHANGES OF CLOTHING, LINENS, AND TOWELS FOR AS LONG AS THEY REMAIN IN DETENTION.

| COMPONENTS                                                                                                 | RATING         | REMARKS (1000 CHAR MAX) |
|------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. All new detainees are issued clean, temperature-appropriate, presentable clothing during in-processing. | Meets Standard |                         |
| 2. New detainees are issued clean bedding, linens, and a towel.                                            | Meets Standard |                         |

**ISSUANCE AND EXCHANGE OF CLOTHING, BEDDING, AND TOWELS – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form sub**

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

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

**RELIGIOUS PRACTICES (Key: H)**

**POLICY:** FACILITIES WILL PROVIDE ICE DETAINEES OF ALL FAITHS WITH REASONABLE AND EQUITABLE OPPORTUNITIES TO PARTICIPATE IN THE PRACTICES OF THEIR FAITH, LIMITED ONLY BY THE CONSTRAINTS OF SAFETY, SECURITY, THE ORDERLY OPERATIONS OF THE FACILITY AND BUDGETARY CONSIDERATIONS.

| COMPONENTS                                                                                  | RATING         | REMARKS (1000 CHAR MAX) |
|---------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Detainees are allowed to engage in religious services.                                   | Meets Standard |                         |
| 2. The facility allows detainees to observe the major "holy days" of their religious faith. | Meets Standard |                         |
| 3. Each detainee is allowed religious items in his/her immediate possession.                | Meets Standard |                         |

**RELIGIOUS PRACTICES – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed)** (b)(6); (b)(7)(C) **Completion Date:** 9/11/2018

**Reviewer Signature (for printed form sub)** (b)(6); (b)(7)(C)

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### DETAINEE TELEPHONE ACCESS (Key: I)

**POLICY:** ALL FACILITIES HOUSING ICE DETAINEES WILL PERMIT DETAINEES' REASONABLE AND EQUITABLE ACCESS TO TELEPHONES.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                    | RATING         | REMARKS (1000 CHAR MAX) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Detainees are allowed access to telephones during established facility waking hours.                                                                                                                                                                                                                                                                       | Meets Standard |                         |
| 2. Upon admittance, detainees are made aware of the facility's telephone access policy.                                                                                                                                                                                                                                                                       | Meets Standard |                         |
| 3. Detainees are afforded a <i>reasonable degree of privacy</i> for legal phone calls.                                                                                                                                                                                                                                                                        | Meets Standard |                         |
| 4. Emergency phone call messages are immediately given to detainees.                                                                                                                                                                                                                                                                                          | Meets Standard |                         |
| 5. Detainees are allowed to return emergency phone calls as soon as possible.                                                                                                                                                                                                                                                                                 | Meets Standard |                         |
| 6. Detainees in disciplinary segregation are allowed phone calls to consular/embassy officials.                                                                                                                                                                                                                                                               | Meets Standard |                         |
| 7. The OIG phone number for reporting abuse is programmed into the detainee phone system and the phone number was checked by the inspector during the review.                                                                                                                                                                                                 | Meets Standard |                         |
| 8. Detainees in disciplinary segregation are allowed phone calls for family emergencies.                                                                                                                                                                                                                                                                      | Meets Standard |                         |
| 9. Detainees in administrative segregation and protective custody are afforded the same telephone privileges as detainees in general population.                                                                                                                                                                                                              | Meets Standard |                         |
| 10. When detainee phone calls are monitored, notification is posted by detainee telephones that phone calls made by the detainees may be monitored. Special Access calls are not monitored.                                                                                                                                                                   | Meets Standard |                         |
| 11. <b>LYON AGREEMENT:</b> When a detainee requests a direct or free Legal Call to an attorney, court, or government agency or demonstrates a compelling need for other direct or free calls, access is granted within 24 hours of the request and ordinarily within 8 facility waking hours. Further delays may be justified by extraordinary circumstances. | Meets Standard |                         |
| 12. <b>LYON AGREEMENT:</b> The facility documents and reports to ICE/ERO any delays in responding to requests for free or direct Legal Calls beyond 8 facility waking hours.                                                                                                                                                                                  | Meets Standard |                         |
| 13. <b>LYON AGREEMENT:</b> Detainees are provided private settings for Legal Calls such that calls cannot be overheard by officers, other staff, or other detainees.                                                                                                                                                                                          | Meets Standard |                         |
| 14. <b>LYON AGREEMENT:</b> The facility has a system for taking and delivering telephone messages to detainees, including but not limited to attorney messages, other messages related to a detainee's legal case, and emergency messages, and ensures the timeliness of such message delivery.                                                               | Meets Standard |                         |

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| DETAINEE TELEPHONE ACCESS (Key: I)                                                                                                                                                                                                                                        |                |                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>POLICY:</b> ALL FACILITIES HOUSING ICE DETAINEES WILL PERMIT DETAINEES' REASONABLE AND EQUITABLE ACCESS TO TELEPHONES.                                                                                                                                                 |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                                | RATING         | REMARKS (1000 CHAR MAX) |
| 15. <b>LYON AGREEMENT:</b> The facility provides translation and interpretation services to detainees who are unable to read written telephone access rules in the languages provided.                                                                                    | Meets Standard |                         |
| 16. <b>LYON AGREEMENT:</b> Detainees in segregation or other environments with limited physical access to telephones have reasonable and equitable access to telephones during waking hours (i.e., they can request telephone calls and receive them in a timely manner). | Meets Standard |                         |

| DETAINEE TELEPHONE ACCESS – REVIEWER SUMMARY                                                                   |                                   |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------|
| (Use following format for dates: mm/dd/yyyy)                                                                   |                                   |
| <b>Overall Remarks:</b> (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                                   |
| <b>Overall Rating:</b> Meets Standard                                                                          |                                   |
| <b>Reviewer Name (Printed)</b> (b)(6); (b)(7)(C)                                                               | <b>Completion Date:</b> 9/11/2018 |
| <b>Reviewer Signature (for printed form sub)</b> (b)(6); (b)(7)(C)                                             |                                   |



| VISITATION (Key: J)                                                                                                                   |                |                         |
|---------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| POLICY: ICE SHALL PERMIT DETAINEES TO VISIT WITH FAMILY, FRIENDS, LEGAL REPRESENTATIVES, SPECIAL INTEREST GROUPS, AND THE NEWS MEDIA. |                |                         |
| COMPONENTS                                                                                                                            | RATING         | REMARKS (1000 CHAR MAX) |
| 1. There is a written visitation schedule and hours for general visitation.                                                           | Meets Standard |                         |
| 2. The visitation schedule and rules are available to the public.                                                                     | Meets Standard |                         |
| 3. A general visitation log is maintained.                                                                                            | Meets Standard |                         |
| 4. Visitors are searched and identified according to standard requirements.                                                           | Meets Standard |                         |

| VISITATION – REVIEWER SUMMARY<br>(Use following format for dates: mm/dd/yyyy)                           |                            |
|---------------------------------------------------------------------------------------------------------|----------------------------|
| Overall Remarks: (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                            |
| Overall Rating: Meets Standard                                                                          |                            |
| Reviewer Name (Printed) (b)(6); (b)(7)(C)                                                               | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form signature) (b)(6); (b)(7)(C):                                      |                            |

## ***Section II***

### **Health Services Standards**

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



### ACCESS TO MEDICAL CARE (Key: K)

**POLICY:** EVERY FACILITY WILL ESTABLISH AND MAINTAIN AN ACCREDITED/ACCREDITATION-WORTHY HEALTH PROGRAM FOR THE GENERAL WELL-BEING OF ICE DETAINEES.

| COMPONENTS                                                                                                                                                                                           | RATING         | REMARKS (1000 CHAR MAX) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Facilities operate a health care facility in compliance with state and local laws and guidelines.                                                                                                 | Meets Standard |                         |
| 2. The facility's in-processing procedures for arriving detainees include medical screening.                                                                                                         | Meets Standard |                         |
| 3. All detainees have access to and receive medical care.                                                                                                                                            | Meets Standard |                         |
| 4. Pharmaceuticals are stored in a secure area.                                                                                                                                                      | Meets Standard |                         |
| 5. Medical screening includes a Tuberculosis (TB) test.                                                                                                                                              | Meets Standard |                         |
| 6. Detainees in the Special Management Unit have access to health care services.                                                                                                                     | Meets Standard |                         |
| 7. The facility has a written plan for the delivery of 24-hour emergency health care when no medical personnel are on duty at the facility, or when immediate outside medical attention is required. | Meets Standard |                         |
| 8. Detention staff is trained to respond to health-related emergencies within a 4-minute response time.                                                                                              | Meets Standard |                         |
| 9. Where staff is used to distribute medication, a health care provider properly trains these officers.                                                                                              | Meets Standard |                         |
| 10. The medical unit keeps written records of medication that is distributed.                                                                                                                        | Meets Standard |                         |
| 11. Detainees are required to sign a refusal to consent form when medical treatment is refused.                                                                                                      | Meets Standard |                         |

### ACCESS TO MEDICAL CARE – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Print)** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form sub**

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

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

| SUICIDE PREVENTION AND INTERVENTION (Key: L)                                                                                                                                                                                                                                                           |                |                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>POLICY:</b> ALL DETENTION STAFF WORKING WITH ICE DETAINEES WILL BE TRAINED TO RECOGNIZE SUICIDE-RISK INDICATORS. STAFF WILL HANDLE POTENTIALLY SUICIDAL INDIVIDUALS WITH SENSITIVITY, SUPERVISION, AND REFERRALS. A CLINICALLY SUICIDAL DETAINEE WILL RECEIVE PREVENTIVE SUPERVISION AND TREATMENT. |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                                                             | RATING         | REMARKS (1000 CHAR MAX) |
| 1. Every new staff member receives suicide-prevention training. Suicide-prevention training occurs during the employee orientation program.                                                                                                                                                            | Meets Standard |                         |
| 2. Training prepares staff to: <ul style="list-style-type: none"> <li>Recognize potentially suicidal behavior;</li> <li>Refer potentially suicidal detainees, following facility procedures; and</li> <li>Understand and apply suicide-prevention techniques.</li> </ul>                               | Meets Standard |                         |

| SUICIDE PREVENTION AND INTERVENTION – REVIEWER SUMMARY                                                  |                            |
|---------------------------------------------------------------------------------------------------------|----------------------------|
| (Use following format for dates. mm/dd/yyyy)                                                            |                            |
| Overall Remarks: (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                            |
| Overall Rating: Meets Standard                                                                          |                            |
| Reviewer Name (Print (b)(6); (b)(7)(C))                                                                 | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form (b)(6); (b)(7)(C))                                                 |                            |



# ***Section III***

## **Security And Control Standards**

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

**CONTRABAND (Key: M)**

**POLICY:** ALL DETENTION FACILITIES WILL ENSURE THE PROPER HANDLING AND DISPOSAL OF ALL CONTRABAND. DOCUMENTATION OF CONTRABAND DESTRUCTION IS REQUIRED.

| COMPONENTS                                                                                                                                                                            | RATING         | REMARKS (1000 CHAR MAX) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. The facility follows a written procedure for handling illegal contraband. Staff inventory, hold, and report it when necessary to the proper authority for action/possible seizure. | Meets Standard |                         |
| 2. Upon admittance, detainees receive notice of items they can and cannot possess.                                                                                                    | Meets Standard |                         |

**CONTRABAND -- REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed)** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed for** (b)(6); (b)(7)(C) **sion):**

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 - Form Key TBD



### DETENTION FILES (Key: N)

**POLICY:** EVERY FACILITY WILL CREATE A DETENTION FILE FOR EVERY ICE DETAINEE BOOKED INTO THE FACILITY, EXCLUDING ONLY DETAINEES SCHEDULED TO DEPART WITHIN 24 HOURS. THE DETENTION FILE WILL CONTAIN COPIES AND, IN SOME CASES, THE ORIGINAL OF SPECIFIED DOCUMENTS CONCERNING THE DETAINEE'S STAY IN THE FACILITY: CLASSIFICATION SHEET, MEDICAL QUESTIONNAIRE, PROPERTY INVENTORY SHEET, DISCIPLINARY DOCUMENTS, ETC.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                        | RATING         | REMARKS (1000 CHAR MAX) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. A detention file is created for every new arrival whose stay will exceed 24 hours.                                                                                                                                                                                                                                                                             | Meets Standard |                         |
| 2. The detainee detention file contains either originals or copies of documentation and forms generated during the admissions process.                                                                                                                                                                                                                            | Meets Standard |                         |
| 3. The detainee's detention file also contains documents generated during the detainee's custody. <ul style="list-style-type: none"> <li>• Special requests</li> <li>• Any G-589s and/or I-77s closed-out during the detainee's stay</li> <li>• Disciplinary forms/Segregation forms</li> <li>• Grievances, complaints, and the disposition(s) of same</li> </ul> | Meets Standard |                         |
| 4. The detention files are located and maintained in a secure area. If not, the cabinets are lockable and distribution of the keys is limited to supervisors.                                                                                                                                                                                                     | Meets Standard |                         |
| 5. The detention file remains active during the detainee's stay. When the detainee is released from the facility, staff adds copies of completed release documents, the original closed-out receipts for property and valuables, the original I-385 or equivalent, and other documentation.                                                                       | Meets Standard |                         |
| 6. The officer closing the detention file makes a notation that the file is complete and ready to be archived.                                                                                                                                                                                                                                                    | Meets Standard |                         |
| 7. Staff makes copies and sends documents from the file when properly requested by supervisory personnel at the receiving facility or office.                                                                                                                                                                                                                     | Meets Standard |                         |
| 8. Appropriate staff has access to the detention files, and other departmental requests are accommodated by making a request for the file. Each file is properly logged out and in by a representative of the responsible department.                                                                                                                             | Meets Standard |                         |

### DETENTION FILES -- REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed)** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

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**DETENTION FILES – REVIEWER SUMMARY**

*(Use following format for dates: mm/dd/yyyy)*

**Reviewer Signature (for printed form submission)**

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

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



### DISCIPLINARY POLICY (Key: O)

**POLICY:** ALL FACILITIES HOUSING ICE DETAINEES ARE AUTHORIZED TO IMPOSE DISCIPLINE ON DETAINEES WHOSE BEHAVIOR IS NOT IN COMPLIANCE WITH FACILITY RULES AND REGULATIONS.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                      | RATING         | REMARKS (1000 CHAR MAX) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. The facility has a written disciplinary system using progressive levels of reviews and appeals.                                                                                                                                                                                                                                                                                                              | Meets Standard |                         |
| 2. The facility rules state that disciplinary action shall not be capricious or retaliatory.                                                                                                                                                                                                                                                                                                                    | Meets Standard |                         |
| 3. Written rules prohibit staff from imposing or permitting the following sanctions: <ul style="list-style-type: none"> <li>• corporal punishment</li> <li>• deviations from normal food service</li> <li>• clothing deprivation</li> <li>• bedding deprivation</li> <li>• denial of personal hygiene items</li> <li>• loss of correspondence privileges</li> <li>• deprivation of physical exercise</li> </ul> | Meets Standard |                         |
| 4. The rules of conduct, sanctions, and procedures for violations are defined in writing and communicated to all detainees verbally and in writing.                                                                                                                                                                                                                                                             | Meets Standard |                         |
| 5. The following items are conspicuously posted in Spanish and English, and other dominate languages used in the facility: <ul style="list-style-type: none"> <li>• Rights and Responsibilities</li> <li>• Prohibited Acts</li> <li>• Disciplinary Severity Scale</li> <li>• Sanctions</li> </ul>                                                                                                               | Meets Standard |                         |
| 6. When minor rule violations or prohibited acts occur, informal resolutions are encouraged.                                                                                                                                                                                                                                                                                                                    | Meets Standard |                         |

### DISCIPLINARY POLICY – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6);  
(b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submission):** (b)(6);  
(b)(7)(C)

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

**EMERGENCY (CONTINGENCY) PLANS (Key: P)**

**POLICY** ALL FACILITIES HOLDING ICE DETAINEES WILL RESPOND TO EMERGENCIES WITH A PREDETERMINED STANDARDIZED PLAN TO MINIMIZE THE HARMING OF HUMAN LIFE AND THE DESTRUCTION OF PROPERTY. IT IS RECOMMENDED THAT SPCs AND CDFs ENTER INTO AGREEMENT, VIA MEMORANDUM OF UNDERSTANDING (MOU), WITH FEDERAL, LOCAL AND STATE AGENCIES TO ASSIST IN TIMES OF EMERGENCY.

| COMPONENTS                                                                                                                                                                                                                                          | RATING         | REMARKS (1000 CHAR MAX) |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Policy precludes detainees or detainee groups from exercising control or authority over other detainees.                                                                                                                                         | Meets Standard |                         |
| 2. Detainees are protected from: <ul style="list-style-type: none"><li>• Personal abuse</li><li>• Corporal punishment</li><li>• Personal injury</li><li>• Disease</li><li>• Property damage</li><li>• Harassment from other detainees</li></ul>     | Meets Standard |                         |
| 3. Written procedures cover: <ul style="list-style-type: none"><li>• Work/Food Strike</li><li>• Disturbances</li><li>• Escapes</li><li>• Bomb Threats</li><li>• Adverse Weather</li><li>• Facility Evacuation</li><li>• Internal Hostages</li></ul> | Meets Standard |                         |

**EMERGENCY (CONTINGENCY) PLANS – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for print):**

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



### ENVIRONMENTAL HEALTH AND SAFETY (Key: Q)

**POLICY:** EVERY FACILITY WILL CONTROL FLAMMABLE, TOXIC, AND CAUSTIC MATERIALS THROUGH A HAZARDOUS MATERIALS PROGRAM. THE PROGRAM WILL INCLUDE, AMONG OTHER THINGS, THE IDENTIFICATION AND LABELING OF HAZARDOUS MATERIALS IN ACCORDANCE WITH APPLICABLE STANDARDS (E.G., NATIONAL FIRE PROTECTION ASSOCIATION [NFPA]); IDENTIFICATION OF INCOMPATIBLE MATERIALS, AND SAFE-HANDLING PROCEDURES

| COMPONENTS                                                                                                                                                                                                                                                                                               | RATING         | REMARKS (1000 CHAR MAX)               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|---------------------------------------|
| 1. The facility has a system for storing, issuing, and maintaining inventories of hazardous materials.                                                                                                                                                                                                   | Meets Standard |                                       |
| 2. Constant inventories are maintained for all flammable, toxic, and caustic substances used/stored in each section of the facility.                                                                                                                                                                     | Meets Standard |                                       |
| 3. The manufacturer's Material Safety Data Sheet (MSDS) file is up-to-date for every hazardous substance used.                                                                                                                                                                                           | Meets Standard | Facility has MSDS Officer             |
| 4. All personnel using flammable, toxic, and/or caustic substances follow the prescribed procedures. They: <ul style="list-style-type: none"> <li>Wear personal protective equipment; and</li> <li>Report hazards and spills to the designated official.</li> </ul>                                      | Meets Standard |                                       |
| 5. The MSDSs are readily accessible to staff and detainees in work areas.                                                                                                                                                                                                                                | Meets Standard |                                       |
| 6. Hazardous materials are always issued under proper supervision. <ul style="list-style-type: none"> <li>Quantities are limited; and</li> <li>Staff always supervises detainees using these substances.</li> </ul>                                                                                      | Meets Standard |                                       |
| 7. The facility has sufficient ventilation, and provides and ensures clean air exchanges throughout all buildings.                                                                                                                                                                                       | Meets Standard |                                       |
| 8. Vents return vents, and air conditioning ducts are not blocked or obstructed in cells or anywhere in the facility.                                                                                                                                                                                    | Meets Standard |                                       |
| 9. Living units are maintained at appropriate temperatures in accordance with industry standards. (68 to 74 degrees in the winter and 72 to 78 degrees in the summer.)                                                                                                                                   | Meets Standard |                                       |
| 10. Shower and sink water temperatures do not exceed the industry standard of 120 degrees.                                                                                                                                                                                                               | Meets Standard |                                       |
| 11. Staff directly supervise and account for products with methyl alcohol. Staff receives a list of products containing diluted methyl alcohol, e.g., shoe dye. All such products are clearly labeled. "Accountability" includes issuing such products to detainees in the smallest workable quantities. | N/A            | No Methyl Alcohol product in facility |
| 12. A technically qualified officer conducts the fire and safety inspections.                                                                                                                                                                                                                            | Meets Standard |                                       |
| 13. The facility has an approved fire prevention, control, and evacuation plan.                                                                                                                                                                                                                          | Meets Standard |                                       |

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 - Form Key TBD

**ENVIRONMENTAL HEALTH AND SAFETY (Key: Q)**

**POLICY:** EVERY FACILITY WILL CONTROL FLAMMABLE, TOXIC, AND CAUSTIC MATERIALS THROUGH A HAZARDOUS MATERIALS PROGRAM. THE PROGRAM WILL INCLUDE, AMONG OTHER THINGS, THE IDENTIFICATION AND LABELING OF HAZARDOUS MATERIALS IN ACCORDANCE WITH APPLICABLE STANDARDS (E.G., NATIONAL FIRE PROTECTION ASSOCIATION [NFPA]); IDENTIFICATION OF INCOMPATIBLE MATERIALS, AND SAFE-HANDLING PROCEDURES

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                         | RATING         | REMARKS (1000 CHAR MAX) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 14. The plan requires: <ul style="list-style-type: none"><li>• Monthly fire inspections;</li><li>• Fire protection equipment strategically located throughout the facility;</li><li>• Public posting of emergency plans with accessible building/room floor plans;</li><li>• Exit signs and directional arrows; and</li><li>• An area-specific exit diagram conspicuously posted in the diagrammed area.</li></ul> | Meets Standard |                         |
| 15. Written procedures regulate the handling and disposal of used needles and other sharp objects.                                                                                                                                                                                                                                                                                                                 | Meets Standard |                         |
| 16. Standard cleaning practices include: <ul style="list-style-type: none"><li>• Using specified equipment; cleansers; disinfectants and detergents.</li><li>• An established schedule of cleaning and follow-up inspections.</li></ul>                                                                                                                                                                            | Meets Standard |                         |
| 17. A licensed/Certified/Trained pest-control professional inspects for rodents, insects, and vermin. <ul style="list-style-type: none"><li>• At least monthly.</li><li>• The pest-control program includes preventative spraying for indigenous insects.</li></ul>                                                                                                                                                | Meets Standard | Once a month            |

**ENVIRONMENTAL HEALTH AND SAFETY – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):**

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

**Completion Date:** 9/11/2018

**Reviewer Signature (for pr**

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



| HOLD ROOMS IN DETENTION FACILITIES (Key: R)                                                                                                                                                                                                                                      |                |                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>POLICY:</b> HOLD ROOMS WILL BE USED ONLY FOR TEMPORARY DETENTION OF DETAINEES AWAITING REMOVAL, TRANSFER, EOIR HEARINGS, MEDICAL TREATMENT, INTRA-FACILITY MOVEMENT, OR OTHER PROCESSING INTO OR OUT OF THE FACILITY.                                                         |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                                       | RATING         | REMARKS (1000 CHAR MAX) |
| 1. The hold rooms are situated within the secure perimeter.                                                                                                                                                                                                                      | Meets Standard |                         |
| 2. The hold rooms are well ventilated well lighted, and all activating switches are located outside the room.                                                                                                                                                                    | Meets Standard |                         |
| 3. The hold rooms contain sufficient seating for the number of detainees held.                                                                                                                                                                                                   | Meets Standard |                         |
| 4. The walls and ceilings of the hold rooms are tamper and escape proof.                                                                                                                                                                                                         | Meets Standard |                         |
| 5. Individuals are not held in hold rooms for more than 12 hours.                                                                                                                                                                                                                | Meets Standard |                         |
| 6. Male and females are segregated from each other.                                                                                                                                                                                                                              | Meets Standard |                         |
| 7. Detainees under the age of 18 are not held with adult detainees.                                                                                                                                                                                                              | N/A            | No juveniles            |
| 8. In older facilities, officers are within visual or audible range to allow detainees access to toilet facilities on a regular basis.                                                                                                                                           | Meets Standard |                         |
| 9. All detainees are given a pat down search for weapons or contraband before being placed in the room.                                                                                                                                                                          | Meets Standard |                         |
| 10. Officers closely supervise the detention hold rooms using direct supervision (Irregular visual monitoring.). <ul style="list-style-type: none"> <li>• Hold rooms are irregularly monitored every 15 minutes.</li> <li>• Unusual behavior or complaints are noted.</li> </ul> | Meets Standard |                         |

| HOLD ROOMS IN DETENTION FACILITIES – REVIEWER SUMMARY                                                          |                                   |
|----------------------------------------------------------------------------------------------------------------|-----------------------------------|
| (Use following format for dates: mm/dd/yyyy)                                                                   |                                   |
| <b>Overall Remarks:</b> (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                                   |
| <b>Overall Rating:</b> Meets Standard                                                                          |                                   |
| <b>Reviewer Name (Printed)</b> (b)(6); (b)(7)(C)                                                               | <b>Completion Date:</b> 9/11/2018 |
| <b>Reviewer Signature (for printed form submission):</b> (b)(6); (b)(7)(C)                                     |                                   |

**KEY AND LOCK CONTROL (Key: S)**  
**(SECURITY, ACCOUNTABILITY AND MAINTENANCE)**

**POLICY** IT IS THE POLICY OF THE ICE SERVICE TO MAINTAIN AN EFFICIENT SYSTEM FOR THE USE, ACCOUNTABILITY AND MAINTENANCE OF ALL KEYS AND LOCKS.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                              | RATING         | REMARKS (1000 CHAR MAX) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Facility policies and procedures address the issue of compromised keys and locks.                                                                                                                                                                                                                                                                                                                                                                                    | Meets Standard |                         |
| 2. Padlocks and/or chains are prohibited from use on cell doors.                                                                                                                                                                                                                                                                                                                                                                                                        | Meets Standard |                         |
| 3. The entrance/exit door locks to detainee living quarters, or areas with an occupant load of 50 or more people, conform to: <ul style="list-style-type: none"> <li>Occupational Safety and Environmental Health Manual, Ch. 3;</li> <li>National Fire Protection Association Life Safety Code 101.</li> </ul>                                                                                                                                                         | Meets Standard |                         |
| 4. Emergency keys are available for all areas of the facility.                                                                                                                                                                                                                                                                                                                                                                                                          | Meets Standard |                         |
| 5. The facilities use a key accountability system.                                                                                                                                                                                                                                                                                                                                                                                                                      | Meets Standard | New key tracking system |
| 6. Authorization is necessary to issue any restricted key.                                                                                                                                                                                                                                                                                                                                                                                                              | Meets Standard |                         |
| 7. Individual gun lockers are provided. <ul style="list-style-type: none"> <li>They are located in an area that permits constant officer observation.</li> <li>In an area that does not allow detainee or public access.</li> </ul>                                                                                                                                                                                                                                     | Meets Standard |                         |
| 8. All staff members are trained and held responsible for adhering to proper procedures for the handling of keys. <ul style="list-style-type: none"> <li>Issued keys are returned immediately in the event an employee inadvertently carries a key ring home.</li> <li>When a key or key ring is lost, misplaced, or not accounted for, the shift supervisor is immediately notified.</li> <li>Detainees are not permitted to handle keys assigned to staff.</li> </ul> | Meets Standard |                         |

**KEY AND LOCK CONTROL – REVIEWER SUMMARY**

*(Use following format for dates: mm/dd/yyyy)*

**Overall Remarks:** *(Record significant facts, observations, other sources used, etc.)(5000 Character Max)*

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

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**KEY AND LOCK CONTROL – REVIEWER SUMMARY**

*(Use following format for dates: mm/dd/yyyy)*

**Reviewer Signature (for printed form submission)**

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

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### POPULATION COUNTS (Key: T)

**POLICY:** ALL DETENTION FACILITIES SHALL ENSURE AROUND-THE-CLOCK ACCOUNTABILITY FOR ALL DETAINEES. THIS REQUIRES THAT THEY CONDUCT AT LEAST ONE FORMAL COUNT OF THE DETAINEE POPULATION PER SHIFT, WITH ADDITIONAL FORMAL AND INFORMAL COUNTS CONDUCTED AS NECESSARY.

| COMPONENTS                                                                                                                                                             | RATING         | REMARKS (1000 CHAR MAX) |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Staff conduct a formal count at least once each shift.                                                                                                              | Meets Standard |                         |
| 2. Activities cease or are strictly controlled while a formal count is being conducted.                                                                                | Meets Standard |                         |
| 3. Formal counts in all units take place simultaneously.                                                                                                               | Meets Standard |                         |
| 4. Detainee participation in counts is prohibited.                                                                                                                     | Meets Standard |                         |
| 5. Officers positively identify each detainee before counting him/her as present.                                                                                      | Meets Standard |                         |
| 6. Written procedures cover informal and emergency counts. <ul style="list-style-type: none"> <li>They are followed during informal counts and emergencies.</li> </ul> | Meets Standard |                         |
| 7. The control officer (or other designated position) maintains an out-count record of all detainees temporarily leaving the facility.                                 | Meets Standard |                         |

### POPULATION COUNTS – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Print)** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submit)**

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

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### SECURITY INSPECTIONS (Key: U)

**POLICY:** POST ASSIGNMENTS IN THE FACILITY'S HIGH-RISK AREAS, WHERE SPECIAL SECURITY PROCEDURES MUST BE FOLLOWED, WILL BE RESTRICTED TO EXPERIENCED PERSONNEL WITH A THOROUGH GROUNDING IN FACILITY OPERATIONS.

| COMPONENTS                                                                                                     | RATING         | REMARKS (1000 CHAR MAX) |
|----------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. The facility has a comprehensive security inspection policy.                                                | Meets Standard |                         |
| 2. Every officer is required to conduct a security check of his/her assigned area. The results are documented. | Meets Standard |                         |
| 3. The front-entrance officer checks the ID of everyone entering or exiting the facility.                      | Meets Standard |                         |
| 4. Every Control Center officer receives specialized training.                                                 | Meets Standard |                         |
| 5. The Control Center is staffed around the clock.                                                             | Meets Standard |                         |
| 6. Policy restricts staff access to the Control Center.                                                        | Meets Standard |                         |
| 7. Detainees are restricted from access to the Control Center.                                                 | Meets Standard |                         |
| 8. Officers monitor all vehicular traffic entering and leaving the facility.                                   | Meets Standard |                         |
| 9. The facility maintains a log of all incoming and departing vehicles to sensitive areas of the facility.     | Meets Standard |                         |
| 10. Officers thoroughly search each vehicle entering and leaving the facility.                                 | Meets Standard |                         |
| 11. Every search of the SMU and other housing units is documented.                                             | Meets Standard |                         |

### SECURITY INSPECTIONS – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6), (b)(7)(C) **Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submit):** (b)(6); (b)(7)(C)

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

**SPECIAL MANAGEMENT UNIT (SMU) (Key: V)****ADMINISTRATIVE SEGREGATION**

**POLICY:** THE SPECIAL MANAGEMENT UNIT REQUIRED IN EVERY FACILITY ISOLATES CERTAIN DETAINEES FROM THE GENERAL POPULATION. THE SPECIAL MANAGEMENT UNIT WILL CONSIST OF TWO SECTIONS. ONE, ADMINISTRATIVE SEGREGATION, HOUSES DETAINEES ISOLATED FOR THEIR OWN PROTECTION; THE OTHER FOR DETAINEES BEING DISCIPLINED FOR WRONGDOING (SEE THE "SPECIAL MANAGEMENT UNIT [DISCIPLINARY SEGREGATION]" STANDARD).

| COMPONENTS                                                                                                                                                                                                                                                                                       | RATING         | REMARKS (1000 CHAR MAX) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. The Administrative Segregation unit provides non-punitive protection from the general population and individuals undergoing disciplinary segregation. <ul style="list-style-type: none"><li>• Detainees are placed in the SMU (administrative) in accordance with written criteria.</li></ul> | Meets Standard |                         |
| 2. In exigent circumstances, staff may place a detainee in the SMU (administrative) before a written order has been approved. <ul style="list-style-type: none"><li>• A copy of the order given to the detainee within 24 hours.</li></ul>                                                       | Meets Standard |                         |
| 3. Administratively segregated detainees enjoy the same general privileges as detainees in the general population.                                                                                                                                                                               | Meets Standard |                         |
| 4. The SMU is: <ul style="list-style-type: none"><li>• Well ventilated;</li><li>• Adequately lighted;</li><li>• Appropriately heated; and</li><li>• Maintained in a sanitary condition.</li></ul>                                                                                                | Meets Standard |                         |
| 5. All cells are equipped with beds. <ul style="list-style-type: none"><li>• Every bed is securely fastened to the floor or wall.</li></ul>                                                                                                                                                      | Meets Standard |                         |
| 6. The number of detainees in any cell does not exceed the occupancy limit.                                                                                                                                                                                                                      | Meets Standard |                         |
| 7. Detainees receive three nutritious meals per day, from the general population's menu of the day.                                                                                                                                                                                              | Meets Standard |                         |
| 8. Each detainee maintains a normal level of personal hygiene in the SMU.                                                                                                                                                                                                                        | Meets Standard |                         |
| 9. A health care professional visits every detainee at least three times a week.                                                                                                                                                                                                                 | Meets Standard |                         |
| 10. The SMU maintains a permanent log of detainee-related activity, e.g., meals served, recreation, visitors etc.                                                                                                                                                                                | Meets Standard |                         |
| 11. Staff record whether the detainee ate, showered, exercised, and took any applicable medication during every shift.                                                                                                                                                                           | Meets Standard |                         |

**SPECIAL MANAGEMENT UNIT (SMU) ADMINISTRATIVE SEGREGATION – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



| SPECIAL MANAGEMENT UNIT (SMU) ADMINISTRATIVE SEGREGATION – REVIEWER SUMMARY |                      |                            |
|-----------------------------------------------------------------------------|----------------------|----------------------------|
| <i>(Use following format for dates: mm/dd/yyyy)</i>                         |                      |                            |
| Overall Rating: Meets Standard                                              |                      |                            |
| Reviewer Name (Printed)                                                     | (b)(6); (b)(7)(C)    | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form submission)                            | (b)(6);<br>(b)(7)(C) |                            |

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**SPECIAL MANAGEMENT UNIT (Key: W)****DISCIPLINARY SEGREGATION**

**POLICY:** EACH FACILITY WILL ESTABLISH A SPECIAL MANAGEMENT UNIT IN WHICH TO ISOLATE CERTAIN DETAINEES FROM THE GENERAL POPULATION. THE SPECIAL MANAGEMENT UNIT WILL HAVE TWO SECTIONS, ONE FOR DETAINEES IN ADMINISTRATIVE SEGREGATION; THE OTHER FOR DETAINEES BEING SEGREGATED FOR DISCIPLINARY REASONS.

| COMPONENTS                                                                                                                                                                                                                                | RATING         | REMARKS (1000 CHAR MAX) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. Officers placing detainees in disciplinary segregation follow written procedures.                                                                                                                                                      | Meets Standard |                         |
| 2. A completed Disciplinary Segregation Order accompanies the detainee into the SMU.                                                                                                                                                      | Meets Standard |                         |
| 3. Standard procedures include reviewing the cases of individual detainees housed in disciplinary segregation at set intervals.                                                                                                           | Meets Standard |                         |
| 4. The conditions of confinement in the SMU are proportional to the amount of control necessary to protect detainees and staff.                                                                                                           | Meets Standard |                         |
| 5. All cells are equipped with beds that are securely fastened to the floor or wall of the cell.                                                                                                                                          | Meets Standard |                         |
| 6. When a detainee is segregated without clothing, mattress, blanket, or pillow (in a dry cell setting), a justification is made and the decision is reviewed each shift. Items are returned as soon as it is safe.                       | Meets Standard |                         |
| 7. Detainees in the SMU receive three nutritious meals per day, selected from the Food Service's menu of the day.                                                                                                                         | Meets Standard |                         |
| 8. Detainees are allowed to maintain a normal level of personal hygiene, including the opportunity to shower and shave at least three times/week.                                                                                         | Meets Standard |                         |
| 9. A health care professional visits every detainee in disciplinary segregation every week day.                                                                                                                                           | Meets Standard |                         |
| 10. All detainee-related activities are documented, e.g. meals served, recreation activities, visitors, etc.                                                                                                                              | Meets Standard |                         |
| 11. SMU staff record whether the detainee ate, showered, exercised, took medication, etc. <ul style="list-style-type: none"><li>• Details about the detainee logged, e.g., a medical condition, suicidal/violent behavior, etc.</li></ul> | Meets Standard |                         |

**SPECIAL MANAGEMENT UNIT DISCIPLINARY SEGREGATION – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed):** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form submission):** (b)(6); (b)(7)(C)

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| TOOL CONTROL (Key: X)                                                                                                                                                                                                                                                                                                                                                                                                               |                |                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>POLICY:</b> IT IS THE POLICY OF ALL FACILITIES THAT ALL EMPLOYEES SHALL BE RESPONSIBLE FOR COMPLYING WITH THE TOOL CONTROL POLICY. THE MAINTENANCE SUPERVISOR SHALL MAINTAIN A COMPUTER GENERATED OR TYPEWRITTEN MASTER INVENTORY LIST OF TOOLS AND EQUIPMENT AND THE LOCATION IN WHICH TOOLS ARE STORED. THESE INVENTORIES SHALL BE CURRENT, FILED AND READILY AVAILABLE FOR TOOL INVENTORY AND ACCOUNTABILITY DURING AN AUDIT. |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                                          | RATING         | REMARKS (1000 CHAR MAX) |
| 1. The facility has a tool classification system. Tools are classified according to: <ul style="list-style-type: none"> <li>• Restricted (dangerous/hazardous); and</li> <li>• Non-Restricted (non-hazardous).</li> </ul>                                                                                                                                                                                                           | Meets Standard |                         |
| 2. Each facility has procedures for the issuance of tools to staff and detainees.                                                                                                                                                                                                                                                                                                                                                   | Meets Standard |                         |

| TOOL CONTROL – REVIEWER SUMMARY                                                                         |                            |
|---------------------------------------------------------------------------------------------------------|----------------------------|
| <i>(Use following format for dates: mm/dd/yyyy)</i>                                                     |                            |
| Overall Remarks: (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                            |
| Overall Rating: Meets Standard                                                                          |                            |
| Reviewer Name (Printed) (b)(6); (b)(7)(C)                                                               | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form sub) (b)(6); (b)(7)(C)                                             |                            |

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

**TRANSPORTATION (Key: Y)****LAND TRANSPORTATION**

**POLICY:** THE IMMIGRATION AND NATURALIZATION SERVICE WILL TAKE ALL NECESSARY PRECAUTIONS TO PROTECT THE LIVES, SAFETY, AND WELFARE OF OUR OFFICERS, THE GENERAL PUBLIC, AND THOSE IN ICE CUSTODY DURING THE TRANSPORTATION OF DETAINEES. STANDARDS HAVE BEEN ESTABLISHED FOR PROFESSIONAL TRANSPORTATION UNDER THE SUPERVISION OF EXPERIENCED AND TRAINED DETENTION ENFORCEMENT OFFICERS OR AUTHORIZED CONTRACT PERSONNEL.

Standard N/A

Click the above button if all ICE Transportation is handled only by the ICE Field Office or Sub-Office in control of the detainee case. (All Line Items and standard will be rated "N/A")

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | RATING         | REMARKS (1000 CHAR MAX)        |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|--------------------------------|
| 1. Transporting officers comply with applicable local, state, and federal motor vehicle laws and regulations. Records support this finding of compliance.                                                                                                                                                                                                                                                                                                                                                                                                                           | Meets Standard |                                |
| 2. Every transporting officer required to drive a commercial size bus has a valid Commercial Driver's License (CDL) issued by the state of employment.                                                                                                                                                                                                                                                                                                                                                                                                                              | N/A            | Do not use Commercial size bus |
| 3. Supervisors maintain records for each vehicle operator.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Meets Standard |                                |
| 4. Officers use a checklist during every vehicle inspection. <ul style="list-style-type: none"> <li>Officers report deficiencies affecting operability; and</li> <li>Deficiencies are corrected before the vehicle goes back into service.</li> </ul>                                                                                                                                                                                                                                                                                                                               | Meets Standard |                                |
| 5. Transporting officers: <ul style="list-style-type: none"> <li>Limit driving time to 10 hours in any 15 hour period;</li> <li>Drive only after eight consecutive off-duty hours;</li> <li>Do not receive transportation assignments after having been on duty, in any capacity, for 15 hours;</li> <li>Drive a 50-hour maximum in a given work week; a 70-hour maximum during eight consecutive days;</li> <li>During emergency conditions (including bad weather), officers may drive as long as necessary and safe to reach a safe area—exceeding the 10-hour limit.</li> </ul> | Meets Standard |                                |
| 6. (b)(7)(E) with valid CDLs required in any bus transporting detainees. <ul style="list-style-type: none"> <li>When buses travel in tandem with detainees, (b)(7)(E) per vehicle.</li> <li>An unaccompanied driver may transport an empty vehicle.</li> </ul>                                                                                                                                                                                                                                                                                                                      | N/A            | No busses.                     |
| 7. Before the start of each detail, the vehicle is thoroughly searched.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Meets Standard |                                |

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**TRANSPORTATION (Key: Y)****LAND TRANSPORTATION**

**POLICY:** THE IMMIGRATION AND NATURALIZATION SERVICE WILL TAKE ALL NECESSARY PRECAUTIONS TO PROTECT THE LIVES, SAFETY, AND WELFARE OF OUR OFFICERS, THE GENERAL PUBLIC, AND THOSE IN ICE CUSTODY DURING THE TRANSPORTATION OF DETAINEES. STANDARDS HAVE BEEN ESTABLISHED FOR PROFESSIONAL TRANSPORTATION UNDER THE SUPERVISION OF EXPERIENCED AND TRAINED DETENTION ENFORCEMENT OFFICERS OR AUTHORIZED CONTRACT PERSONNEL.

**Standard N/A**

Click the above button if all ICE Transportation is handled only by the ICE Field Office or Sub-Office in control of the detainee case. (All Line Items and standard will be rated "N/A")

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | RATING         | REMARKS (1000 CHAR MAX) |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 8. Positive identification of all detainees being transported is confirmed.                                                                                                                                                                                                                                                                                                                                                                                                          | Meets Standard |                         |
| 9. All detainees are searched immediately prior to boarding the vehicle by staff controlling the bus or vehicle.                                                                                                                                                                                                                                                                                                                                                                     | Meets Standard |                         |
| 10. The facility ensures that the number of detainees transported does not exceed the vehicles manufacturer's occupancy level.                                                                                                                                                                                                                                                                                                                                                       | Meets Standard |                         |
| 11. Protective vests are provided to all transporting officers.                                                                                                                                                                                                                                                                                                                                                                                                                      | Meets Standard |                         |
| 12. The vehicle crew conducts a visual count once all passengers are on board and seated. <ul style="list-style-type: none"> <li>Additional visual counts are made whenever the vehicle makes a scheduled or unscheduled stop.</li> </ul>                                                                                                                                                                                                                                            | Meets Standard |                         |
| 13. Policies and procedures are in place addressing the use of restraining equipment on transportation vehicles.                                                                                                                                                                                                                                                                                                                                                                     | Meets Standard |                         |
| 14. Officers ensure that no one contacts the detainees. <ul style="list-style-type: none"> <li>(b)(7)(E) remains in the vehicle at all times when detainees are present.</li> </ul>                                                                                                                                                                                                                                                                                                  | Meets Standard |                         |
| 15. Meals are provided during long distance transfers. <ul style="list-style-type: none"> <li>The meals meet the minimum dietary standards, as identified by dieticians utilized by ICE.</li> </ul>                                                                                                                                                                                                                                                                                  | Meets Standard |                         |
| 16. The vehicle crew inspects all Food Service pickups before accepting delivery (food wrapping, portions, quality, quantity, thermos-transport containers, etc.). <ul style="list-style-type: none"> <li>Before accepting the meals, the vehicle crew raises and resolves questions, concerns, or discrepancies with the Food Service representative;</li> <li>Basins, latrines, and drinking-water containers/dispensers are cleaned and sanitized on a fixed schedule.</li> </ul> | Meets Standard |                         |

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**TRANSPORTATION (Key: Y)****LAND TRANSPORTATION**

**POLICY:** THE IMMIGRATION AND NATURALIZATION SERVICE WILL TAKE ALL NECESSARY PRECAUTIONS TO PROTECT THE LIVES, SAFETY, AND WELFARE OF OUR OFFICERS, THE GENERAL PUBLIC, AND THOSE IN ICE CUSTODY DURING THE TRANSPORTATION OF DETAINEES. STANDARDS HAVE BEEN ESTABLISHED FOR PROFESSIONAL TRANSPORTATION UNDER THE SUPERVISION OF EXPERIENCED AND TRAINED DETENTION ENFORCEMENT OFFICERS OR AUTHORIZED CONTRACT PERSONNEL.

**Standard N/A**

Click the above button if all ICE Transportation is handled only by the ICE Field Office or Sub-Office in control of the detainee case. (All Line Items and standard will be rated "N/A")

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                      | RATING         | REMARKS (1000 CHAR MAX) |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 17. Vehicles have:<br>(b)(7)(E)                                                                                                                                                                                                                                                                                                                                                 | Meets Standard |                         |
| 18. The vehicles are clean and sanitary at all times.                                                                                                                                                                                                                                                                                                                           | Meets Standard |                         |
| 19. Personal property of a detainee transferring to another facility is: <ul style="list-style-type: none"><li>• Inventoried; Inspected; and</li><li>• Accompanies the detainee.</li></ul>                                                                                                                                                                                      | Meets Standard |                         |
| 20. The following contingencies are included in the written procedures for vehicle crews: <ul style="list-style-type: none"><li>• Attack, Escape, Hostage-taking, Detainee sickness</li><li>• Detainee death, Vehicle fire, Riot, Traffic accident</li><li>• Mechanical problems, Natural disasters, Severe weather</li><li>• Passenger list includes women or minors</li></ul> | Meets Standard |                         |

**TRANSPORTATION – REVIEWER SUMMARY***(Use following format for dates mm/dd/yyyy)*

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed)**

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

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form sub)**

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

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| USE OF FORCE (Key: Z)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                |                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>Policy:</b> THE U.S. DEPARTMENT OF HOMELAND SECURITY AUTHORIZES THE USE OF FORCE ONLY AS A LAST ALTERNATIVE AFTER ALL OTHER REASONABLE EFFORTS TO RESOLVE A SITUATION HAVE FAILED. ONLY THAT AMOUNT OF FORCE NECESSARY TO GAIN CONTROL OF THE DETAINEE, TO PROTECT AND ENSURE THE SAFETY OF DETAINEES, STAFF AND OTHERS, TO PREVENT SERIOUS PROPERTY DAMAGE AND TO ENSURE INSTITUTION SECURITY AND GOOD ORDER MAY BE USED. PHYSICAL RESTRAINTS NECESSARY TO GAIN CONTROL OF A DETAINEE WHO APPEARS TO BE DANGEROUS MAY BE EMPLOYED WHEN THE DETAINEE: |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | RATING         | REMARKS (1000 CHAR MAX) |
| 1. There is a use of force policy outlining immediate and calculated use of force, and confrontation avoidance.                                                                                                                                                                                                                                                                                                                                                                                                                                          | Meets Standard |                         |
| 2. Staff members are trained in the performance of the Use-of-Force Team Technique.                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Meets Standard |                         |
| 3. All use-of-force incidents are documented and reviewed.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Meets Standard |                         |
| 4. Staff: <ul style="list-style-type: none"> <li>Do not use force as punishment;</li> <li>Attempt to gain the detainee's voluntary cooperation before resorting to force;</li> <li>Use only as much force as necessary to control the detainee; and</li> </ul>                                                                                                                                                                                                                                                                                           | Meets Standard |                         |
| 5. Medication may only be used for restraint purposes when authorized by the Medical Authority as medically necessary.                                                                                                                                                                                                                                                                                                                                                                                                                                   | Meets Standard |                         |
| 6. In immediate-use-of-force situations, staff contacts medical staff once the detainee is under control.                                                                                                                                                                                                                                                                                                                                                                                                                                                | Meets Standard |                         |
| 7. Special precautions are taken when restraining pregnant detainees. <ul style="list-style-type: none"> <li>Medical personnel are consulted</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                  | Meets Standard |                         |
| 8. The officers are thoroughly trained in the use of soft and hard restraints.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Meets Standard |                         |
| 9. For incidents involving calculated use of force, a videotape is made and retained for review.                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Meets Standard |                         |

| USE OF FORCE – REVIEWER SUMMARY<br>(Use following format for dates: mm/dd/yyyy)                         |                            |
|---------------------------------------------------------------------------------------------------------|----------------------------|
| Overall Remarks: (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                            |
| Overall Rating: Meets Standard                                                                          |                            |
| Reviewer Name (Printed) (b)(6); (b)(7)(C)                                                               | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form) (b)(6); (b)(7)(C) n):                                             |                            |

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD

| STAFF DETAINEE COMMUNICATIONS (Key: AA)                                                                                                                                                                                                                        |                |                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| <b>POLICY:</b> PROCEDURES MUST BE IN PLACE TO ALLOW FOR FORMAL AND INFORMAL CONTACT BETWEEN KEY FACILITY STAFF AND ICE STAFF AND ICE DETAINEE AND TO PERMIT DETAINEES TO MAKE WRITTEN REQUESTS TO ICE STAFF AND RECEIVE AN ANSWER IN AN ACCEPTABLE TIME FRAME. |                |                         |
| COMPONENTS                                                                                                                                                                                                                                                     | RATING         | REMARKS (1000 CHAR MAX) |
| 1. ICE information request Forms are available at the IGSA for use by ICE detainees.                                                                                                                                                                           | Meets Standard |                         |
| 2. The IGSA treats detainee correspondence to ICE staff as Special Correspondence.                                                                                                                                                                             | Meets Standard |                         |

| STAFF DETAINEE COMMUNICATIONS – REVIEWER SUMMARY                                                        |                            |
|---------------------------------------------------------------------------------------------------------|----------------------------|
| (Use following format for dates: mm/dd/yyyy)                                                            |                            |
| Overall Remarks: (Record significant facts, observations, other sources used, etc.)(5000 Character Max) |                            |
| Overall Rating: Meets Standard                                                                          |                            |
| Reviewer Name (Printed): (b)(6); (b)(7)(C)                                                              | Completion Date: 9/11/2018 |
| Reviewer Signature (for printed form s                                                                  | (b)(6); (b)(7)(C)          |

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



### DETAINEE TRANSFER STANDARD (Key: AB)

**POLICY:** ICE WILL MAKE ALL NECESSARY NOTIFICATIONS WHEN A DETAINEE IS TRANSFERRED. IF A DETAINEE IS BEING TRANSFERRED VIA THE JUSTICE PRISONER ALIEN TRANSPORTATION SYSTEM (JPATS), ICE WILL ADHERE TO JPATS PROTOCOLS. IN DECIDING WHETHER TO TRANSFER A DETAINEE, ICE WILL TAKE INTO CONSIDERATION WHETHER THE DETAINEE IS REPRESENTED BEFORE THE IMMIGRATION COURT. IN SUCH CASES, THE FIELD OFFICE DIRECTOR WILL CONSIDER THE DETAINEE'S STAGE WITHIN THE REMOVAL PROCESS, WHETHER THE DETAINEE'S ATTORNEY IS LOCATED WITHIN REASONABLE DRIVING DISTANCE OF THE FACILITY, AND WHERE THE IMMIGRATION COURT PROCEEDINGS ARE TAKING PLACE.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                     | RATING         | REMARKS (1000 CHAR MAX) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. When a detainee is represented by legal counsel or a legal representative, and a G-28 has been filed, the representative of record is notified by the detainee's Deportation Officer. <ul style="list-style-type: none"> <li>The notification is recorded in the detainee's file; and</li> <li>When the A File is not available, notification is noted within DACS</li> </ul>                               | Meets Standard |                         |
| 2. Notification includes the reason for the transfer and the location of the new facility.                                                                                                                                                                                                                                                                                                                     | Meets Standard |                         |
| 3. The deportation officer is allowed discretion regarding the timing of the notification when extenuating circumstances are involved.                                                                                                                                                                                                                                                                         | Meets Standard |                         |
| 4. The attorney and detainee are notified that it is their responsibility to notify family members regarding a transfer.                                                                                                                                                                                                                                                                                       | Meets Standard |                         |
| 5. Facility policy mandates that: <ul style="list-style-type: none"> <li>Times and transfer plans are never discussed with the detainee prior to transfer;</li> <li>The detainee is not notified of the transfer until immediately prior to departing the facility; and</li> <li>The detainee is not permitted to make any phone calls or have contact with any detainee in the general population.</li> </ul> | Meets Standard |                         |
| 6. The detainee is provided with a completed Detainee Transfer Notification Form.                                                                                                                                                                                                                                                                                                                              | Meets Standard |                         |
| 7. Form G-391 or equivalent authorizing the removal of a detainee from a facility is used.                                                                                                                                                                                                                                                                                                                     | Meets Standard |                         |
| 8. For medical transfers: <ul style="list-style-type: none"> <li>The Detainee Immigration Health Service (or IGSA) (DIHS) Medical Director or designee approves the transfer;</li> <li>Medical transfers are coordinated through the local ICE office; and</li> <li>A medical transfer summary is completed and accompanies the detainee.</li> </ul>                                                           | Meets Standard |                         |
| 9. Detainees in ICE facilities having DIHS staff and medical care are transferred with a completed transfer summary sheet in a sealed envelope with the detainee's name and A-number, and the envelope is marked Medical Confidential.                                                                                                                                                                         | Meets Standard |                         |

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**DETAINEE TRANSFER STANDARD (Key: AB)**

**POLICY:** ICE WILL MAKE ALL NECESSARY NOTIFICATIONS WHEN A DETAINEE IS TRANSFERRED. IF A DETAINEE IS BEING TRANSFERRED VIA THE JUSTICE PRISONER ALIEN TRANSPORTATION SYSTEM (JPATS), ICE WILL ADHERE TO JPATS PROTOCOLS. IN DECIDING WHETHER TO TRANSFER A DETAINEE, ICE WILL TAKE INTO CONSIDERATION WHETHER THE DETAINEE IS REPRESENTED BEFORE THE IMMIGRATION COURT. IN SUCH CASES, THE FIELD OFFICE DIRECTOR WILL CONSIDER THE DETAINEE'S STAGE WITHIN THE REMOVAL PROCESS, WHETHER THE DETAINEE'S ATTORNEY IS LOCATED WITHIN REASONABLE DRIVING DISTANCE OF THE FACILITY, AND WHERE THE IMMIGRATION COURT PROCEEDINGS ARE TAKING PLACE.

| COMPONENTS                                                                                                                | RATING         | REMARKS (1000 CHAR MAX) |
|---------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 10. For medical transfers, transporting officers receive instructions regarding medical issues.                           | Meets Standard |                         |
| 11. Detainee's funds, valuables, and property are returned and transferred with the detainee to his/her new location.     | Meets Standard |                         |
| 12. Transfer and documentary procedures outlined in Section C and D are followed.                                         | Meets Standard |                         |
| 13. Meals are provided when transfers occur during normally schedule meal times.                                          | Meets Standard |                         |
| 14. An A File or work folder accompanies the detainee when transferred to a different field office or sub-office.         | Meets Standard |                         |
| 15. Files are forwarded to the receiving office via overnight mail no later than one business day following the transfer. | Meets Standard |                         |

**DETAINEE TRANSFER STANDARD – REVIEWER SUMMARY**

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed)** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/2018

**Reviewer Signature (for printed form subm**

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

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### SEXUAL ABUSE AND ASSAULT PREVENTION AND INTERVENTION (Key: AC)

**POLICY:** THIS DETENTION STANDARD REQUIRES THAT FACILITIES THAT HOUSE ICE/ERO DETAINEES AFFIRMATIVELY ACT TO PREVENT SEXUAL ABUSE AND ASSAULTS ON DETAINEES, PROVIDE PROMPT AND EFFECTIVE INTERVENTION AND TREATMENT FOR VICTIMS OF SEXUAL ABUSE AND ASSAULT, AND CONTROL, DISCIPLINE, AND PROSECUTE THE PERPETRATORS OF SEXUAL ABUSE AND ASSAULT.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                                                                                  | RATING         | REMARKS (1000 CHAR MAX) |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 1. The facility has a Sexual Abuse and Assault Prevention and Intervention Program consistent with the ICE Zero Tolerance Policy.                                                                                                                                                                                                                                                                           | Meets Standard |                         |
| 2. The facility administrator has designated a Sexual Abuse and Assault Prevention and Intervention Program coordinator for the facility.                                                                                                                                                                                                                                                                   | Meets Standard |                         |
| 3. All staff are trained, during orientation and in annual refresher training, in the prevention and intervention areas required by the Detention Standard.                                                                                                                                                                                                                                                 | Meets Standard |                         |
| 4. The facility maintains written documentation verifying employee, volunteer, and contractor training.                                                                                                                                                                                                                                                                                                     | Meets Standard |                         |
| 5. Detainees are informed about the program in facility orientation and the detainee handbook (or equivalent).                                                                                                                                                                                                                                                                                              | Meets Standard |                         |
| 6. The Sexual Assault Awareness Notice, along with the name of the program coordinator and local organizations that can assist detainees who have been victims of sexual assault, is posted on all housing unit bulletin boards.                                                                                                                                                                            | Meets Standard |                         |
| 7. The Sexual Assault Awareness Information brochure is distributed to detainees.                                                                                                                                                                                                                                                                                                                           | Meets Standard |                         |
| 8. Detainees are screened upon arrival for "high risk" sexual assaultive and sexual victimization potential and housed and counseled accordingly.                                                                                                                                                                                                                                                           | Meets Standard |                         |
| 9. A detainee who is subjected to sexual abuse or assault is not returned to general population until proper re-classification, taking into consideration any increased vulnerability of the detainee as a result of the sexual abuse or assault, is completed.                                                                                                                                             | Meets Standard |                         |
| 10. There is prompt and effective intervention when any detainee is sexually abused or assaulted and policy and procedures for required chain-of-command and immediate ICE reporting.                                                                                                                                                                                                                       | Meets Standard |                         |
| 11. The facility uses a coordinated, multidisciplinary team approach to responding to sexual abuse, such as a sexual assault response team (SART), which includes a medical practitioner, a mental health practitioner, a security staff member, and an investigator from the assigned investigative entity, as well as representatives from outside entities that provide relevant services and expertise. | Meets Standard |                         |

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 -- Form Key TBD

### SEXUAL ABUSE AND ASSAULT PREVENTION AND INTERVENTION (Key: AC)

**POLICY:** THIS DETENTION STANDARD REQUIRES THAT FACILITIES THAT HOUSE ICE/ERO DETAINEES AFFIRMATIVELY ACT TO PREVENT SEXUAL ABUSE AND ASSAULTS ON DETAINEES, PROVIDE PROMPT AND EFFECTIVE INTERVENTION AND TREATMENT FOR VICTIMS OF SEXUAL ABUSE AND ASSAULT, AND CONTROL, DISCIPLINE, AND PROSECUTE THE PERPETRATORS OF SEXUAL ABUSE AND ASSAULT.

| COMPONENTS                                                                                                                                                                                                                                                                                                                                   | RATING         | REMARKS (1000 CHAR MAX) |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| 12. Care is taken to place a victimized detainee in a supportive environment that represents the least restrictive housing option possible (e.g. protective custody), but victims are not held for longer than five days in any type of administrative segregation except in highly unusual circumstances or at the request of the detainee. | Meets Standard |                         |
| 13. Staff suspected of perpetrating sexual abuse or assault are removed from all duties requiring detainee contact pending the outcome of an investigation.                                                                                                                                                                                  | Meets Standard |                         |
| 14. When there is an alleged sexual assault, staff gather and maintain evidence, make referrals to appropriate law enforcement agencies for possible prosecution, and ensure that qualified investigators conduct a prompt, thorough, objective, and fair investigation.                                                                     | Meets Standard |                         |
| 15. When there is an alleged or proven sexual assault, the required notifications are promptly made to facility supervisors and ICE management.                                                                                                                                                                                              | Meets Standard |                         |
| 16. When possible and feasible, victims of sexual abuse or assault are referred to specialized community resources for treatment and gathering of evidence.                                                                                                                                                                                  | Meets Standard |                         |
| 17. All records associated with claims of sexual abuse or assault is maintained, and such incidents are specifically logged and tracked by a designated staff coordinator.                                                                                                                                                                   | Meets Standard |                         |
| 18. The Sexual Abuse and Assault Prevention and Intervention Program coordinator conducts an annual review of aggregate data regarding incidents of sexual abuse or assault, and presents the findings to the Field Office Director and ICE/ERO HQ for use in determining whether changes are needed to existing policies and practices.     | Meets Standard |                         |
| 19. Tracking statistics and reports are readily available for review by the inspectors.                                                                                                                                                                                                                                                      | Meets Standard |                         |

### SEXUAL ABUSE AND ASSAULT PREVENTION AND INTERVENTION – REVIEWER SUMMARY

(Use following format for dates: mm/dd/yyyy)

**Overall Remarks:** (Record significant facts, observations, other sources used, etc.)(5000 Character Max)

**Overall Rating:** Meets Standard

**Reviewer Name (Printed)** (b)(6); (b)(7)(C)

**Completion Date:** 9/11/201

**Reviewer Signature (for printed form sub**

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

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSA's - Rev: 5/1/2018 – Form Key TBD



# DOCUMENT CHECK

The document check should be run upon completion of the review form and PRIOR to submission to DHS-ICE. This check will help ensure the form is ready for upload to DHS-ICE systems. Errors indicate issues were found with specific data entered into the form. Items Not Rated indicate there were line items found on the form which remain in a "Not Rated" status. This action will also update the table of contents.

| Review Document Issue Summary |                  | Ratings Check Status |   |                  |   |
|-------------------------------|------------------|----------------------|---|------------------|---|
| Check Document:               | <u>Run Check</u> | Error(s) Found:      | 0 | Items Not Rated: | 0 |
| <b>Errors:</b>                |                  |                      |   |                  |   |
|                               |                  |                      |   |                  |   |
| <b>Items Not Rated:</b>       |                  |                      |   |                  |   |
|                               |                  |                      |   |                  |   |

Run Indicator: ☐

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G-324B (NDS) (Coded 10132010) Detention Inspection Form Worksheet for IGSAs - Rev: 5/1/2018 - Form Key TBD

**DETAINEE DEATH REVIEW: Simratpal SINGH, A201432202**  
**Healthcare and Security Compliance Analysis**  
**La Paz County Sheriff's Office Adult Detention Facility**  
**Parker, 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 Simratpal SINGH while in the custody of the La Paz County Sheriff's Office Adult Detention Facility (LPCADF) in Parker, Arizona. On June 18 and 19, 2019, an ERAU team consisting of team leader (b)(6); (b)(7)(C), Inspection and Compliance Specialist (b)(6); (b)(7)(C), Inspection and Compliance Specialist, and Creative Corrections contract subject matter experts (SME) (b)(6); (b)(7)(C), security, and (b)(6); (b)(7)(C) RN, healthcare. ERAU requested contractor participation to assess compliance with the ICE National Detention Standards (NDS) 2000 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 is a case synopsis, description of the facility's healthcare services, a narrative summary of events, and conclusions. The information and findings herein are based on analysis of SINGH's medical record and detention file; tour of the medical clinic, cell, and booking areas; interviews of staff; and review of policies, video surveillance footage, records of care by external sources, and available incident related documentation.

## **SYNOPSIS**

In the early morning hours of April 30, 2019, the La Paz County Sheriff's Office arrested Simratpal SINGH on charges of assault and sexual assault. He was taken to the LPCADF later the same day and booked as a county inmate. Staff did not complete admission and medical and mental health intake processes because SINGH did not speak English and they did not use interpretation assistance to communicate with him in his language, Punjabi. Due to the sexual assault charge, security personnel housed SINGH in a cell but did not assign him to administrative segregation status and did not log activities, privileges, and staff rounds.

Two days following his arrival, May 2, 2019, staff classified SINGH maximum security and formally assigned him to administrative segregation. Family members or associates of SINGH arrived at the facility to post his \$5000 bond but before the bail was fully processed, the facility received an ICE detainer and Order to Detain. Informed the detainer would mean La Paz County would hold SINGH pending his transfer to ICE custody, the associates opted to proceed. Pursuant to the Order to Detain, SINGH became an ICE detainee at approximately 4:30 p.m. when the bond was fully processed. ICE Enforcement and Removal Operations (ERO)



requested SINGH's physical transfer from La Paz County to ERO custody the next day, May 3, 2019.

At approximately 5:15 p.m. on May 2, 2019, security personnel returned SINGH to his cell after a visit with the associates who posted his bond. Approximately 40 minutes later, an officer found him hanging from a ligature fabricated from socks. Other security personnel and a nurse responded to the scene and performed cardio pulmonary resuscitation until emergency medical services personnel arrived and took over life-saving efforts. They transported him to the local hospital where rescue efforts continued. SINGH was air-lifted to a hospital offering higher level care where his death was pronounced approximately three hours and 15 minutes after arrival, at 1:58 a.m. on May 3, 2019.

The Maricopa County Medical Examiner's Report, also dated May 4, 2019, noted the cause of death as hanging and the manner of death by suicide.

## HEALTHCARE SERVICES

A registered nurse (RN) and two licensed practical nurses (LPN) staff the medical unit from 5:00 a.m. to 10:00 p.m. Monday through Friday, and during two to four-hour shifts on Saturday and Sunday for medication distribution. The nurses are county employees. A physician assistant and a psychiatrist, the latter of whom serves as Clinical Director, provide services on Wednesdays under contract with the county. Their hours vary based on workload. In addition to performing clinical duties, the RN serves as the Medical Services Administrator and is on call 24 hours a day. Nurses reported to ERAU that they work long hours and the LPNs are often on duty without supervision and oversight by the RN or a provider.<sup>1</sup> According to Commander Rico Suffle, managing official of the LPCADF, a recent insurance audit resulted in a recommendation to hire an additional RN.<sup>2</sup>

LPCADF has an electronic medical record system, CorEMR.<sup>3</sup> The clinic consists of one room used for patient encounters and charting. The room is cluttered and does not have a separate room or curtained area to provide patient privacy during examinations.<sup>4</sup> The Medical Services Administrator stated healthcare staff protect patient privacy by allowing only one inmate/detainee in the clinic at a time<sup>5</sup>. However, an inmate interviewed as part of the law enforcement investigation following SINGH's death incidentally offered that inmate workers are able to hear nurses' communications.<sup>6</sup> Near the clinic and adjacent to the booking section of

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<sup>1</sup> ERAU interviews with RN Tiffany Brannon, LPN (b)(6); (b)(7)(C) and LPN (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>2</sup> ERAU interview with Commander (b)(6); (b)(7)(C), dated June 18, 2019.

<sup>3</sup> ERAU interview with RN (b)(6); (b)(7)(C), dated June 18, 2019. See also, SINGH medical record.

<sup>4</sup> ERAU tour of LPCADF.

<sup>5</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>6</sup> See Mohave County Sheriff's Office Incident Information, undated.

LPCADF is a separate area designated as the medical wing. The area has an entrance area and three cells, two of which are equipped with negative pressure capability for respiratory isolation. The third cell, designated as the Juvenile cell, is used for protective custody purposes.<sup>7</sup>

ERAU confirmed the nurses involved in SINGH's care have current, primary source verified licenses.<sup>8</sup> Review of nurses' and officers' training records found no record of current training in suicide prevention and intervention, and no record of current cardio pulmonary certification for two of four Sheriff's Officer personnel who responded to the medical emergency.

## SUMMARY

SINGH was in ICE custody from February 12, 2019 until April 29, 2019. He was first detained at the San Luis Regional Detention and Support Center, San Luis, AZ where he was held until February 20, 2019 when he was transferred to the La Palma Correctional Center. He was released on April 29, 2019 upon posting \$73,000 bail. As detailed below, SINGH was arrested on criminal charges and admitted to LPCADF the next day, April 30, 2019. He again became an ICE detainee on May 2, 2019 after posting bail in the criminal matter and upon issuance of an Order to Detain the same day. Although there was a break in ICE custody, ERAU reviewed SINGH's medical records from the San Luis and La Palma facilities for the purpose of learning any current or past medical or mental health history not identified at LPCADF. A summary of the records is as follows.

### San Luis Regional Detention and Support Center

On February 12, 2019, an RN conducted SINGH's intake screening noting the following<sup>9</sup>:

- SINGH's native language was Punjabi. To conduct the intake, the nurse used a form listing screening questions translated to Punjabi.
- SINGH denied taking any medications currently or in the past year, to include over the counter and herbal supplements.
- SINGH denied pain or disability.
- SINGH was appropriate in behavior and did not appear to have abnormal physical, mental, or emotional characteristics.
- There were no abnormal findings associated with SINGH's medical, dental, or mental health status.
- SINGH denied a history of suicide attempt or current thoughts of suicide.

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<sup>7</sup> ERAU tour of LPCADF.

<sup>8</sup> RN Bannon and LPN Bissell credential files.

<sup>9</sup> See LaSalle Corrections Intake Screening, dated February 12, 2019. LaSalle Corrections is the healthcare contractor for the San Luis Regional Detention and Support Center healthcare contractor.



**On February 18, 2019**, an RN conducted SINGH's initial physical examination using a form listing assessment questions translated to Punjabi. The nurse found no medical, mental health, or dental issues<sup>10</sup>.

### **La Palma Correctional Center**

**On February 20, 2019**, an RN conducted SINGH's intake screening using an interpretation service. Findings of the intake screen were consistent with those documented at the San Luis facility<sup>11</sup>.

**On February 27, 2019**, a Ph.D. Psychologist conducted a mental health evaluation using an interpretation service. The findings were normal with an impression of stable<sup>12</sup>. The psychologist placed SINGH on care level one status<sup>13</sup>.

**On February 28, 2019**, SINGH refused his initial health appraisal. The nurse practitioner documented he refused the examination because he had no problems, and that she counseled him on the risks of refusing medical care. She did not address language or use of interpretation assistance on either the health appraisal or refusal form SINGH signed.<sup>14</sup>

**On March 16, 2019**, a nurse treated SINGH with over-the-counter acetaminophen for complaint of cold symptoms per the applicable nursing protocol. The nurse did not address language or use of interpretation assistance.<sup>15</sup>

**On April 19, 2019**, SINGH submitted a sick call request for complaint of back pain<sup>16</sup>. At sick call the next day, a nurse gave him over-the-counter ibuprofen per protocol. The nurse did not address language or use of interpretation assistance.

### **La Paz County Sheriff's Office Adult Detention Facility**

**On April 30, 2019** at 1:07 a.m., La Paz County Sheriff's Office (LPCSO) Deputy (b)(6); (b)(7)(C) arrested SINGH on charges of assault and sexual assault.<sup>17</sup> He noted SINGH spoke Punjabi<sup>18</sup>.

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<sup>10</sup> See LaSalle Corrections Physical Examination/Health Appraisal, dated February 18, 2019.

<sup>11</sup> See La Palma Correctional Center Intake Screening, dated February 20, 2019.

<sup>12</sup> See La Palma Correctional Center Comprehensive Mental Health Evaluation, dated February 27, 2019.

<sup>13</sup> Care level one is associated with detainees who are healthy and do not take regularly scheduled medications.

<sup>14</sup> See La Palma Correctional Center Inmate/Resident Health Appraisal and Refusal to Accept Medical Treatment forms, dated February 28, 2019.

<sup>15</sup> See Upper Respiratory Complaints form, dated March 16, 2019.

<sup>16</sup> See Sick Call Request, dated April 19, 2019.

<sup>17</sup> See LPCSO Incident, dated May 8, 2019.

<sup>18</sup> See Form 4(a), Release Questionnaire/Law Enforcement, dated April 30, 2019.

and that he used the language line during the arrest process due to the language barrier.<sup>19</sup> At an unknown time, Sheriff's Office personnel turned SINGH over to the jail for processing and booking as a county inmate. The available jail booking record includes a property inventory listing no funds and a backpack, jacket, pants, shirt, shoes and papers<sup>20</sup>, and a Booking Sign off Sheet documenting staff secured SINGH's property in a property bag.<sup>21</sup> Commander Suffle informed ERAU that Sergeant (b)(6); (b)(7)(C) booked SINGH and that additional records related to SINGH's admission are not available<sup>22</sup>. He later clarified that officers did not complete the booking process due to a language barrier.<sup>23</sup>

In describing booking procedures to ERAU, Commander (b)(6); (b)(7)(C) reported that all arriving inmates and detainees are strip-searched.<sup>24</sup> He also said LPCADF does not offer orientation to provide information about operations and services, and that inmates and detainees may access the facility's handbook by way of kiosks in booking and the housing areas.<sup>25</sup>

At 7:20 p.m., RN (b)(6); (b)(7)(C) attempted a receiving screening.<sup>26</sup> She documented SINGH weighed 195 pounds, his temperature was elevated at 100.1<sup>27</sup>, his pulse was rapid at 108 beats per minute<sup>28</sup>, and his blood pressure was elevated at 133/79<sup>29</sup>. She did not record his height, and left all questions on the form blank with the exception of the following, to which she entered answers of no:

- Have you had a skin test for tuberculosis?
- Are you allergic to any medication?

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<sup>19</sup> See LPCSO Incident, dated May 8, 2019.

<sup>20</sup> See untitled form listing the property items received April 30, 2019. SINGH did not sign the inventory.

<sup>21</sup> See LPCSO-ADF Booking Sign off Sheet, undated and unsigned by the booking officer and supervisor.

<sup>22</sup> ERAU interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019. There is no record of classification upon admission, orientation, and issuance of a handbook, jail clothing, linens, and hygiene items.

<sup>23</sup> See email from Commander (b)(6); (b)(7)(C) to Supervisory Detention and Deportation Office (b)(6); (b)(7)(C) dated June 27, 2019. Booking personnel did not document SINGH's primary language, English language proficiency, the reason the booking was not completed, or consideration of using the Sheriff's Office language line.

<sup>24</sup> Interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>25</sup> ERAU verified the facility handbook is available on the kiosk. The handbook is in English, only. The ICE National Detainee Handbook is not on the kiosk system and is not available at LPCADF in printed form.

<sup>26</sup> See Risk and Needs Screening, dated April 30, 2019.

<sup>27</sup> According to Mayo Clinic, a normal temperature is 98.6 degrees Fahrenheit. Oral temperature readings of 100 degrees Fahrenheit or higher generally indicate a fever. As a temperature of 100.1 could result from dehydration, RN (b)(6); (b)(7)(C) failure to use interpretation assistance meant she could not provide SINGH with patient education to increase fluid intake.

<sup>28</sup> According to the Mayo Clinic, a normal pulse rate is 60 to 100 beats per minute, and a doctor should be informed if the resting heart rate is consistently above 100 beats per minute. RN (b)(6); (b)(7)(C) did not recheck SINGH's pulse.

<sup>29</sup> According to the American Heart Association, a normal blood pressure is less than 120 systolic over 80 diastolic. A blood pressure of 133/79 falls within parameters for stage one hypertension. RN (b)(6); (b)(7)(C) did not recheck SINGH's blood pressure.



Because RN (b)(6); (b)(7)(C) entered no to the first question, the electronic medical record system automatically created a task for completion of a purified protein derivative (PPD) skin test for tuberculosis on May 7, 2019.<sup>30</sup>

(b)(6); (b)(7)(C) did not note a language barrier on the form, but informed ERAU she was not able to complete the screening because SINGH did not speak English. She stated she was not aware of any telephonic interpretation service offered by LPCSO and instead, attempted to use Google Translate, without success. Questions R (b)(6); (b)(7)(C) left blank included all related to a past medical or psychiatric history, tuberculosis symptoms, medications, substance abuse, and suicide risk.<sup>31</sup> Other sections left blank include consent for treatment and emergency contact information.

In a late entry to the medical record entered following SINGH's death (b)(6); (b)(7)(C) documented an addendum to the April 30, 2019 screening. She noted the following:<sup>32</sup>

- SINGH spoke (b)(6); (b)(7)(C) communication was difficult, and she used resources at hand to obtain any information concerning his risks and needs.
- SINGH exhibited no suicidal or homicidal ideation.
- SINGH had no medication allergies, he weighed 195 pounds, and his all vital signs were within normal limits.
- SINGH asked about court and a lawyer.
- SINGH was placed per detention facility protocol.

(b)(6); (b)(7)(C) stated to ERAU that she based her determination that SINGH was not suicidal on her observation of SINGH's appearance.<sup>33</sup> She stated she concluded that his vital signs were within normal limits in the absence of nursing protocols setting thresholds and establishing guidelines for nursing action. She explained her documentation regarding SINGH's questions about court and a lawyer by stating he knew limited words in English, including those particular words.

Commander (b)(6); (b)(7)(C) stated that because SINGH's charges included a sexual offense, security personnel assigned him to single-cell housing.<sup>34</sup> During interview with Detectives (b)(6); (b)(7)(C) of the Mohave County Sheriff's Office, (b)(6); (b)(7)(C) explained staff assigned him to the Juvenile cell for his own protection, consistent with standing procedure for inmates charged with sexual offenses.<sup>35</sup> Sergeant (b)(6); (b)(7)(C) confirmed for ERAU that there is

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<sup>30</sup> LPCADF policy 5-1, Receiving Screening Assessment, dated January 15, 2011, allows seven days for planting PPDs.

<sup>31</sup> See Risk and Needs Screening, dated Tuesday, April 30, 2019.

<sup>32</sup> See Chart Notes, dated May 7, 2019.

<sup>33</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>34</sup> ERAU interview with Commander (b)(6); (b)(7)(C) June 18, 2019.

<sup>35</sup> See Mohave County Sheriff's Office Incident Information report, undated. The Mohave County Sheriff's office investigated the incident as an agency assist.

no documentation of SINGH's housing placement this date, no administrative segregation order, no documented supervisory authority for the placement, and staff did not initiate a segregation log to record activities, privileges, and rounds by officers, supervisors, and medical staff.<sup>36</sup>

The cell to which staff assigned SINGH, referred to as the Juvenile cell, is one of three in the designated medical wing accessed through a door from the booking area<sup>37</sup>. The first two cells are used for medical housing; the Juvenile cell is used for protective custody purposes. A door separates the walkway outside the medical cells from the walkway outside the Juvenile cell. The door to the Juvenile cell has a single, narrow window on the top left side. Commander (b)(6); (b)(7)(C) reported that at the time of SINGH'S death, the Juvenile cell had a bunk bed that the facility subsequently replaced with a single bed.<sup>38</sup> In addition to the bed, the cell has a sink/toilet combination fixture, a shower, intercom button for communication with an officer, and two stationary cameras mounted to the ceiling, one of which Commander (b)(6); (b)(7)(C) stated was not operational while SINGH occupied the cell.<sup>39</sup> According to Officer (b)(6); (b)(7)(C) live feed from the cameras is monitored by staff in the booking area rather than staff in the jail's control center<sup>40</sup>, referred to at LPCADF as the tower control.

An officer does not directly supervise the three cells in the medical wing. Asked by ERAU about the frequency and documentation of security rounds, Commander (b)(6); (b)(7)(C) stated LPCADF expects officers to make rounds in all areas of the facility on an hourly basis and record them using the facility's electronic security system.<sup>41</sup> He acknowledged officers do not consistently use the system to electronically record rounds, and there is no redundant system for officers to document security rounds or log post activities manually. Asked for post orders detailing expectations for officers with respect to supervising persons assigned to the Juvenile or second cell in the area, and monitoring the camera feed, Commander (b)(6); (b)(7)(C) stated LPCADF has not had post orders since approximately 2011.

**On May 1, 2019**, the ERO Phoenix Field Office prepared a detainer directed to LPCADF.<sup>42</sup> Neither ERO nor LPCSADF documentation reflects when, how or if ERO transmitted the detainer to the facility. Also on this date, SINGH's bail was set at \$5000 at his initial appearance hearing in the Quartzsite Justice Court.<sup>43</sup>

A report of electronically recorded rounds shows an officer conducted a round at 8:39 p.m.<sup>44</sup>

<sup>36</sup> ERAU interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>37</sup> ERAU tour of LPCADF.

<sup>38</sup> ERAU interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>39</sup> ERAU tour of LPCADF and interview of Commander Suffe.

<sup>40</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>41</sup> ERAU interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>42</sup> See Department of Homeland Security, Immigration Detainer – Notice of Action, Form 127-A, dated May 1, 2019.

<sup>43</sup> See Determination of Release Conditions and Release Order or Commit before Conviction, dated May 1, 2019.

<sup>44</sup> See Download Details report starting May 1, 2019, printed May 15, 2019.



**On May 2, 2019** at 7:18 a.m., an officer electronically recorded a security round of the two medical cells, but did not record a round of the Juvenile cell.<sup>45</sup>

Officer (b)(6); (b)(7)(C) documented that between 9:30 a.m. and 11:30 a.m., he observed SINGH was in the Juvenile cell and noted that his booking and classification remained incomplete.<sup>46</sup> He was aware SINGH's charges included sexual assault and that there was a language barrier, stating to ERAU that he understood but could not recall how he learned SINGH spoke Punjabi.<sup>47</sup> Officer (b)(6); (b)(7)(C) escorted SINGH to the booking desk and attempted to communicate with him using Google Translate, without success.<sup>48</sup> During the attempted communication, SINGH seemed to reference a phone number he had in his possession when arrested. He also placed his hand over his mouth and appeared to breathe hard, prompting Officer (b)(6); (b)(7)(C) to ask if he needed oxygen or wore a mask. Officer (b)(6); (b)(7)(C) did not understand SINGH's replies so left for the Sheriff's Office dispatch area to obtain the language interpretation service number and access code. After dispatch personnel told him that the interpretation service might not have a Punjabi interpreter<sup>49</sup>, Officer (b)(6); (b)(7)(C) returned to the booking area and accessed an address book from SINGH property.<sup>50</sup> He did not attempt to call the language interpretation service. SINGH wrote down three phone numbers, one of which Officer (b)(6); (b)(7)(C) decided to call.<sup>51</sup> Because of SINGH's earlier gestures around his mouth, the officer summonsed (b)(6); (b)(7)(C) to be present for the phone call. Over speakerphone and in his language, SINGH spoke for approximately 30 seconds with an individual who also spoke English. When Officer (b)(6); (b)(7)(C) took over the conversation, the individual informed him he was on his way to LPCADF to post SINGH's bail. Officer (b)(6); (b)(7)(C) shared his understanding that there was an ICE detainer, although the detainer was not found in SINGH's booking file at the time. The individual stated he was two to three hours away and that he assumed the facility would work out the matter of the possible detainer during that time.

Officer (b)(6); (b)(7)(C) also asked if SINGH had any medical problems, mentioning his earlier gestures. The individual stated that SINGH was doing fine except for minor back pain, for which he requested Tylenol.<sup>52</sup> LPN (b)(6); (b)(7)(C) documented in the medical record that the individual stated SINGH followed a vegetarian diet; also, that he had no allergies to food or medications.<sup>53</sup> LPN

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<sup>45</sup> *Id.*

<sup>46</sup> See Officer (b)(6); (b)(7)(C) written statement, dated May 7, 2019.

<sup>47</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>48</sup> See Officer (b)(6); (b)(7)(C) written statement, dated May 7, 2019.

<sup>49</sup> Deputy Tacey, who arrested SINGH, wrote in his Investigation Narrative that he used the language line during the arrest process, suggesting interpreters who spoke Punjabi were available. See LPCSO Investigation Narrative, dated April 30, 2019, 1200 hours.

<sup>50</sup> An address book is not listed on SINGH's property inventory.

<sup>51</sup> Officer (b)(6); (b)(7)(C) did not determine the relationship of SINGH and the person called.

<sup>52</sup> See Officer (b)(6); (b)(7)(C) written statement, dated May 7, 2019.

<sup>53</sup> See Chart Notes, dated May 7, 2019.

(b)(6); (b)(7)(C) asked no other questions relating to SINGH's medical or mental health history.<sup>54</sup> At 10:51 a.m., LPN (b)(6); (b)(7)(C) entered an Alert History for a special diet.<sup>55</sup>

After the call concluded, Officer (b)(6); (b)(7)(C) returned SINGH to his cell and completed the initial classification assessment.<sup>56</sup> He applied a rating of maximum based on the SINGH's current criminal charges of sexual assault and assault.<sup>57</sup> Officer (b)(6); (b)(7)(C) completed the classification two days after SINGH arrived, and a supervisor did not approve the rating. Commander (b)(6); (b)(7)(C) stated supervisors are not required to review classification decisions.<sup>58</sup> Officer (b)(6); (b)(7)(C) also completed a Segregated Housing Order assigning SINGH to protective custody in H Pod based on the sexual assault charge.<sup>59</sup> Officer (b)(6); (b)(7)(C) erroneously documented on the form that SINGH's arrest date was May 1, 2019, and signed the order as approving authority. Commander (b)(6); (b)(7)(C) informed ERAU that although the form lists Shift Supervisor, Command Staff and Medical as authorized approving authorities, officers do not obtain approval to assign inmates/detainees to segregation in practice.<sup>60</sup> Officer (b)(6); (b)(7)(C) noted on the form that the time of segregation placement was 10:00 a.m.; however, security personnel did not transfer SINGH prior to the medical emergency at approximately 5:57 p.m. There were no recorded security round encompassing the Juvenile cell this date, before and after Officer (b)(6); (b)(7)(C) formally assigned SINGH to segregation.

At 3:13 p.m., LPN (b)(6); (b)(7)(C) entered an electronic task for daily nursing segregation rounds until Wednesday, May 15, 2019.<sup>61</sup> Nursing staff did not complete a round prior to the medical emergency.

(b)(6); (b)(7)(C) arrived at LPCADF to post SINGH's bond. Sergeant (b)(6); (b)(7)(C) started to process the bond when he learned there might be an ICE detainer.<sup>62</sup> By facsimile transmission time-stamped 3:59 p.m., the ERO Phoenix, Yuma sub-office forwarded to LPCADF an Immigration Detainer – Notice of Action.<sup>63</sup> A Facsimile Transmission cover sheet documents ERO also forwarded form I-203A/B, Order to Detain or Release Aliens, and form I-216. On the cover sheet, Deportation Officer (b)(6); (b)(7)(C) requested that LPCADF transport SINGH to the Yuma ERO office on May 3, 2019 with all his property.<sup>64</sup>

When Sergeant (b)(6); (b)(7)(C) received confirmation of the ICE detainer, he informed (b)(6); (b)(7)(C) that if he posted the bond, SINGH would remain detained at LPCADF pending transfer to an

<sup>54</sup> ERAU interviews with (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>55</sup> See Alert History dated May 2, 2019.

<sup>56</sup> See Officer (b)(6); (b)(7)(C) written statement, dated May 7, 2019.

<sup>57</sup> See LPCSO Formal Classification Assessment form, dated May 2, 2019.

<sup>58</sup> ERAU interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>59</sup> See LPCADF Segregated Housing Order, dated May 2, 2019.

<sup>60</sup> ERAU interview with Commander Suffle, dated June 18, 2019.

<sup>61</sup> See CorEMR Tasks, dated May 2, 2019.

<sup>62</sup> See Sergeant Donahue's written statement, dated May 2, 2019.

<sup>63</sup> See Department of Homeland Security, Immigration Detainer – Notice of Action, Form 247A, dated May 2, 2019.

<sup>64</sup> See Facsimile Transmission, dated May 2, 2019, and Form I-203A, Order to Detain Aliens. Form I-216 was not included in materials provided to ERAU.



ICE facility. Mr. Singh informed him that he wished to proceed with posting the bond, whereupon Sergeant (b)(6); (b)(7)(C) completed the bond documentation at 4:39 p.m.<sup>65</sup> Pursuant to the Order to Detain received at 3:59 p.m. and upon posting bond in the criminal matter, SINGH became an ICE detainee.

Before leaving the facility (b)(6); (b)(7)(C) if he and (b)(6); (b)(7)(C) could visit SINGH, asking for his consideration of the distance they traveled and the fact that SINGH had medical issues the facility may not know of due to the language barrier.<sup>66</sup> Sergeant (b)(6); (b)(7)(C) decided to allow a non-contact visit, and asked (b)(6); (b)(7)(C) to identify the medical issues so he could inform medical staff. After the visit, (b)(6); (b)(7)(C) gave Sergeant (b)(6); (b)(7)(C) piece of paper stating SINGH had a breathing problem, his nose needed surgery and he had back pain. Observing no medical issues himself (b)(6); (b)(7)(C) decided to wait to provide the information to medical. While Sergeant (b)(6); (b)(7)(C) was escorting SINGH to back to his cell, SINGH stopped at the intake clothing rack and pointed to his feet. He was wearing no socks, so Sergeant (b)(6); (b)(7)(C) gave him a pair before returning SINGH to the cell.<sup>67</sup>

Video surveillance footage taken by the operational stationary security camera in SINGH's cell starts with Sergeant (b)(6); (b)(7)(C) closing the cell door after SINGH entered. The time was approximately 5:15 p.m.<sup>68</sup> Because the camera does not capture all angles and the quality is poor, SINGH is not in clear view for most of the video; however, for 31 minutes after he returned to the cell, ERAU was able to observe movement. The movement includes SINGH twice entering the shower holding socks, appearing to try to tie something to the upper bunk, and placing a blanket on the upper bunk with a portion draping down in a manner that partially obstructs the lower bunk. The time movement is last evident was 5:46 p.m.

SINGH's suicide attempt was discovered by Officer (b)(6); (b)(7)(C) while she was distributing the evening meal throughout the facility.<sup>69</sup> Officer (b)(6); (b)(7)(C) whose employment at LPCADF started approximately three weeks earlier, had not yet completed any formal training in the duties of a detention officer or attended the training academy.<sup>70</sup> She

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<sup>65</sup> Sergeant Donahue's written statement dated May 2, 2019 and ICE Significant Incident Report dated May 4, 2019 state the bond process was completed at approximately 4:30 p.m. According to ERAU team leader (b)(6); (b)(7)(C) Commander (b)(6); (b)(7)(C) confirmed after the site visit that the bond was completed at 4:39 p.m.

<sup>66</sup> See Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

<sup>67</sup> Because booking staff did not document clothing items issued to SINGH upon arrival, ERAU cannot verify whether he received a pair of socks when admitted. Sergeant (b)(6); (b)(7)(C) told Mohave County detectives inmates are given one pair of socks at intake, and another pair when housed. See Mohave County Sheriff's Office Incident Information, undated.

<sup>68</sup> Video surveillance footage, time stamped 11:43 p.m. on May 2, 2019 to 12:46 a.m. on May 3, 2019. Based on all other evidence, the time stamp is inaccurate. ERAU determined the timing of key events by working backward from 6:03 p.m., the time Emergency Medical Services responders documented they were at the patient's side and video shows them entering the cell. All times are approximate and rounded to the nearest minute.

<sup>69</sup> See Officer (b)(6); (b)(7)(C) written statement, dated May 2, 2019, and Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

<sup>70</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019.

informed Mohave County Detectives (b)(6); (b)(7)(C) that although not a certified officer, LPCADF allowed her to work on her own in tower control and to serve meals.<sup>71</sup> The inmate worker who was assisting Officer (b)(6); (b)(7)(C) distribute meals approached the Juvenile cell first and informed her that SINGH hanged himself. She approached the window and observed SINGH hanging from the bunk, his face pale, and his tongue hanging out. She ran from the medical wing into booking to notify Sergeant (b)(6); (b)(7)(C)

Sergeant (b)(6); (b)(7)(C) was booking a new arrestee brought to LPCADF by Department of Public Safety (b)(6); (b)(7)(C) when Officer (b)(6); (b)(7)(C) ran from the medical wing and stated, "It's bad."<sup>73</sup> He then ran to the Juvenile cell and observed SINGH hanging by the neck. He informed ERAU that the fabricated noose appeared to be fashioned from socks and possibly pieces torn from bed sheets or blanket.<sup>74</sup> The video corresponding to these events suggests the time of Sergeant (b)(6); (b)(7)(C) observation was 5:57 p.m. when a person out of camera range opened then shut the cell door. A minute thereafter, two uniformed male personnel, assumed Sergeant (b)(6); (b)(7)(C), entered the cell.<sup>75</sup> The time elapsed between 5:46 when movement in SINGH's cell is last evident and Sergeant (b)(6); (b)(7)(C) confirmation that he hanged himself was approximately 11 minutes. Asked by ERAU why he did not call medical emergency over the radio and, pending arrival of assistance, immediately lift SINGH upward to relieve pressure on his neck, Sergeant (b)(6); (b)(7)(C) said he believed SINGH was already deceased. He saw no signs of life, he was gray, foam was coming from his mouth, and he had urinated on himself.<sup>76</sup>

Sergeant (b)(6); (b)(7)(C) documented that he asked Trooper (b)(6); (b)(7)(C) to go to the dispatch area to inform personnel assigned there of the situation, and instructed Officer (b)(6); (b)(7)(C) to relieve Officer (b)(6); (b)(7)(C) in the control tower. Officer (b)(6); (b)(7)(C) told Mohave County detectives that Sergeant (b)(6); (b)(7)(C) relieve him and report to the scene because he is an experienced officer.<sup>77</sup> Officer (b)(6); (b)(7)(C) so remarked to the detectives that prior to the suicide, SINGH repeatedly used the intercom to report he could not breathe, and that he responded to SINGH's cell to check on his well-being. Officer (b)(6); (b)(7)(C) included that

<sup>71</sup> See Mohave County Sheriff's Office Incident Investigation report, undated.

<sup>72</sup> Because she had not been trained, Officer (b)(6); (b)(7)(C) did not know the proper steps to take in the event of a medical emergency.

<sup>73</sup> See Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019. Trooper (b)(6); (b)(7)(C) first name is unknown.

<sup>74</sup> ERAU interview with Sergeant (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>75</sup> Video surveillance footage, dated May 2, 2019. See also Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

<sup>76</sup> ERAU interview with Sergeant (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>77</sup> See Mohave County Sheriff's Office Incident Investigation report, undated. Officer (b)(6); (b)(7)(C) had left LPCADF employment; therefore, ERAU was not able to interview him.



SINGH was fine, commenting that in his experience inmates often claim health issues that may or may not be valid.<sup>78</sup>

In addition to issuing directions to Officer (b)(6); (b)(7)(C) Sergeant (b)(6); (b)(7)(C) called by radio for medical staff to report to the scene<sup>79</sup> and radioed tower control to call 911.<sup>80</sup> Emergency Medical Services (EMS) received the call at 5:58 p.m.<sup>81</sup>

In a late entry to the medical record, (b)(6); (b)(7)(C) wrote that when she arrived on the scene, she observed SINGH hanging by socks from the top bunk of his bed.<sup>82</sup> Based on video evidence, the time was approximately 5:59 p.m.<sup>83</sup> She did not bring any emergency equipment with her, stating to ERAU that Sergeant (b)(6); (b)(7)(C) radio call for medical to come to the scene was unclear as to purpose and location.<sup>84</sup> In her medical record note, she described SINGH as ashen and limp, with a protruding tongue and legs extended to the right side of his body. She did not detect a carotid pulse<sup>85</sup>. (b)(6); (b)(7)(C) who had returned to the cell, and Officer (b)(6); (b)(7)(C) who had arrived at the scene, repositioned SINGH's legs to stabilize his neck and body.<sup>86</sup> Sergeant (b)(6); (b)(7)(C) documented he cut SINGH down, but did not specify whether he used a cut-down tool to cut through the ligature<sup>87</sup>. He, Trooper (b)(6); (b)(7)(C) then moved him to the floor. Although these actions are not clearly shown on the video, it appears the actions took place approximately three minutes after Officer (b)(6); (b)(7)(C) first discovered SINGH's suicide attempt; two minutes after Sergeant (b)(6); (b)(7)(C) likely first arrived at the cell.<sup>88</sup>

Once SINGH was on the floor, Sergeant (b)(6); (b)(7)(C) immediately started chest compressions. (b)(6); (b)(7)(C) relieved him after one round.<sup>89</sup> Sheriff's Office patrol Sergeant (b)(6); (b)(7)(C)

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<sup>78</sup> Because ERAU did not interview Officer (b)(6); (b)(7)(C) and absent post logs, ERAU was not able to determine the timeframe during which SINGH reported he could not breathe, or the post to which Officer (b)(6); (b)(7)(C) was assigned when the reported events occurred.

<sup>79</sup> See Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

<sup>80</sup> ERAU interview with Sergeant (b)(6); (b)(7)(C) dated June 18, 2019. If a control logbook is maintained, LPCADF did not provide ERAU with the portion documenting the time 911 was called and subsequent events relating to EMS arrival and departure.

<sup>81</sup> See River Medical, Incorporated Pre-Hospital Care Report, dated May 2, 2019. ERAU rounded times taken from the report to the nearest minute.

<sup>82</sup> See chart note dated May 7, 2019.

<sup>83</sup> See Video surveillance footage, dated May 2, 2019.

<sup>84</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>85</sup> A carotid pulse is detected beside the windpipe on the neck.

<sup>86</sup> See Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

<sup>87</sup> ERAU interview with Sergeant (b)(6); (b)(7)(C) dated June 18, 2019. A cut-down, sometimes referred to as a 911 knife, is used to quickly remove a person's clothing during emergencies, or to rapidly removing a ligature.

<sup>88</sup> Video surveillance footage, dated May 2, 2019.

<sup>89</sup> See Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

(b)(6); (b)(7)(C) no heard Sergeant (b)(6); (b)(7)(C) radio calls, also responded and assisted with chest compressions.<sup>90</sup>

Parker Fire Department EMS and a River Medical, Incorporated ambulance arrived at the facility at 6:01 p.m. and responders were at SINGH's side at 6:03 p.m.<sup>91</sup> Upon arrival they were told SINGH was found in his cell with a noose around his neck. The responders noted they could not establish the time staff last saw him alive; also, that LPCADF staff were performing CPR.

Video footage from patrol Sergeant (b)(6); (b)(7)(C) body camera starts after EMS personnel were in the cell.<sup>92</sup> Asked by Mohave County Sheriff's Office detectives if they, too, had body cameras, Officer (b)(6); (b)(7)(C) said his was not charged because he had no charger; Sergeant (b)(6); (b)(7)(C) did not provide a coherent response.<sup>93</sup> Shortly after Sergeant (b)(6); (b)(7)(C) body camera video starts, an EMS responder relieved a Sheriff's Office responder in performing chest compressions. An unknown voice asks (b)(6); (b)(7)(C) who was standing in the doorway, to retrieve the automated external defibrillator.<sup>94</sup> Sergeant (b)(6); (b)(7)(C) documented he issued the instruction and that EMS responders were first to use the AED.<sup>95</sup> (b)(6); (b)(7)(C) documented that she retrieved the AED after she first arrived on scene and did not find SINGH's pulse. She also documented that when she returned to the cell, she activated the AED, resulting in a no shock analysis.<sup>96</sup> The EMS report supports RN (b)(6); (b)(7)(C) account, stating the AED was used prior to EMS arrival, without defibrillation<sup>97</sup>. However, as noted, the body camera video suggests an AED was brought to the scene after EMS responders arrived.<sup>98</sup> ERAU cannot resolve the discrepancy.

Within seconds of when the AED was requested and as chest compressions continued, a voice is heard asking if anyone had a seatbelt cutter.<sup>99</sup> Someone stated no, then the video shows Sergeant (b)(6); (b)(7)(C) using a what appears to be a switchblade knife to first cut SINGH's shirt open, then cut through the ligature on his neck. Asked about the knife by Mohave County detectives, Sergeant (b)(6); (b)(7)(C) stated he had retrieved it from a box behind the booking desk in order to cut SINGH down from the bunk.<sup>100</sup> He said the knife, which the Mohave County evidence list documents is a Zombie Killer folding knife, was in the box because he had not had a chance to

<sup>90</sup> ERAU interview with Sergeant (b)(6); (b)(7)(C) dated June 18, 2019. ERAU verified Sergeant (b)(6); (b)(7)(C) current certification in cardiopulmonary resuscitation (CPR); however, Sergeant (b)(6); (b)(7)(C) and responding patrol sergeant (b)(6); (b)(7)(C) did not have current certification.

<sup>91</sup> See River Medical, Inc. Pre-Hospital Care Report, dated May 2, 2019.

<sup>92</sup> Body camera video footage (b)(6); (b)(7)(C) dated May 2, 2019.

<sup>93</sup> See Mohave County Sheriff's Office Incident Investigation report, undated.

<sup>94</sup> Body camera video footage (b)(6); (b)(7)(C) dated May 2, 2019.

<sup>95</sup> See Sergeant (b)(6); (b)(7)(C) written statement, dated May 2, 2019.

<sup>96</sup> See chart note dated May 7, 2019.

<sup>97</sup> See River Medical, Inc. Pre-Hospital Care Report, dated May 2, 2019.

<sup>98</sup> Body camera video footage, (b)(6); (b)(7)(C) dated May 2, 2019.

<sup>99</sup> *Id.*

<sup>100</sup> See Mohave County Sheriff's Office Incident Investigation report, undated. As noted above, Sergeant (b)(6); (b)(7)(C) stated he used a cut-down tool to cut the ligature from the bunk; therefore, ERAU was unaware and did not inquire about the knife.



dispose of it.<sup>101</sup> Sergeant (b)(6); (b)(7)(C) explained that in the commotion of the emergency, he told Officer (b)(6); (b)(7)(C) to get the cut-down tool, but realized that as a new employee, she may not know to what he was referring.<sup>102</sup> He told detectives he recalled the knife he had not yet discarded the knife and retrieved it himself because he knew where to find it.

Despite continued rescue efforts, SINGH remained asystole.<sup>103</sup> Responders moved him to a gurney and left the facility at 6:27 p.m. SINGH remained asystole during the four-minute trip to the La Paz Regional Hospital.<sup>104</sup> At approximately 6:30 p.m., (b)(6); (b)(7)(C) responded to the hospital per direction of Sergeant (b)(6); (b)(7)(C) Command (b)(6); (b)(7)(C) confirmed that Sergeant (b)(6); (b)(7)(C) and Deputy (b)(6); (b)(7)(C) are Sheriff's Office personnel not assigned to LPCADF. He also confirmed they did not keep a log recording events.<sup>106</sup>

The La Paz Regional Hospital Nursing Chart documents SINGH came to the emergency department due to a suicide attempt by hanging.<sup>107</sup> Recorded on the Nursing Chart is a birth date of May 29, 1987, discrepant from SINGH's date of birth of September 29, 1998 documented on LPCSO booking documentation<sup>108</sup> and in his ICE Alien file<sup>109</sup>. The Nursing Chart also lists five current medications and states there was a history of a prior suicide attempt.<sup>110</sup> At 6:50 p.m., emergency room personnel placed SINGH on a ventilator<sup>111</sup>. At 7:40 p.m., (b)(6); (b)(7)(C) documented SINGH was to be transferred by air to the Abrazo West Campus in Goodyear, AZ for higher acuity care.<sup>112</sup>

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<sup>101</sup> See Mohave County Sheriff's Office Incident Investigation report, undated. ERAU speculates law enforcement confiscated the knife during search of an arrestee and turned it over to LPCADF for disposition.

<sup>102</sup> See Mohave County Sheriff's Office Incident Investigation report, undated. In their reports and during interview by ERAU, neither Officer (b)(6); (b)(7)(C) spoke of instruction to retrieve the cut-down tool.

<sup>103</sup> Asystole refers to total cessation of the heart's electrical activity, also referred to flat line on the heart monitor.

<sup>104</sup> See River Medical, Inc. Pre-Hospital Care Report, dated May 2, 2019.

<sup>105</sup> See Law Supplemental Narratives by Deputy (b)(6); (b)(7)(C) dated July 25, 2019. Based on these reports, information on a document LPCSO provided to ERAU (see listing of staff on shift, untitled and undated) inaccurately states both Deputy (b)(6); (b)(7)(C) and Sergeant (b)(6); (b)(7)(C) were present at the hospital. LPCSO did not provide continuous custody supervision of SINGH after he left LPCADF in the ambulance.

<sup>106</sup> ERAU interview with Commander (b)(6); (b)(7)(C) June 18, 2019. Facility policy 5.6, Hospitalization of Detainee's (sic), requires that escorting officers maintain a Hospital Log.

<sup>107</sup> See Emergency Department Record, Nursing Chart, date of service May 2, 2019.

<sup>108</sup> See LPCSO Individual Arrest Report, dated April 30, 2019.

<sup>109</sup> See ICE Alien file.

<sup>110</sup> ERAU was unable to identify the source of the information relating to current medications and past suicide attempt. The listed medications were Clonazepam, Divalproex, Doxepin, Olanzapine, and Prazosin, medications which treat mental health disorders.

<sup>111</sup> A ventilator is a breathing machine that provides a patient with oxygen when they are unable to breathe on their own.

<sup>112</sup> See Emergency Department Record, Physician Chart, date of service May 2, 2019.

The Native Air report documents a unit from Lake Havasu City, Arizona was dispatched t 7:21 p.m. to provide rapid air transport to Abrazo West Valley. The flight departed with SINGH on board at 9:08 p.m. and arrived at the Abrazo West emergency room at 9:57 p.m.

The Abrazo West Campus Hospital record documents SINGH presented with an altered mental state when seen at 10:03 p.m. He was determined to be in critical condition.<sup>113</sup> LPCADF personnel (b)(6); (b)(7)(C) arrived at approximately 11:00 p.m. to provide custody supervision.<sup>114</sup> Officer (b)(6); (b)(7)(C) documented that they both reported to SINGH's room when they arrived, then Sergeant (b)(6); (b)(7)(C) left to check into a local hotel. Officer (b)(6); (b)(7)(C) as to provide vigil until 8:00 a.m. when Sergeant (b)(6); (b)(7)(C) would relieve him.<sup>115</sup>

**On May 3, 2019** at 1:43 a.m., attending physician (b)(6); (b)(7)(C) documented she was called to SINGH's bedside for a code event, at which time advanced cardiac life support measures were undertaken.<sup>116</sup> When measures became futile, the decision was made to provide supportive care until SINGH suffered another code, at which point care would be withdrawn.<sup>117</sup> After multiple resuscitation attempts SINGH succumbed to his injuries and died at 1:58 a.m.<sup>118</sup> The preliminary cause of death was cardiopulmonary arrest caused by a suicide attempt.<sup>119</sup>

At 10:30 a.m., ERO Phoenix notified the Consulate General of India in San Francisco, CA of SINGH's death.<sup>120</sup>

At LPCADF Sergeant (b)(6); (b)(7)(C) generated a Receipt for Property Returned form listing SINGH's personal property items. Sergeant (b)(6); (b)(7)(C) did not sign the form or document to whom he gave the property.<sup>121</sup>

Commander (b)(6); (b)(7)(C) referred all LPCADF staff involved in the emergency response to an employee assistance resource in Phoenix.<sup>122</sup> (b)(6); (b)(7)(C) reported nursing staff were offered supportive counseling as well.<sup>123</sup>

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<sup>113</sup> See Abrazo West Campus Emergency/Urgent Care note, dated May 2, 2019.

<sup>114</sup> See listing of staff on shift, untitled and undated. (b)(6); (b)(7)(C) did not maintain a log documenting events. LPCSO did not maintain continuous custody supervision of SINGH after he left La Paz Regional Hospital.

<sup>115</sup> See (b)(6); (b)(7)(C) written statement, dated May 9, 2019.

<sup>116</sup> See Abrazo West Campus Progress Note, dated, May 3, 2019.

<sup>117</sup> *Id.*

<sup>118</sup> See Abrazo West Campus Discharge Summary, dated May 10, 2019.

<sup>119</sup> *Id.* Officers (b)(6); (b)(7)(C) did not write an incident report as required by facility policy 5.3, Inmate Death.

<sup>120</sup> See ERO Phoenix Notification of the Death of an ICE Detainee Report, dated May 3, 2019.

<sup>121</sup> See LPCSO Receipt for Property Returned, dated May 3, 2019.

<sup>122</sup> ERAU interview with Commander (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>123</sup> ERAU interview with RN (b)(6); (b)(7)(C) dated June 18, 2019.



The Mohave County Sheriff's Office investigated the incident under cooperative agreement with the La Paz County Sheriff.<sup>124</sup> The report of investigation includes transcripts of interviews with

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

and the inmate worker who first observed SINGH's suicide attempt. It also includes a summary describing footage from the security camera in the Juvenile cell, and a description of the cell and its contents when inspected by the detectives. The report does not include referenced photographs, findings or conclusions. LPCADF did not conduct an internal after action review to assess compliance with facility policy.

## CONCLUSIONS

Pursuant to the Order to Detain issued by ERO on May 2, 2019, SINGH fell under the authority of ICE approximately an hour and seven minutes before video last shows movement in his cell, and approximately an hour and 18 minutes half before staff discovered his suicide attempt. LPCADF took no action to apply the ICE NDS when custody responsibility was transferred. The below Compliance Findings reflect deficiencies in the NDS applicable to SINGH's hour and a half as an ICE detainee. Following Compliance Findings are Areas of Concern identifying issues not addressed in the NDS. Areas of Concern also identify any applicable components of the NDS in which ERAU would have cited deficient had SINGH been a detainee before LPCADF received the Order to Detain. ERAU identified the latter to point to practices that fall short of LPCSO's contractual obligation to comply with the NDS with respect to inmates who convert to detainee status, and any detainees directly admitted pending transfer to ICE custody.

### Compliance Findings

ERAU cites the following deficiencies in the ICE NDS applicable to the time SINGH was an ICE detainee.

1. ICE NDS, Medical Care, Section (III)(H)(2), which states "Detention staff will be trained to respond to health-related emergencies within a 4-minute response time. This training will be provided by a responsible medical authority in cooperation with the OIC and will include the following: The administration of first aid and cardiopulmonary resuscitation (CPR)."

  - Officer (b)(6); (b)(7)(C) did not have certification in CPR. Although neither administered CPR, Officer (b)(6); (b)(7)(C) was first to discover SINGH's suicide attempt, and Officer (b)(6); (b)(7)(C) responded. In addition, LPCSO did not provide documentation of current CPR certification for Sergeant (b)(6); (b)(7)(C)

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<sup>124</sup> See Lieutenant (b)(6); (b)(7)(C) written statement, dated May 2, 2019 and Mohave County Sheriff's Office Incident Investigation, undated.

Although an LPCSO patrol sergeant and not detention staff, he responded to the emergency and participated in CPR.

2. ICE NDS, Suicide Prevention and Intervention, Section (III)(A), which states, “All staff will receive training, during orientation and periodically, in the following: recognizing signs of suicidal thinking, including suspect behavior; facility referral procedures; suicide-prevention techniques; and responding to an in-progress suicide attempt. All training will include the identification of suicide risk factors and the psychological profile of a suicidal detainee.”
  - LPCADF security personnel receive suicide prevention and intervention training during initial training, only. Office (b)(6); (b)(7)(C) had not yet received training when she discovered SINGH’s suicide attempt. In addition, LPCADF did not produce documentation of periodic refresher training, and did not produce curricula or lesson plans to show the initial training includes required topics.
  - Nursing staff reported they have not received suicide prevention and intervention training during their employment.

#### Areas of Concern

1. Despite SINGH’s very limited English language proficiency, security and medical personnel did not use the Sheriff’s Office telephonic language interpretation service to complete intake processes, detailed below. Booking Sergeant (b)(6); (b)(7)(C) did not document SINGH’s primary language and the reason he did not complete the intake process; RN (b)(6); (b)(7)(C) not address the language barrier in the medical record until after SINGH’s death. (b)(6); (b)(7)(C) stated she did not know the Sheriff’s Office had a telephonic interpretation service.

Applicable NDS component: Medical Care, Section (III)(D), which states, “If language difficulties prevent the health provider/officer from completing the medical screening, the officer shall obtain translation assistance. Such assistance may be provided by another officer or by a professional service, such as a telephone translation service.”

2. The only documented admission process completed by Sergeant (b)(6); (b)(7)(C) was an inventory of SINGH’s funds and property. SINGH’s signature does not appear on the inventory, nor does an address book later found by Officer (b)(6); (b)(7)(C)
3. There is no record (b)(6); (b)(7)(C) issued SINGH clothing, bed linens, towels and hygiene items.



Applicable NDS component: Admission and Release, Section (V)(A)(2), which states, “Staff will issue arriving detainees personal hygiene items, clothing, sheets and blankets appropriate for local weather conditions.”

4. LPCADF does not have an orientation procedures. The LPCADF handbook is available in English only, and only by way of kiosk. Because of the language barrier, SINGH had no access to information about facility operations, including how to access healthcare.

Applicable NDS component: Admission and Release, Section (III)(A)(1), which states, “The orientation process supported by a video (INS) and handbook shall inform new arrivals about facility operations, programs, and services.”

5. Due to the language barrier, (b)(6); (b)(7)(C) did not complete SINGH’s medical and mental health screening, or assess his suicide risk.

Applicable NDS components: Medical Care, Section (III)(D), which states, “All new arrivals shall receive initial medical and mental health screening immediately upon their arrival by a health care provider or an officer trained to perform this function. This screening shall include observation and interview items related to the detainee’s potential suicide risk and possible mental disabilities, including mental illness and mental retardation”; and, Suicide Prevention and Intervention, Section (III)(B), which states, “Suicide potential will be an element of the initial health screening of a new detainee, conducted by either the health care provider or a specially trained officer.”

6. (b)(6); (b)(7)(C) scheduled SINGH’s tuberculosis testing for seven days following his arrival in accordance with LPCADF policy 5-1, Receiving Screening Assessment, dated January 15, 2011.

Applicable NDS component: Medical Care, Section (III)(D), which states, “All new arrivals shall receive TB screening by PPD or chest x-ray.”

7. (b)(6); (b)(7)(C) did not re-check SINGH’s elevated pulse and blood pressure identified during intake.
8. SINGH did not sign general consent for medical treatment.

Applicable NDS component: Medical Care, Section (III)(L), which states, “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.”

9. Security personnel did not document SINGH’s assignment to the Juvenile cell following booking, including when or why he was placed in the cell and supervisory approval. According to Commander (b)(6); (b)(7)(C) he was placed in the cell for protective custody purposes due to the sexual assault charge; however, an administrative segregation order

for protective custody was not completed until two days following intake, May 2, 2019. The administrative segregation order completed by Officer (b)(6); (b)(7)(C) was not approved by a supervisor. Commander (b)(6); (b)(7)(C) stated LPCADF does not require supervisory approval of administrative segregation placement as a matter of routine.

Applicable NDS component: Special Management Unit, Administrative Segregation, 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.”

10. When security personnel placed SINGH in the Juvenile cell for segregation, they did not initiate a log to record activities and privileges, including meals, time out of cell, and staff rounds. Between his assignment to the cell at an unknown time on April 30, 2019 and the medical emergency shortly before 6:00 p.m. on May 2, 2019, security personnel recorded one round, on May 1, 2019 at 8:39 p.m. Nurses made no rounds, reportedly because they did not know SINGH was in the Juvenile cell.

Applicable NDS component: Special Management Unit, Administrative Segregation, 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.”

11. SINGH was not classified until two days after admission, May 2, 2019. A supervisor did not approve the classification. Commander Suffle stated supervisors do not routinely review classification decisions.

Applicable NDS components: Detainee Classification System, Section (III)(A)(1), which states, “The classification system ensures: All detainees are classified upon arrival, before being admitted into the general population.” Admission staff will use the documentation accompanying each new arrival for identification and classification purposes”; also, Detainee Classification System, Section (III)(A)(3), which states, “The first-line supervisor will review and approve each detainee’s classification.”

12. Two days after SINGH’s admission to LPCADF, during a phone conversation with Officer (b)(6); (b)(7)(C) and SINGH’s English-speaking associate, LPN (b)(6); (b)(7)(C) did not take the opportunity to inquire about any known medical or mental health history, or possible suicidal ideation. LPN (b)(6); (b)(7)(C) entered a task order for a vegetarian diet pursuant to the phone conversation, but did not make a chart note until May 7, 2019, four days following SINGH’s death.

13. LPCADF allowed Officer (b)(6); (b)(7)(C) to perform duties of a detention officer on an unsupervised basis before she completed formal training of any kind. Having not



been trained, she was unprepared and unqualified to take appropriate action when she discovered SINGH's suicide attempt.

14. When he responded to SINGH's cell, Sergeant (b)(6); (b)(7)(C) did not call medical emergency by radio and did not enter the cell to lift him upward pending the arrival of additional staff. Approximately two minutes elapsed before staff entered and cut SINGH from the bunk.
15. (b)(6); (b)(7)(C) did not respond with medical equipment, reportedly because Sergeant (b)(6); (b)(7)(C) radio call asking for medical assistance was unclear. She did not make a medical record entry detailing the medical emergency until May 7, 2019.
16. (b)(6); (b)(7)(C) used a knife rather than a cut-down tool to cut SINGH from the bunk, cut through his shirt, and remove the ligature from his neck, placing SINGH at risk for further injury. (b)(6); (b)(7)(C) reported the knife was in a box behind his desk in the booking area, and that he had not had the chance to dispose of it.

Applicable NDS: Contraband, Section (III)(A), which states, which states, "Hard contraband includes any item that is inherently dangerous as a weapon or tool of violence; e.g., a knife, explosives, a 'zipgun', brass knuckles, etc."

17. LPCSO did not maintain continuous supervision of SINGH after EMS departed the facility. Deputy (b)(6); (b)(7)(C) lived at La Paz County Regional Hospital after the ambulance, and left when SINGH was air-lifted the West Abruzzo hospital. Sergeant (b)(6); (b)(7)(C) did not arrive at the West Abruzzo until after SINGH was admitted. Deputy (b)(6); (b)(7)(C) did not maintain a log of events during his watch at La Paz County Regional Hospital, nor did Officer (b)(6); (b)(7)(C) prior to SINGH's death at West Abruzzo. Facility policy 5.6, Hospitalization of Detainee's (sic), section 5.6.2.1, states, "Escorting officers shall maintain a Hospital Log throughout the duration of the detainees medical stay."
18. LPCSO turned over investigation of the incident to the Mohave County Sheriff's Office. Although not documented by LPCADF, the Mohave County report suggests SINGH's cell was treated as a crime scene in accordance with facility policy 5.3.3, Inmate Death. The Mohave County report did not offer any conclusions within its scope, and LPCSO did not conduct an internal after action review to identify any internal policy violations.

In addition to the above concerns specific to SINGH, ERAU notes the following:

19. According to Commander (b)(6); (b)(7)(C) all prisoners admitted to LPCADF are strip searched. In the event LPCADF were to directly admit an ICE detainee, these procedures would conflict with ICE Change Notice, Admission and Release, dated April 14, 2003, "Strip Search Guidelines for Admissions to a Detention Facility". The Change Notice states

immigration detainees shall not be strip searched unless there is reasonable suspicion that an individual may be concealing a weapon or other contraband.

20. LPCADF has not had post orders since 2011.

Applicable NDS components: Post Orders, Section (III)(A), which states, “Written orders shall specify the duties of each post in the facility, along with the procedures to be followed in carrying out those duties”; also, Post Orders, Section (III)(D), which states, “Post orders will be kept current at all times. Post orders will be reviewed and updated yearly or sooner when deemed necessary.”

21. LPCADF’s single-room medical clinic is cluttered and does not have a curtained area for patient privacy. An inmate worker reported overhearing medical information being exchanged in the clinic.

Applicable NDS component: Medical Care, Section (V)(M), which states, “All medical providers shall protect the privacy of detainees medical information to the extent possible while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well-being of detainees.”

22. Healthcare policies and procedures were last updated and reviewed between 2013 and 2016. None were signed by the current Clinical Director.

23. Nurses report overwhelming workload and long hours. There is no backup RN for LPN supervision when the RN is unavailable.



ORIGINAL  
STATE COPY

STATE OF ARIZONA  
DEPARTMENT OF HEALTH SERVICES-BUREAU OF VITAL RECORDS  
**CERTIFICATE OF DEATH**

State File Number  
102-2019-031160

|                                                                                                                                                              |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------|
| 1. DECEDENT'S LEGAL NAME (FIRST, MIDDLE, LAST, SUFFIX)<br><b>SIMRATPAL, SINGH</b>                                                                            |                                                 | 2. AKA'S (IF ANY)                                                                                             |                                                                                                     | 3. DATE OF DEATH<br><b>05/03/2019</b>                                                                   |                                         |
| 4. SEX<br><b>MALE</b>                                                                                                                                        | 5. SOCIAL SECURITY NUMBER<br><b>000-00-0000</b> | 6. DATE OF BIRTH<br><b>09/29/1998</b>                                                                         | 7. AGE<br><b>20 YEARS</b>                                                                           |                                                                                                         |                                         |
| 8. CITY/TOWN, COUNTY AND ZIP OR LOCATION OF DEATH<br><b>GOODYEAR, MARICOPA, 85395</b>                                                                        |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 9. PLACE OF DEATH (TYPE OF PLACE OF DEATH AND FACILITY NAME/ADDRESS)<br><b>EMERGENCY - ABRAZO WEST CAMPUS</b>                                                |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 10. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY)<br><b>TARN TARAN, INDIA</b>                                                                               |                                                 | 11. MARITAL STATUS<br><b>NEVER MARRIED</b>                                                                    |                                                                                                     | 12. NAME OF SURVIVING SPOUSE PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST, SUFFIX)<br><b>NOT LISTED</b> |                                         |
| 13. DECEDENT'S USUAL RESIDENCE ADDRESS (STREET, CITY, COUNTY, STATE, ZIP)<br><b>3545 MATHER FIELD ROAD #49, RANCHO CORDOVA, SACRAMENTO, CA, 95670</b>        |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 14. DECEDENT'S HISPANIC ORIGIN(S):<br><b>NO, NOT SPANISH/HISPANIC/LATINO</b>                                                                                 |                                                 | 15. DECEDENT'S RACE(S):<br><b>ASIAN INDIAN</b>                                                                |                                                                                                     | 16. EVER IN ARMED FORCES<br><b>NO</b>                                                                   |                                         |
| 17. OCCUPATION<br><b>UNKNOWN</b>                                                                                                                             |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 18. FATHER'S NAME (FIRST, MIDDLE, LAST, SUFFIX)<br><b>(b)(6); (b)(7)(C)</b>                                                                                  |                                                 |                                                                                                               | 19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (FIRST, MIDDLE, LAST, SUFFIX)<br><b>(b)(6); (b)(7)(C)</b> |                                                                                                         |                                         |
| 20. DECEASED'S RELATIONSHIP TO INFORMANT<br><b>(b)(6); (b)(7)(C)</b>                                                                                         |                                                 |                                                                                                               |                                                                                                     | 21. RELATIONSHIP<br><b>FAMILY FRIEND</b>                                                                |                                         |
| 22. INFORMANT'S MAILING ADDRESS<br><b>(b)(6); (b)(7)(C)</b>                                                                                                  |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 23. NAME AND ADDRESS OF FUNERAL FACILITY OR RESPONSIBLE PERSON<br><b>WHITNEY &amp; MURPHY FUNERAL HOME<br/>4800 E INDIAN SCHOOL ROAD, PHOENIX, AZ, 85018</b> |                                                 | 24. FUNERAL DIRECTOR'S NAME OR RESPONSIBLE PERSON<br><b>DEREK, BEACH</b>                                      |                                                                                                     | 25. LICENSE NUMBER<br><b>F1295</b>                                                                      |                                         |
| 26. METHOD(S) OF DISPOSITION<br><b>CREMATION</b>                                                                                                             |                                                 | 27. NAME AND LOCATION OF 1ST DISPOSITION FACILITY<br><b>DECA CREMATION SERVICES, INC.<br/>PHOENIX, AZ, US</b> |                                                                                                     | 28. NAME AND LOCATION OF 2ND DISPOSITION FACILITY                                                       |                                         |
| <b>MEDICAL CERTIFICATION SECTION CAUSE OF DEATH PART I</b>                                                                                                   |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 29. A. IMMEDIATE CAUSE OF DEATH<br><b>HANGING</b>                                                                                                            |                                                 |                                                                                                               |                                                                                                     | 30. APPROXIMATE INTERVAL<br><b>HOURS</b>                                                                |                                         |
| 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                                                                                |                                         |
| <b>CAUSE OF DEATH PART II</b>                                                                                                                                |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 37. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN PART I:                                        |                                                 | 38. INJURY?<br><b>YES</b>                                                                                     | 39. INJURY AT WORK?<br><b>NO</b>                                                                    | 40. MANNER OF DEATH<br><b>SUICIDE</b>                                                                   |                                         |
|                                                                                                                                                              |                                                 | 41. TIME OF DEATH<br><b>01:58</b>                                                                             | 42. WAS AN AUTOPSY PERFORMED?<br><b>NO</b>                                                          | 43. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?                                     |                                         |
| <b>CAUSE AND MANNER CERTIFICATION</b>                                                                                                                        |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |
| 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<br><b>(b)(6); (b)(7)(C)</b>                                      |                                                                                                     |                                                                                                         | 45. DATE CERTIFIED<br><b>05/04/2019</b> |
| 46. CERTIFIER'S ADDRESS<br><b>701 W JEFFERSON STREET, PHOENIX, AZ, 85007</b>                                                                                 |                                                 |                                                                                                               |                                                                                                     |                                                                                                         |                                         |

Date Registered: 07/08/2019

Date Issued: 08/19/2019

VS-49 Rev. 12/2017



## Detainee Death Review Report

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# Simratpal Singh

Date of Death: May 3, 2019

Alien File Number: 201 432 202

Joint Integrity Case Management System (JICMS) # (b)(6); (b)(7)(C);  
(b)(7)(F)

March 30, 2020

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



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## **DETAILS OF REVIEW**

From June 18 to 19, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the La Paz County Adult Detention Facility (LPCADF) to review the circumstances surrounding Simratpal SINGH'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.<sup>1</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to SINGH, in addition to conducting in-person interviews of individuals employed by LPCADF and the local ICE Enforcement and Removal Operations (ERO) field office.

SINGH was detained at LPCADF from April 30, 2019, through May 2, 2019. SINGH was a La Paz County Sheriff's Office (LPCSO) inmate from April 30, 2019 until the afternoon of May 2, 2019. On May 2, 2019 at 4:39 p.m., upon posting bond, SINGH's custody status changed from an LPCSO inmate to an ICE detainee. Approximately one hour later, LPCADF called a medical emergency after finding SINGH unresponsive in his cell. SINGH would eventually be transferred to the Abrazo West Campus (AWC) hospital from the La Paz Regional Hospital (LPRH), for a higher level of care. SINGH remained at AWC until his death on May 3, 2019. The Maricopa County Office of the Medical Examiner documented SINGH's cause of death as hanging and the manner of death as suicide.

## **FACILITY PROFILE**

LPCADF is owned and operated by the LPCSO under a U.S. Marshals Service (USMS) Inter-Governmental Agreement (IGA), which authorizes ICE to utilize the facility for detainee bed space. LPCADF is authorized by ICE to house male and female detainees for periods less than 72 hours and has an as needed ICE detainee bed capacity.<sup>2</sup> The contract does not detail specific ICE standards LPCADF is required to comply with; however, the facility is required to conduct a yearly Operational Review Self-Assessment (ORSA) designed to assess the facility's compliance with certain requirements of the ICE National Detention Standards (NDS) 2000. Facility medical care and security are both provided by LPCADF staff. At the time of SINGH's death, the average ICE detainee daily population was three, and the facility housed no other ICE detainees.<sup>3</sup>

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<sup>1</sup> See [Exhibit 1](#): Creative Corrections Healthcare and Security Compliance Analysis.

<sup>2</sup> See ERO Facility List Report, dated May 6, 2019; see also ERO Records Request, dated May 15, 2019.

<sup>3</sup> *Ibid.*



## IMMIGRATION AND CRIMINAL HISTORY

On February 5, 2019, U.S. Customs and Border Protection (CBP) arrested SINGH and seven other individuals SINGH was traveling with immediately upon their illegal entry into the United States near Otay Mesa, CA.

On February 12, 2019, CBP transferred SINGH into ICE ERO's custody at the San Luis Regional Detention Center (SLRDC).<sup>4</sup>

On February 20, 2019, ERO Phoenix transferred SINGH to the La Palma Correctional Center (LPCC), pending a credible fear interview.<sup>5</sup>

On March 27, 2019, a USCIS Asylum Officer conducted SINGH's credible fear interview, and determined the following day that SINGH demonstrated credible fear.<sup>6</sup>

On April 2, 2019, a supervisory asylum officer concurred that SINGH established a credible claim of fear.<sup>7</sup>

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

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

USCIS served SINGH a Notice to Appear, Form I-862, charging inadmissibility pursuant to Sections 212(a)(6)(A)(i) and 212(a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA), as an alien present in the United States without being admitted or paroled, or who, at the time of application for admission, was not in possession of a valid entry document, respectively.<sup>9</sup>

On April 17, 2019, at an unknown time, ICE Deportation Officer (DO) (b)(6); (b)(7)(C) recommended SINGH's bond be set at \$73,500 per a Bond Determination Checklist. At 3:08 p.m., (b)(6); (b)(7)(C) supervisor, ICE Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) approved SINGH's release on bond for the recommended amount.<sup>10</sup>

On April 29, 2019, SINGH posted bond in the amount of \$73,500 and at that time, ERO Phoenix released him from ICE custody.<sup>11</sup>

<sup>4</sup> See Department of Homeland Security (DHS) Form I-216, Record of Persons Transferred, dated February 12, 2019. Although the ICE Enforce Alien Removal Module (EARM) records SINGH's SLRDC book-in date as February 9, 2019, ERAU confirmed with both CBP and ICE ERO, the date CBP physically transferred SINGH to SLRDC was February 12, 2019.

<sup>5</sup> See EARM Detention History, entry dated February 20, 2019; see also EARM Case Actions & Decisions, entries dated February 8 and 21, 2019.

<sup>6</sup> See DHS USCIS Form I-870, Record of Determination/Credible Fear Worksheet, dated March 28, 2019; see also Credible Fear Interview Notes, dated March 27, 2019.

<sup>7</sup> (b)(6); (b)(7)(C)

<sup>9</sup> See DHS Form I-862, dated April 2, 2019.

<sup>10</sup> See Bond Determination Checklist – Recommended Bond worksheet, dated April 17, 2019; see also DHS Form I-286, Notice of Custody Determination, dated April 17, 2019.

<sup>11</sup> See DHS Form I-352, Immigration Bond, dated April 29, 2019.

On April 30, 2019, at 1:07 p.m., the La Paz County Sheriff's Office (LPCSO) arrested SINGH for an alleged assault and sexual assault. At 3:50 p.m., LPCSO booked SINGH into LPCADF.<sup>12</sup>

On May 1, 2019, ERO Phoenix received an Alien Criminal Response Information Management System (ACRIME) notification of SINGH's arrest and book-in at LPCADF and lodged an DHS Form I-247A, Immigration Detainer – Notice of Action, against SINGH with the facility.<sup>13</sup> On the same date, the Quartzsite Justice Court in Quartzsite, AZ, granted SINGH bond in the amount of \$5,000.<sup>14</sup>

On May 2, 2019, at approximately 4:39 p.m., SINGH's custody status changed from an LPSCO inmate to an ICE detainee at LPCADF as SINGH posted bond. On the same date, at an unknown time, the Executive Office for Immigration Review (EOIR) in Tucson, AZ, scheduled SINGH for a master hearing on May 17, 2019.<sup>15</sup>

## **CHRONOLOGY OF EVENTS**

As there was a break in custody when ICE released SINGH on bond on April 29, 2019, ERAU is providing a summary of SINGH's medical care at the two ICE detention facilities that housed him prior to his detention at LPCADF for contextual purposes only.

## **SAN LUIS REGIONAL DETENTION CENTER**

**On February 12, 2019**, at an unknown time, CBP transferred SINGH into ICE custody at SLRDC,<sup>16</sup> where he was housed for 8 days.<sup>17</sup>

At 10:10 p.m., an unidentified<sup>18</sup> nurse conducted SINGH's intake screening. Although the nurse did not use an interpreter for the encounter, he or she used an Intake form<sup>19</sup> translated into Punjabi to complete the assessment and documented the following:

---

<sup>12</sup> See LPCSO Department Incident Report and narrative for incident 190401141; *see also* untitled LPCJ document with Booking Time, dated April 30, 2019. LPCADF is also known as the La Paz County Jail.

<sup>13</sup> See ICE Significant Incident Report (SIR), dated May 4, 2019. Times listed in this report are based on the time zone in which an action or event occurred.

<sup>14</sup> See La Paz County Bail Receipt and Release Order, dated May 1, 2019.

<sup>15</sup> See ICE SIR, dated May 4, 2019.

<sup>16</sup> SLRDC is contractually obligated to adhere to ICE NDS 2000.

<sup>17</sup> See DHS Form I-216, DHS Records of Persons Transferred, dated February 12, 2019. Although SINGH's ICE EARM profile records that CBP transferred SINGH into ICE custody at SLRDC on February 9, 2019, CBP and SLRDC documents record SINGH's arrival date to SLRDC as February 12, 2019.

<sup>18</sup> See LaSalle Corrections SLRDC Medical Intake Packet: Intake Screening section, dated February 12, 2019. A nurse initialed the LaSalle Medical Intake Packet; however, the individual's initials are illegible. (b)(6); (b)(7)(C) reviewed the Intake Screening form and signed it at 3:22 a.m. on February 13, 2019.

<sup>19</sup> Although the LaSalle SLRDC Intake Screening form is approximately eight pages long, the Punjabi Intake form provided consists of one page with twelve primary questions. It is unclear how this form is used if not accompanied by an interpreter as not all questions solicit a simple yes or no response.



- SINGH's vital signs were within normal limits.<sup>20</sup>
- SINGH denied pain, disability, and taking any medications currently or in the past year, to include over the counter or herbal supplements.
- SINGH was appropriate in behavior and did not appear to have abnormal physical, mental, or emotional characteristics.
- SINGH denied current or past thoughts of self-harm or suicide.
- There were no abnormal findings associated with SINGH's medical, dental, or mental health assessments.
- SINGH initialed an English copy of the SLRDC General Medical Consent Form.<sup>21</sup>

**On February 14, 2019**, SINGH's screening for tuberculosis (TB) symptoms came back negative.<sup>22</sup>

**On February 18, 2019**, at 10:50 p.m., Registered Nurse (RN) [REDACTED] (b)(6); (b)(7)(C) conducted SINGH's physical examination.<sup>23</sup> Using an abbreviated Assessment form translated into Punjabi, the RN made the same conclusions as the unidentified nurse, with the exception of documenting SINGH's elevated blood pressure of 127/82.<sup>24</sup>

**On February 19, 2019**, the SLRDC Health Authority [REDACTED] (b)(6); (b)(7)(C) (first name unknown), cleared SINGH for travel.<sup>25</sup> Another RN, [REDACTED] (b)(6); (b)(7)(C) documented SINGH had no medical, dental, or mental health problems.

SLRDC medical staff did not prescribe SINGH medication during his detention.

## LA PALMA CORRECTIONAL CENTER

**On February 20, 2019**, ICE transferred SINGH to LPCC,<sup>26</sup> where he was housed for 68 days.<sup>27</sup>

At 11:25 a.m., an unidentified RN conducted SINGH's intake screening, utilizing interpretation services, and documented the following:<sup>28</sup>

<sup>20</sup> The average body temperature is 98.6 F; a normal resting heart rate/pulse for an adult ranges from 60 to 100 beats per minute; the normal range for respirations is 12 to 20 breaths per minute; and, according to the American Heart Association (AHA), a normal blood pressure reading is generally characterized as less than 120/80.

<sup>21</sup> See LaSalle Corrections General Medical Consent Form, dated February 12, 2109.

<sup>22</sup> See LaSalle Corrections SLRDC TB Screening and Testing form, dated February 14, 2019.

<sup>23</sup> See LaSalle Corrections SLRDC Medical Intake Packet: Physical Examination/Health Appraisal form, dated February 12, 2019.

<sup>24</sup> 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 less than 80. ERAU notes, no medical staff at any of the three facilities SINGH resided at diagnosed him with hypertension. High blood pressure readings, especially for younger individuals, can be the result of a number of factors such as stress and physical activity.

<sup>25</sup> See LaSalle Corrections SLRDC Medical Transfer Summary, dated February 19, 2019.

<sup>26</sup> LPCC is contractually obligated to adhere to ICE's Performance Based National Detention Standards (PBNDS) 2011.

<sup>27</sup> See ICE EARM Detention History, dated February 20, 2019, to April 29, 2019.

<sup>28</sup> The nurse's signature is illegible; however, the nurse listed his or her title as an RN. See CoreCivic LPCC Intake Screening form, dated February 20, 2019.

- SINGH arrived with a transfer form from SLRDC.
- SINGH's vital signs were all within normal limits except for an elevated blood pressure of 120/86.<sup>29</sup>
- SINGH denied experiencing pain, taking any medications, or having any medical complaints.

SINGH signed an English copy of the LPCC Healthcare Services General Consent form.<sup>30</sup> The RN cleared SINGH for general population.

**On February 27, 2019**, at an unknown time, (b)(6); (b)(7)(C) psychologist, conducted a mental health evaluation using an interpretation service.<sup>31</sup> Under the mental health status section, the doctor noted SINGH's affect and mood were normal and that SINGH had no suicidal ideation or intent to harm himself. (b)(6); (b)(7)(C) documented that his impression was that SINGH was stable and that no actions needed to be taken in response to his assessment.

**On February 28, 2019**, at approximately 2:34 p.m., SINGH refused his initial health appraisal.<sup>32</sup> (b)(6); (b)(7)(C) family nurse practitioner (FNP), documented that SINGH refused the examination because he stated he did not have any problems, and that she counseled him on the risks of refusing medical care.

**On March 5, 2019**, at 11:56 a.m., SINGH refused his dental screening as he stated he did not have any dental problems.<sup>33</sup> The nurse educated SINGH on the risks of refusing dental care.

**On March 16, 2019**, at 12:33 p.m., RN (b)(6); (b)(7)(C) treated SINGH with over-the-counter medication, acetaminophen (325 mg), 2 tablets, 3 times daily for 4 days, for complaints of a sore throat and non-productive cough,<sup>34</sup> utilizing the facility's Upper Respiratory Complaints nursing protocol form. All SINGH's vital signs were within normal limits.

**On April 19, 2019**, at an unknown time, SINGH submitted a sick call request with a complaint of back pain he said he had experienced for two days.<sup>35</sup> At 12:19 p.m. the next day, (b)(6); (b)(7)(C) assessed SINGH, who said his pain was a 6 out of 10, and treated him with over-the-counter

<sup>29</sup> According to the 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.

<sup>30</sup> See CoreCivic Healthcare Services General Consent form, dated February 20, 2019.

<sup>31</sup> See CoreCivic Comprehensive Mental Health Evaluation form, dated February 27, 2019.

<sup>32</sup> See CoreCivic Refusal to Accept Medical Treatment form; see also CoreCivic Inmate/Resident Health Appraisal form, dated February 28, 2019. The FNP did not document if she utilized interpretation services to communicate with SINGH.

<sup>33</sup> See CoreCivic Refusal to Accept Medical Treatment form, dated March 5, 2019; see also Dental Progress Notes by Doug Smith, Doctor of Dental Surgery, dated March 5, 2019. Medical staff did not document if they utilized interpretation services to effectively communicate with SINGH.

<sup>34</sup> A non-productive cough is one that does not produce phlegm or mucus. See CoreCivic Upper Respiratory Complaints form, dated March 16, 2016; See also SINGH's Medication Administration Record (MAR). The RN did not note if he utilized interpretation services to effectively communicate with SINGH. The authorizing provider for the medication was (b)(6); (b)(7)(C).

<sup>35</sup> See SINGH's Sick Call Request, dated April 19, 2019; see also Back Pain form, dated April 20, 2019. The RN did not note if he utilized interpretation services to effectively communicate with SINGH. The authorizing provider for the medication was (b)(6); (b)(7)(C).



medication ibuprofen (200 mg), 2 tablets, 3 times daily for 4 days, utilizing the facility's Back Pain nursing protocol form. SINGH's vital signs were all within normal limits.

On April 29, 2019, at approximately 3:40 p.m.,<sup>36</sup> ICE Enforcement and Removal Assistant (b)(6); (b)(7)(C) processed SINGH's bond. At an unspecified time that day, ICE transported SINGH by bus from LPCC to Eloy Detention Center (EDC),<sup>37</sup> to be officially processed out of ICE custody. At this time, SINGH was no longer in ICE custody.

At 7:08 p.m.,<sup>38</sup> a bus contracted by ICE to transport detainees who have been released from ICE custody at LPCC and EDC departed for the Phoenix Greyhound station.

### SINGH'S NON-ICE ARREST EVENT

On April 30, 2019, at approximately 12:00 p.m., LPCSO Deputy (b)(6); (b)(7)(C) responded to a call from a Greyhound bus driver reporting that a female passenger had allegedly been sexually assaulted while the bus was heading westbound on Interstate 10, near Ehrenberg, AZ.<sup>39</sup> Deputy (b)(6); (b)(7)(C) noted that when he attempted to speak with SINGH, he did not speak English.

At approximately 1:07 p.m., (b)(6); (b)(7)(C) placed SINGH under arrest at the direction of another detective, and an Arizona Department of Public Safety state trooper transported SINGH to LPCADF.

### LA PAZ COUNTY ADULT DETENTION FACILITY<sup>40</sup>

#### April 30, 2019

At approximately 3:50 p.m.,<sup>41</sup> LPSCO Sergeant (Sg. (b)(6); (b)(7)(C)) and Corporal (Cpl. (b)(6); (b)(7)(C)) (b)(6); (b)(7)(C) booked SINGH into LPCADF as a county inmate.<sup>42</sup> SINGH had a backpack, jacket, pants, miscellaneous papers, a shirt, and a pair of shoes in his possession.<sup>43</sup>

At 7:20 p.m., RN (b)(6); (b)(7)(C) the LPCADF Medical Services Administrator, signed off on SINGH's intake screening and documented the following:<sup>44</sup>

<sup>36</sup> See ICE Immigration Bond receipt, Form I-352, MIL-C-19-00180; see also (b)(6); (b)(7)(C) email: 'Bond Question,' dated September 13, 2019.

<sup>37</sup> See (b)(6); (b)(7)(C) email: "ICE OPR Bond Question," dated September 16, 2019.

<sup>38</sup> *Ibid.*

<sup>39</sup> See LPCSO Investigation Narrative for incident 190401141 by LPCSO Deputy (b)(6); (b)(7)(C).

<sup>40</sup> At this time, SINGH entered LPCSO custody. The following information is included for contextual purposes as SINGH's custody status does not change to an ICE detainee at LPCADF until approximately 4:39 p.m. on May 2, 2019.

<sup>41</sup> See untitled LPSCO document with booking time, dated April 30, 2019; see also LPCSO Booking Sign Off Sheet, undated.

<sup>42</sup> ERAU interview with Commander (CDR) (b)(6); (b)(7)(C) dated June 18, 2019; see also LPCSO Booking Sign Off Sheet, undated.

<sup>43</sup> See untitled LPSCO property form, dated April 30, 2019.

<sup>44</sup> See Risk and Needs Screening form, dated April 30, 2019.

- SINGH's temperature was elevated at 100.1,<sup>45</sup> his pulse was elevated at 108 beats per minute, his blood pressure was elevated at 133/79, and his respiratory rate was 20 breaths per minute. He weighed 195 pounds.
- (b)(6); (b)(7)(C) selected "no" beside the fields "have you had a skin test for TB" and "are you allergic to any medications."<sup>46</sup>
- (b)(6); (b)(7)(C) left all other fields on the screening form blank, including those about substance abuse, suicide risk, medical health, TB, dental problems, and consent for services.

(b)(6); (b)(7)(C) stated she was unable to complete SINGH's intake screening as he did not speak English and she was not aware LPCADF had a language line at the time.<sup>47</sup> Furthermore, she was unable to clarify how she knew that SINGH was not allergic to or taking any medications. RN (b)(6); (b)(7)(C) recalled the only words SINGH was able to convey to the nurse in English were "court" and "lawyer."

In a late chart note entry for this encounter, (b)(6); (b)(7)(C) documented that SINGH spoke Punjabi, which made communication difficult.<sup>48</sup> She also stated SINGH did not exhibit any suicidal or homicidal ideations, that his vital signs were within normal limits, and that he did not appear in distress. (b)(6); (b)(7)(C) stated that she based her determination that SINGH was not suicidal on her observation of SINGH's appearance. She clarified that she concluded SINGH's vital signs were within normal limits based on her knowledge and experience as the facility did not have nursing protocols that established normal vital sign ranges and thresholds or guidelines for subsequent nursing action. The last note (b)(6); (b)(7)(C) entered in SINGH's medical record related to this encounter was that LPCADF housed SINGH in accordance with the facility's protocol.

CDR (b)(6); (b)(7)(C) explained that because SINGH's charges included a sexual offense, LPCADF assigned him to a single-cell unit.<sup>49</sup> Sgt. (b)(6); (b)(7)(C) explained that LPCADF assigned SINGH to the juvenile cell for his own protection, consistent with standing procedure for inmates

<sup>45</sup> According to the Mayo Clinic, a normal temperature is 98.6 degrees Fahrenheit. Oral temperature readings of 100 degrees Fahrenheit or higher can indicate a fever is present.

<sup>46</sup> A PPD skin test occurs when a solution is injected into the skin to determine whether a person has been infected with TB. ERAU notes that once (b)(6); (b)(7)(C) selected "no" to the TB question, the CorEMR system automatically created a task for LPCADF medical staff to administer a PPD skin test in 7 days, on May 7, 2019. During her interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated officers sometimes house inmates/detainees in general population before they are assessed by medical or PPD's are placed. During her interview with ERAU on June 18, 2019, Licensed Practical Nurse (LPN) (b)(6); (b)(7)(C) also stated officers had a habit of putting arrestees in cells before they were medically cleared and did not always notify medical there was a new arrestee that had been booked in.

<sup>47</sup> ERAU interview with (b)(6); (b)(7)(C), dated June 18, 2019; *see also* LPCADF CorEMR Chart Notes late entry for April 30, 2019, dated May 7, 2019. In his interview with ERAU on June 18, 2019, LPN (b)(6); (b)(7)(C) stated after SINGH's death, he learned for the first time, after working at the facility for seven and a half years, that LPCSO dispatch, located in the same building as LPCADF, had access to a language line.

<sup>48</sup> ERAU notes LPCADF medical staff entered all chart notes related to SINGH into CorEMR after his death. During her interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated she did not think to document her actions in the chart notes until she was directed to do so (it is unclear who directed medical staff to document their actions). When asked if the facility had nursing protocols, (b)(6); (b)(7)(C) stated they were very scant.

<sup>49</sup> ERAU interview with CDR (b)(6); (b)(7)(C), dated June 18, 2019.



charged with sexual offenses.<sup>50</sup> (b)(6); (b)(7)(C) confirmed for ERAU that there is no documentation of SINGH's housing placement on this date, no administrative segregation order, and no documented supervisory authority for the placement. Additionally, staff did not initiate a segregation log to record activities, privileges, and rounds by officers, supervisors, and medical staff.<sup>51</sup>

## May 1, 2019

At approximately 9:00 a.m.,<sup>52</sup> the Quartzsite Justice Court set SINGH's bail at \$5,000 during his initial court appearance.

At 7:44 p.m., ICE received an Immigration Alien Query (IAQ) notice of SINGH's arrest.<sup>53</sup> As a result, at approximately 9:26 p.m.,<sup>54</sup> ERO Phoenix DC (b)(6); (b)(7)(C) looked into the information sent by the ICE LESC and prepared a detainer to place a hold on SINGH at LPCADF.<sup>55</sup>

At 8:39 p.m.,<sup>56</sup> an unknown officer conducted LPCADF's first and only documented security round of the cell<sup>57</sup> SINGH was housed in.

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<sup>50</sup> See Mohave County Sheriff's Office (MCSO) Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C) dated May 2, 2019. MCSO investigated the death of SINGH in LPCSO/ICE custody as MCSO and LPCSO assist one another with each other's internal investigations to maintain impartiality.

<sup>51</sup> ERAU interview with CDR (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>52</sup> See Victim Request for, or Waiver of, Pre-Conviction and/or Pre-Adjudication Rights form, entry dated May 1, 2019; see also Determination of Release Conditions and Release Order or Commit before Conviction, dated May 1, 2019.

<sup>53</sup> See IAQ notice, dated May 1, 2019. When a federal, state, or local law enforcement entity makes an arrest and fingerprints a subject, the individual's fingerprints are submitted to the FBI and compared against DHS databases, which creates an IAQ. If a match occurs, ICE's Law Enforcement Support Center (LESC) generates an Immigration Alien Response (IAR), which provides information regarding the subject's immigration status, criminal history, and other important biographical information to ERO teams in the field for review.

<sup>54</sup> See (b)(6); (b)(7)(C) email "ICE OPR Detainer Question," dated September 18, 2019; see also ACRIME Comment Date/Time field, dated May 1, 2019.

<sup>55</sup> *Ibid.* Because LPCADF could not locate that detainer at the time of this review, ERAU was unable to confirm if (b)(6); (b)(7)(C) notified LPCADF of a possible detainer on May 1, 2019.

<sup>56</sup> See Download Details report, entry dated May 1, 2019.

<sup>57</sup> LPCADF housed SINGH in its juvenile cell, which is located in a small secluded area of the facility where no other cells exist; the cell was equipped with a call button/intercom device. LPCADF uses the juvenile cell as overflow when the intake cells are occupied and when individuals need to be placed in protective custody. During his telephonic interview with MCSO detectives on May 22, 2019, (b)(6); (b)(7)(C) stated SINGH consistently used the call button that connected him with the LPCADF Tower Control (central control) in Booking to report he could not breathe. (b)(6); (b)(7)(C) further explained that he thought SINGH may have been claustrophobic and that when he would check on SINGH in the juvenile cell, he did not sense any issues with the air but added that in his experience inmates often claim health issues that may or may not be valid to simply get out of the cell. Additionally, (b)(6); (b)(7)(C) told MCSO detectives SINGH may have been housed in the juvenile cell because the facility already had two inmates on suicide watch in the two single cells located within the intake/booking area.

May 2, 2019

At 7:18 a.m., an unknown officer conducted a security round<sup>58</sup> of the two medical cells immediately adjacent to the juvenile cell SINGH was housed in, separated by a secure door, but did not record a security round of the juvenile cell.

At approximately 9:28 a.m.,<sup>59</sup> as Officer (b)(6); (b)(7)(C) was completing his morning duties, which included ensuring county inmates and ICE detainees were housed appropriately, he noticed LPCADF staff had not completed SINGH's booking and classification assessment since his arrival. Officer (b)(6); (b)(7)(C) then escorted SINGH from his cell to the booking area.

For the first five minutes of their encounter, Officer (b)(6); (b)(7)(C) attempted to communicate with SINGH in Punjabi using Google Translate, without success.<sup>60</sup> Officer (b)(6); (b)(7)(C) stated that SINGH looked at him like he was crazy when he asked SINGH if he could understand what he was typing. SINGH was able to communicate his desire for the officer to call a telephone number he had when he was arrested. SINGH then cupped his hand and motioned as if he were putting a mask over his mouth and nose, appearing to breathe with difficulty. When Officer (b)(6); (b)(7)(C) asked if SINGH needed oxygen, SINGH repeated the same gesture. Officer (b)(6); (b)(7)(C) was unable to understand what SINGH was trying to communicate.

At approximately 9:33 a.m.,<sup>61</sup> Officer (b)(6); (b)(7)(C) left the booking area to find medical staff, but as they were not in their office, he proceeded to Dispatch, who gave him the telephone number and password for the county's interpretation services provider. As Dispatch notified Officer (b)(6); (b)(7)(C) their language line most likely did not have a Punjabi interpreter, he did not attempt to call the language line.

At approximately 9:49 a.m.,<sup>62</sup> Officer (b)(6); (b)(7)(C) returned to the booking area with SINGH's property bag. Within SINGH's backpack was an address book SINGH used to identify three names and numbers. Officer (b)(6); (b)(7)(C) then requested LP (b)(6); (b)(7)(C), who was in the booking area at that time, be present while he called to see if the individuals whose names SINGH identified could interpret for him.

An unknown male individual,<sup>63</sup> who spoke English, answered the number Officer (b)(6); (b)(7)(C) called and spoke with SINGH for approximately 30 seconds in another language before the officer took over

<sup>58</sup> See Download Details, entry dated May 2, 2019. The wands LPCADF staff use to electronically log rounds they conduct do not log who conducted the round. Additionally, as medical staff does not possess a wand, their rounds are not logged unless done so manually.

<sup>59</sup> ERAU is unable to confirm the accuracy of this time as the LPCADF booking area video is not time stamped; however, the video file was labeled 9:28 a.m., which aligns with Officer (b)(6); (b)(7)(C) on May 7, 2019, LPCSO incident statement narrative timeline of events. ERAU has chronologically timed events related to this encounter based on the booking area surveillance footage and the time that elapsed between 9:28 a.m. and subsequent events.

<sup>60</sup> See booking area surveillance footage, dated May 2, 2019; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019; ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>61</sup> *Ibid.*

<sup>62</sup> *Ibid.*

<sup>63</sup> As Officer (b)(6); (b)(7)(C) did not retain a copy of the names of the individuals who he called for SINGH, he was uncertain of their names or relationship to SINGH when asked by ERAU. Although he provided a copy of the individuals' names and numbers to SINGH, ERAU was unable to review SINGH's property to determine who the officer called as Sgt.



the call.<sup>64</sup> The individual on the telephone notified Officer (b)(6); (b)(7)(C) that he was in route to post SINGH's bond, and the officer informed the individual he had been notified that morning ICE had lodged a detainer against SINGH.

At approximately 9:58 a.m.,<sup>65</sup> Sgt. (b)(6); (b)(7)(C) brought SINGH's booking file to the computer desk in the booking area where SINGH, Officer (b)(6); (b)(7)(C) were congregated, but could not locate the ICE detainer. With the individual still on the phone, Officer (b)(6); (b)(7)(C) asked him about the gesture SINGH had made several times and if SINGH had any medical conditions the individual was aware of. The individual said SINGH was fine and only needed Tylenol for back pain. As SINGH was receiving normal food at the facility, but not eating, (b)(6); (b)(7)(C) asked the individual about allergies to any medications or food.<sup>66</sup> The individual responded that SINGH was a vegetarian, did not have any allergies to food or medication, and that he was about two to three hours away and hoped they would have the matter about the detainer resolved by the time he arrived.<sup>67</sup> (b)(6); (b)(7)(C) asked no other questions related to SINGH's medical or mental health history.<sup>68</sup>

At approximately 10:00 a.m.,<sup>69</sup> Officer (b)(6); (b)(7)(C) handed SINGH a piece of paper with the names and numbers of the three individuals he previously wrote down and escorted SINGH back to his cell.

At 10:38 a.m., Officer (b)(6); (b)(7)(C) completed SINGH's initial classification assessment.<sup>70</sup> Officer (b)(6); (b)(7)(C) applied a risk classification of maximum based on SINGH's criminal charges of sexual assault and assault from his recent arrest.<sup>71</sup> Officer (b)(6); (b)(7)(C) also filled out the Alcohol and Drug Abuse section of the form recording that SINGH had "no social, economic, or legal problems related to abuse" but clarified for the ERAU review team that he filled that portion out solely based on SINGH's criminal history.<sup>72</sup> Officer (b)(6); (b)(7)(C) did not obtain supervisory approval of the assessment, but per CDF (b)(6); (b)(7)(C) and facility policy, supervisors are not required to review classification decisions at LPCADF.<sup>73</sup>

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Thomas Moore processed SINGH's property and sent it to the ERO Yuma sub-office prior to ERAU's site visit. As documented on the La Paz County Bail Receipt and Release Order, an individual named Jagroop Singh posted SINGH's \$5,000 bond.

<sup>64</sup> See LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

<sup>65</sup> See booking area surveillance footage, dated May 2, 2019; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

<sup>66</sup> See LPCADF CorEMR Chart Notes late entry for May 2, 2019, dated May 7, 2019.

<sup>67</sup> *Id.*; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

<sup>68</sup> ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019. (b)(6); (b)(7)(C) stated during the call between the individual on the other end of the phone, him, (b)(6); (b)(7)(C) and SINGH, he was not sure if the individual on the phone was conveying everything SINGH was telling them as the individual and SINGH continued to talk back-and-forth with each other outside of prompted questions.

<sup>69</sup> See booking area surveillance footage, dated May 1, 2019; see also LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

<sup>70</sup> See LPCSO Formal Classification Assessment form, dated May 2, 2019.

<sup>71</sup> *Ibid.*

<sup>72</sup> *Ibid.*; ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>73</sup> ERAU interview with CDF (b)(6); (b)(7)(C) dated June 18, 2019.



Officer (b)(6); (b)(7)(C) also completed a Segregated Housing Order assigning SINGH to protective custody in H Pod based on SINGH's sexual assault charge.<sup>74</sup> Officer (b)(6); (b)(7)(C) erroneously documented on the form that SINGH's arrest date was May 1, 2019, and signed the order as the approving authority. CDR (b)(6); (b)(7)(C) informed ERAU that although the form lists Shift Supervisor, Command Staff, and Medical as authorized approving authorities, officers do not obtain approval to assign inmates or detainees to segregation in practice.<sup>75</sup> As the inmate/detainee signature area on the form was also left blank, Officer (b)(6); (b)(7)(C) explained that inmates and detainees at LPCADF do not typically sign for anything except property when they leave. He went on to state that LPCADF has inmates/detainees sign the segregation order form on a case-by-case basis, for instance, if an inmate or detainee requested to be placed in segregation or protective custody.<sup>76</sup>

Officer (b)(6); (b)(7)(C) documented on the form that the time of protective custody placement in H Pod was 10:00 a.m.; however, LPCADF staff did not transfer SINGH from the juvenile cell to H Pod prior to the medical emergency that occurred approximately eight hours later that day. Officer (b)(6); (b)(7)(C) stated SINGH was pending medical clearance to H pod.<sup>77</sup>

At 10:51 a.m., LPN (b)(6); (b)(7)(C) entered a system alert for a vegetarian diet for SINGH.<sup>78</sup>

At 3:13 p.m., LPN (b)(6); (b)(7)(C) entered an electronic task in CorEMR for daily nursing segregation rounds until Wednesday, May 15, 2019.<sup>79</sup> ERAU notes there was no documentation provided to support that nursing staff completed a round prior to the medical emergency.<sup>80</sup>

At an unknown time, two individuals, who identified themselves as (b)(6); (b)(7)(C) arrived at LPCADF to post SINGH's bond.<sup>81</sup> During the process to bond SINGH out of La Paz County custody, Detective (b)(6); (b)(7)(C) (first name unknown) notified (b)(6); (b)(7)(C) that ICE may have lodged a detainer against SINGH.

At 3:59 p.m., ICE D (b)(6); (b)(7)(C) faxed LPCADF SINGH's DHS Form I-247A, DHS Form I-216, and Department of Justice (DOJ) Form I-203A, Order to Detain or Release Alien.<sup>82</sup>

At this point, S (b)(6); (b)(7)(C) told (b)(6); (b)(7)(C) that if he posted SINGH's bond, SINGH would remain at LPCADF until ICE transported him to another ICE detention facility.<sup>83</sup> (b)(6); (b)(7)(C)

<sup>74</sup> See LPSCO-ADF Segregated Housing Order, dated May 2, 2019. The H Pod maintains five individual cells with showers.

<sup>75</sup> ERAU interview with CDR (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>76</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019. ERAU notes Facility Policy 2.6, Special Management Inmates, clarifies county inmates' signatures are not required when they are placed on protective segregation status.

<sup>77</sup> See LPCSO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 7, 2019.

<sup>78</sup> See CorEMR Alert History, entry dated May 2, 2019.

<sup>79</sup> See CorEMR Tasks, entry dated May 2, 2019.

<sup>80</sup> During his interview on June 18, 2019, CDR Suffle stated medical did not have a wand to electronically record their rounds.

<sup>81</sup> See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019. ERAU was unable to confirm the identities of these individuals as LPCADF did not copy the identification the individuals presented to (b)(6); (b)(7)(C) during his Credible Fear interview with a USCIS officer on March 27, 2019, SINGH stated if he were released from custody, he would live with his family friend (b)(6); (b)(7)(C), in the U.S.

<sup>82</sup> See DHS Form I-247A, dated May 2, 2019; see also DHS Form I-216, dated May 2, 2019; see also DOJ Form I-203A, dated May 2, 2019; see also Fax Confirmation 19286695442, dated May 2, 2019

<sup>83</sup> See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.



stated he needed to make a few calls, then returned affirming SINGH's family still wished to post his bond.

At 4:25 p.m., (b)(6); (b)(7)(C) sent an email to (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C), to inform them SINGH was ready for release to ICE. (b)(6); (b)(7)(C) requested they transport SINGH to the ERO Yuma Sub-Office the next day.<sup>84</sup>

Once (b)(6); (b)(7)(C) finished processing SINGH's bond,<sup>85</sup> (b)(6); (b)(7)(C) asked if he and the other individual with him would be able to visit with SINGH.<sup>86</sup> Although according to (b)(6); (b)(7)(C) facility policy protocol dictates visitors should make their requests to visit 24-hours in advance, (b)(6); (b)(7)(C) made an exception, as (b)(6); (b)(7)(C) stated they had traveled from Fresno, California. (b)(6); (b)(7)(C) if they could ask SINGH about any medical issues he had so that he could advise medical staff. (b)(6); (b)(7)(C) agreed.

At approximately 4:27 p.m.,<sup>87</sup> (b)(6); (b)(7)(C) escorted SINGH to the visitation room for a non-contact visit. A minute later, SINGH's two visitors entered the other side of the visitation room, which is separated by glass windows. After some difficulties with the visitor station phones, SINGH sat down at phone station two and spoke with the two individuals for approximately 35 minutes, or until approximately 5:03 p.m. Once the two individuals left the visitation room, they handed (b)(6); (b)(7)(C) a piece of paper that stated, "breathing problem, nose needs surgery and back pain."<sup>88</sup> As SINGH did not appear to have any life-threatening issues, (b)(6); (b)(7)(C) saved the piece of paper to provide to medical staff after evening pill call.<sup>89</sup>

In order for SINGH to be released from La Paz County custody into ICE custody, he first had to post the bond related to his criminal charges. Consequently, at 4:39 p.m., SINGH's custody status changed from a La Paz County inmate to an ICE detainee housed at LPCADF when (b)(6); (b)(7)(C) posted SINGH's bond.<sup>90</sup>

At approximately 5:13 p.m., before (b)(6); (b)(7)(C) escorted SINGH back to his cell from the visitation room, (b)(6); (b)(7)(C) gestured for SINGH to sign a document, and SINGH complied.<sup>91</sup> SINGH then pointed at the air vent on the wall, and again made the same gesture placing his hand, in the shape of a mask, over his nose and mouth, and panted heavily.

<sup>84</sup> See (b)(6); (b)(7)(C) email: 'Transportation – Subject at LPCJ,' dated May 2, 2019.

<sup>85</sup> See CDR (b)(6); (b)(7)(C) email: 'Surveillance Footage Request,' dated September 12, 2019.

<sup>86</sup> See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.

<sup>87</sup> See CAM 16 visitor area surveillance footage, dated May 2, 2019. As LPCADF's surveillance system was not synced properly, ERAU created an estimated timeline of events, working back from when EMS arrived to SINGH's cell at 6:03 p.m., as confirmed by both the EMS report and (b)(6); (b)(7)(C) body camera footage. The LPCADF surveillance system time stamped different camera angles with times that were not possible based on confirmed events, such as the arrival time of EMS and the length of time SINGH was in his cell between Sgt. Donahue returning him from the visitation room and EMS' arrival (approximately 48 minutes between events).

<sup>88</sup> See LPCSO Incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.

<sup>89</sup> *Id.* Pill call refers to the daily time medical staff distributes medications to detainees requiring medication.

<sup>90</sup> See CDR (b)(6); (b)(7)(C) email: 'Surveillance Footage Request,' dated September 12, 2019.

<sup>91</sup> See CAM 16 visitor area surveillance footage, time stamped between 5:00 p.m. and 5:48 p.m. ERAU notes the document could not be identified through the footage. According to CDR (b)(6); (b)(7)(C) the document was most likely related to SINGH's bond or court paperwork. See also CDR (b)(6); (b)(7)(C) email: 'SINGH Questions,' dated September 19, 2019.



On the way back to his cell, SINGH stopped at the intake clothing rack and pointed to his feet. As he was not wearing socks under his clog footwear (b)(6); (b)(7)(C) provided SINGH with a pair of socks before returning him to his cell.<sup>92</sup>

At approximately 5:15 p.m., (b)(6); (b)(7)(C) escorted SINGH into his cell.<sup>93</sup>

The following times are based on the surveillance footage from the camera in SINGH's cell, unless stated otherwise.<sup>94</sup>

At approximately 5:31 p.m., SINGH entered the shower unit in the corner of his room, fully clothed, holding socks.

At approximately 5:38 p.m., SINGH placed his folded bunkbed mattress on the upper bunk and a minute later, drank a cup of water from his sink.

At approximately 5:43 p.m., SINGH appeared to crouch over in front of his bunkbed. This is the last movement that can be seen in the distorted video footage.

LPCADF did not record any security rounds of the juvenile cell on this date.<sup>95</sup> According to CDR (b)(6); (b)(7)(C) officers conduct rounds every hour but do not always use the facility wands that electronically record their rounds, which is why, he explained, the LPCSO Jail Event Summary report he provided ERAU included limited information. When asked about specific post orders officers follow, CDR Suffle stated there had been none in place since 2010 or 2011.<sup>97</sup>

At approximately 5:50 p.m.,<sup>98</sup> as Officer (b)(6); (b)(7)(C) was serving evening meals with county inmate (b)(6); (b)(7)(C) county inmate (b)(6); (b)(7)(C) approached SINGH's cell and informed Officer (b)(6); (b)(7)(C) that SINGH had hanged himself. (b)(6); (b)(7)(C) walked to the

<sup>92</sup> (b)(6); (b)(7)(C) told MCSO detectives inmates are given one pair of socks at intake, and another pair when housed; however, because booking staff did not document clothing items issued to SINGH upon arrival, ERAU cannot verify whether he received a pair of socks when admitted. See MCSO Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C) dated May 2, 2019.

<sup>93</sup> See Camera 6 Surveillance Footage, time stamped 5:47 p.m. to 5:49 p.m., dated May 2, 2019.

<sup>94</sup> ERAU notes, as the quality of the surveillance footage from the one operational camera in SINGH's cell was extremely poor, SINGH is not in clear view for most of the video and it was extremely difficult to decipher the events that transpired. See Juvenile Cell Surveillance Footage, from May 2, 2019.

<sup>95</sup> See Download Details report, entry dated May 1, 2019; see also LPCSO Jail Event Summary Report, dated May 2, 2019 - May 4, 2019.

<sup>96</sup> ERAU interview with CDR (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>97</sup> See CDR Suffle email: 'Post Orders,' dated May 15, 2019.

<sup>98</sup> See LPCSO Incident Narrative by Sgt. Donahue, dated May 2, 2019; see also LPCSO incident narrative by Officer (b)(6); (b)(7)(C) dated May 2, 2019. Officer (b)(6); (b)(7)(C) stated this occurred at approximately 5:40 p.m.; however, (b)(6); (b)(7)(C) stated it occurred at approximately 5:50 p.m., which aligns more appropriately with confirmed events, such as when EMS was called at 5:58 p.m.

<sup>99</sup> Officer (b)(6); (b)(7)(C) informed MCSO Detectives that although she was not a certified officer, LPCADF allowed her to work on her own in Tower Control and to serve meals to inmates and detainees. During her interview with ERAU on June 18, 2019, Officer (b)(6); (b)(7)(C) stated she was unaware of the proper procedures in the event of a medical emergency as she was not slated to start academy training until August 2019. See MCSO Incident Report 19-016384 interview transcript with Officer (b)(6); (b)(7)(C) dated May 2, 2019; see also LPCSO incident Narrative by (b)(6); (b)(7)(C) dated May 2, 2019.



window and saw SINGH's pale face with his eyes open; she ran from the medical wing to intake where (b)(6); (b)(7)(C) was booking a new inmate and stated, "It's bad." (b)(6); (b)(7)(C) then ran to SINGH's cell, and at approximately 5:56 p.m., SINGH's cell door opened (b)(6); (b)(7)(C) then ran back out of the cell to give instructions to staff, and asked (b)(6); (b)(7)(C) responded to SINGH's cell with him, to go to Dispatch and notify them of the situation.<sup>100</sup> (b)(6); (b)(7)(C) told Officer (b)(6); (b)(7)(C) to relieve (b)(6); (b)(7)(C) in Tower Control so (b)(6); (b)(7)(C) could assist him.

At approximately 5:57 p.m., (b)(6); (b)(7)(C) stood near the base of the bunk bed and looked towards SINGH. (b)(6); (b)(7)(C) then called for medical over the radio.<sup>101</sup> When (b)(6); (b)(7)(C) returned to SINGH's cell, he (b)(6); (b)(7)(C) pulled SINGH's legs out from under the bunk, stabilized his body and neck, and then (b)(6); (b)(7)(C) put SINGH down using a knife rather than a cut down tool.<sup>102</sup> Cardiopulmonary resuscitation (CPR) efforts alternated between (b)(6); (b)(7)(C)

When asked by ERAU why he did not immediately call a medical emergency over the radio and, pending arrival for assistance, lift SINGH upward to relieve pressure on his neck, (b)(6); (b)(7)(C) said he believed SINGH was already deceased. (b)(6); (b)(7)(C) reported seeing no signs of life and stated SINGH appeared gray in color, was foaming at the mouth, and had urinated on himself.<sup>103</sup>

At 5:58 p.m., EMS received a call from LPCADF about a potential suicide.<sup>104</sup>

At approximately 6:01 p.m., (b)(6); (b)(7)(C) entered SINGH's cell.<sup>105</sup> (b)(6); (b)(7)(C) stated when she saw an officer running, she knew something was happening, then was directed to the booking area per a call over the radio. LPSCO inmates directed her where to go because she stated no one told her exactly where to be.<sup>106</sup>

<sup>100</sup> See Juvenile Cell Surveillance Footage, from May 2, 2019; see also MCSO Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C), dated May 2, 2019. LPCADF did not provide ERAU with the Tower Control Logbook, which would have recorded the time 911 was called and subsequent events relating to EMS's arrival and departure.

<sup>101</sup> See MCSO Incident Report 19-016384 interview transcript with (b)(6); (b)(7)(C), dated May 2, 2019.

<sup>102</sup> See Sgt. (b)(6); (b)(7)(C) body camera footage, dated May 2, 2019. SINGH's bedsheets appear to be tied around the upper bunk's frame while SINGH's socks appeared to have been tied around his neck to the sheets. When asked about the knife by MCSO detectives, (b)(6); (b)(7)(C) stated he had retrieved it from a box behind the booking desk in order to cut SINGH down from the bunk. He said the knife, which the MCSO evidence list documents is a Zombie Killer folding knife, was in the box because he had not had a chance to dispose of it. (b)(6); (b)(7)(C) explained that in the commotion of the emergency, he told Officer (b)(6); (b)(7)(C) get the cut-down tool, but realized that as a new employee, she may not know to what he was referring.

<sup>103</sup> ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>104</sup> See River Medical Pre-Hospital Care Report, dated May 2, 2019.

<sup>105</sup> See Juvenile Cell Surveillance Footage, from May 2, 2019.

<sup>106</sup> ERAU interview with (b)(6); (b)(7)(C) dated June 18, 2019.

At 6:02 p.m., (b)(6); (b)(7)(C) turned his body camera on<sup>107</sup> and EMS arrived at LPCADF where staff notified them SINGH was in cardiac arrest.<sup>108</sup>

The following times are based on (b)(6); (b)(7)(C) body camera footage,<sup>109</sup> unless stated otherwise:

At 6:02 p.m., while performing chest compressions, S (b)(6); (b)(7)(C) to retrieve the automatic external defibrillator (AED) device. (b)(6); (b)(7)(C) then used a knife to cut SINGH's shirt open and the ligature from around his neck.

At 6:03 p.m., EMS arrived at SINGH's cell and LPCADF staff informed them the facility was unaware of the last time anyone saw SINGH alive.<sup>110</sup> EMS immediately took over CPR, and within 40 seconds of arrival, adhered the AED pads to SINGH's chest.<sup>111</sup> The AED machine analyzed SINGH's heart rhythm after which time it directed CPR to continue. EMS documented SINGH's blood pressure as 0/0 at this time.<sup>112</sup>

At 6:05 p.m., (b)(6); (b)(7)(C) took over CPR from the paramedics, as they started a peripheral intravenous line (IV);<sup>113</sup> CPR switched off between (b)(6); (b)(7)(C) and the paramedics several times.

At 6:08 p.m., a paramedic stated that whoever called EMS did not mention anything about CPR being in process. (b)(6); (b)(7)(C) then stated, "it did not come over the radio very well" to which the paramedic responded in concurrence, "[inaudible] it was attempted."

At 6:12 p.m., (b)(6); (b)(7)(C) assisted a paramedic with attaching an oxygen tank to the bag valve mask (BVM) providing rescue breaths to SINGH.<sup>114</sup>

At 6:16 p.m., paramedics lifted SINGH onto a gurney and continued his CPR as they moved through the facility to the ambulance.

At 6:18 p.m., paramedics lifted SINGH into the ambulance.

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<sup>107</sup> During his interview with ERAU on June 18, 2019, (b)(6); (b)(7)(C) stated he was in the Sheriff's office (where the facility is located) when Dispatch advised there was an attempted suicide. He went back to check on the situation, as he thought the situation had already been handled since Dispatch said it was an "attempted" suicide. (b)(6); (b)(7)(C) stated although he was told he would be interviewed the week after the incident, he was not, and no one requested he write an incident report.

<sup>108</sup> See River Medical Pre-Hospital Care Report, dated May 2, 2019.

<sup>109</sup> See Sgt. Maya body camera footage, dated May 2, 2019.

<sup>110</sup> See River Medical Pre-Hospital Care Report, dated May 2, 2019.

<sup>111</sup> Five days after the medical emergency, (b)(6); (b)(7)(C) documented that she retrieved the AED and applied the AED pads, resulting in a no shock analysis. The River Medical EMS report also states an AED was used prior to EMS arrival, without defibrillation. To the contrary, (b)(6); (b)(7)(C) body camera footage shows that approximately 30 seconds before the EMS responders arrive, (b)(6); (b)(7)(C) to retrieve the AED. In order for (b)(6); (b)(7)(C) to apply the AED pads, SINGH's shirt would first have to be removed to properly adhere the AED pads. Seconds later, Sgt. Maya cuts SINGH's shirt off. When SINGH's chest is exposed, there are no AED pads present. Within seconds, EMS is on scene and shortly thereafter applies AED pads. See CorEMR Chart Notes, entry dated May 7, 2019.

<sup>112</sup> See River Medical Pre-Hospital Care Report Vital Signs, dated May 2, 2019.

<sup>113</sup> *Ibid.*

<sup>114</sup> A BVM, also known as an AMBU (Artificial Manual Breathing Unit) bag, is a hand-held device commonly used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.



At 6:26 p.m., EMS left the facility for LPRH with SINGH still in asystole,<sup>115</sup> where they arrived approximately four minutes later.<sup>116</sup>

The LPRH nursing record documented the reason for SINGH's arrival to the emergency department (ED) as a suicide attempt by hanging.<sup>117</sup> The ED recorded SINGH's date of birth as May 29, 1987, listed five current medications, and stated he had a history of a prior suicide attempt and depression, all of which were inconsistent with SINGH's facility medical record.<sup>118</sup>

At approximately 6:30 p.m., (b)(6); (b)(7)(C) requested LPCSO Patrol Deputy (b)(6); (b)(7)(C) report to the hospital where EMS had transported SINGH.<sup>119</sup> At an unknown time, but shortly after Deputy (b)(6); (b)(7)(C) arrival, LPRH medical staff notified Deputy (b)(6); (b)(7)(C) that SINGH had a pulse and would be airlifted to AWC.

At approximately 6:50 p.m., ED personnel placed SINGH on a ventilator.<sup>120</sup>

At 6:53 p.m., LPRH (b)(6); (b)(7)(C) called AWC to transfer SINGH to a higher acuity care facility.<sup>121</sup>

At 7:11 p.m., Trauma Surgeon (b)(6); (b)(7)(C) at AWC accepted SINGH's transfer to her ED, and Dr. Dressler provided transfer documentation.<sup>122</sup>

At 7:21 p.m., a Native Air flight in Lake Havasu City, AZ, was dispatched.<sup>123</sup> Thirty-one minutes later, the Native Air flight arrived at LPRH. The hospital provided the same medical history it had to the Native Air medical staff.

At 9:08 p.m., the flight departed LPRH for AWC. Deputy (b)(6); (b)(7)(C) stayed at the hospital until the flight departed. Along the way, medical staff continued assisting SINGH's breathing with a BVM and monitored his blood pressure and end-tidal CO<sub>2</sub> (ETCO<sub>2</sub>); however, he was expelling copious amounts of frothy sputum<sup>124</sup> from the endotracheal tube.<sup>125</sup>

<sup>115</sup> Asystole refers to total cessation of the heart's electrical activity, also referred to as flatline on a heart monitor.

<sup>116</sup> See River Medical Pre-Hospital Care Report, dated May 2, 2019.

<sup>117</sup> See LPRH ED Record, dated May 2, 2019.

<sup>118</sup> *Ibid.* It is unclear why the hospital recorded SINGH's date of birth as May 29, 1987. Furthermore, the medications listed were: Clonazepam 1 tablet, daily; Divalproex SOD, (500 mg) 2 tablets at bedtime; Doxepin (100 mg), 1 capsule at bedtime; Olanzapine (10 mg), 1 tablet at bedtime; and Prazosin (2 mg), 1 capsule at bedtime; all but one (i.e. Prazosin) are typically prescribed to treat mental health conditions. Although the medication source field stated "patient/family," the hospital also documented it was unable to verify the medications or the source of the information.

<sup>119</sup> LPCSO did not provide continuous custody supervision of SINGH after he left LPCADF in the ambulance or after he left LPRH. See Law Supplemental Narratives by Deputy (b)(6); (b)(7)(C) dated July 25, 2019.

<sup>120</sup> A ventilator is a breathing machine that provides a patient with oxygen when they are unable to breathe on their own. As the hospital records list three separate times related to when the hospital placed SINGH on a ventilator, ERAU has listed the provided time as an approximate. See LPRH ED Record, dated May 2, 2019.

<sup>121</sup> See LPRH ED Record, dated May 2, 2019.

<sup>122</sup> See Request Consent Transfer - Certification for Transfer form, dated May 2, 2019.

<sup>123</sup> See Native Air Arizona Flight Number FV19-061637 report, dated May 2, 2019. According to the Native Air Arizona Flight Number FV19-061637 report, the estimated drive time to the hospital was 180 minutes versus a 50-minute flight.

<sup>124</sup> Sputum is mucous coughed up from the respiratory tract.

<sup>125</sup> See Native Air Arizona Flight Number FV19-061637 report, dated May 2, 2019.

At approximately 9:10 p.m., CDR (b)(6); (b)(7)(C) called ERO Yuma sub-office DO (b)(6); (b)(7)(C) and notified them SINGH had just attempted suicide and was at the hospital.<sup>126</sup>

At 9:57 p.m., the flight from LPRH arrived at AWC.<sup>127</sup>

At 10:03 p.m., AWC medical staff assessed SINGH and documented he presented with an altered mental state and was in critical condition.<sup>128</sup>

At approximately 11:00 p.m., LPCAD (b)(6); (b)(7)(C) arrived to AWC to provide custody supervision.<sup>129</sup> Officer (b)(6); (b)(7)(C) documented that both he and (b)(6); (b)(7)(C) reported to SINGH's room when they arrived and then approximately 30 minutes later, Sgt. (b)(6); (b)(7)(C) departed to check into a local hotel as (b)(6); (b)(7)(C) as to provide vigil until 8:00 a.m. when (b)(6); (b)(7)(C) would relieve him.<sup>130</sup> (b)(6); (b)(7)(C) reported from about midnight until 1:00 a.m., nurses were entering the room to perform routine checks and then suddenly SINGH's blood pressure dropped.<sup>131</sup>

### DAY OF DEATH – MAY 3, 2019

At 1:43 a.m. (b)(6); (b)(7)(C) documented she was called to SINGH's bedside for a code event, at which time medical staff performed advanced cardiac life support measures. (b)(6); (b)(7)(C) documented that, "Given the extremis [sic] of this patient and subsequent multiorgan system failure secondary to prolonged hypoxia and shock, we will provide supportive care up until the patient suffers another code event at which point we will withdraw care as the current measures are becoming futile." After multiple resuscitation attempts, SINGH succumbed to his injuries.<sup>133</sup>

At 1:58 a.m. (b)(6); (b)(7)(C) pronounced SINGH's death. The preliminary cause of death was cardiac arrest from complications of asphyxia.<sup>134</sup>

At 3:18 a.m., SINGH's body was transported to the morgue.<sup>135</sup>

<sup>126</sup> See IC (b)(6); (b)(7)(C) email: 'Be advised!', dated May 2, 2019.

<sup>127</sup> See Native Air Arizona Flight Number FV19-061637 report, dated May 2, 2019.

<sup>128</sup> See AWC Emergency/Urgent Care Note, dated May 2, 2019.

<sup>129</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated June 18, 2019; *see also* LPSCO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 9, 2019.

<sup>130</sup> During his interview with ERAU on June 18, 2019, Officer (b)(6); (b)(7)(C) stated none of SINGH's friends or relatives were present during the events that transpired. AWC documented that they made multiple attempts to get in touch with SINGH's next of kin by contacting the LPCSO but were told to call back in the morning. (b)(6); (b)(7)(C) did not keep a log of events as he kept watch at the hospital. (b)(6); (b)(7)(C) did not write an incident report.

<sup>131</sup> See LPSCO Supplemental Narrative by Officer (b)(6); (b)(7)(C) dated May 9, 2019.

<sup>132</sup> See AWC Progress Note, dated, May 3, 2019.

<sup>133</sup> See AWC Discharge Summary, dated May 10, 2019.

<sup>134</sup> *Ibid.*; *see also* Exhibit 2: State of Arizona Certificate of Death 102-2019-031160, certified May 4, 2019.

<sup>135</sup> See AWC Notification of Death, dated May 3, 2019. As (b)(6); (b)(7)(C) did not maintain a hospital log, many events that transpired outside of nurses' notes are unclear. During his interview with ERAU (b)(6); (b)(7)(C) stated he remained at AWC until approximately 3:00 or 4:00 a.m.



At approximately 7:46 a.m., ERO Phoenix notified ERO Headquarters of SINGH's death.<sup>136</sup>

At approximately 8:30 a.m., ERO Phoenix called the ICE OPR Joint Intake Center (JIC) to report SINGH's death.<sup>137</sup>

At approximately 10:00 a.m., ERO Phoenix reported SINGH's death to the DHS Office of Inspector General duty agent.<sup>138</sup>

At approximately 10:30 a.m., ERO Phoenix notified the Consulate General of India in San Francisco, California (CA), of SINGH's death.

At 1:14 p.m., the Maricopa County Forensic Science Center (MCFSC) accepted custody of SINGH's body.<sup>139</sup>

## POST DEATH EVENTS

**On May 8, 2019**, at an unknown time, the ERO Yuma sub-office documented receipt of SINGH's property, which LPCADF (b)(6); (b)(7)(C) closed out on May 3, 2019.<sup>140</sup>

**On May 7, 2019**, the Phoenix Field Office Director (FOD) wrote a letter to SINGH's parents, expressing his condolences, addressed to the Consulate General of India in San Francisco.<sup>141</sup>

**On May 10, 2019**, at 12:07 p.m., the MCFSC released SINGH's body to a local funeral home.<sup>142</sup>

**On June 17, 2019**, at approximately 2:58 p.m., the ERO Yuma sub-office shipped SINGH's property to the Consulate General of India in San Francisco, CA, whose staff signed for it on June 20, 2019.

**On July 31, 2019**, the Maricopa County Office of the Medical Examiner documented SINGH's cause of death as hanging and the manner of death as suicide.<sup>143</sup>

## FINDINGS

ERAU reviewed the medical care LPCADF provided SINGH, as well as their efforts to ensure he was safe and secure while detained at the facility. As a facility that houses ICE detainees for less than 72 hours, LPCADF is not contractually obligated to comply with all of the requirements of

<sup>136</sup> See ICE SIR, dated May 3, 2019.

<sup>137</sup> *Ibid.*

<sup>138</sup> *Ibid.*

<sup>139</sup> See Exhibit 3: Maricopa County Forensic Science Center: Record of Admission, dated May 3, 2019.

<sup>140</sup> See untitled LPSCO property form Disposition Release time, entry dated May 3, 2019; see also DOJ INS Baggage and Personal Effects of Detained Alien, Form I-43, and ICE Baggage Check (3882109), Form 12-I-77, dated May 8, 2019.

<sup>141</sup> See letter from ERO FOD Lucero addressed to "Parents of Mr. Simratpal Singh," dated May 7, 2019.

<sup>142</sup> See Exhibit 3: Maricopa County Forensic Science Center: Record of Admission, dated May 3, 2019.

<sup>143</sup> See Exhibit 4: Maricopa County Medical Examiner Report, case 19-03827, date signed July 31, 2019.

the ICE NDS 2000.<sup>144</sup> However, LPCADF is required to conduct a yearly ORSA<sup>145</sup> to assess the facility's compliance with certain requirements of the ICE NDS 2000.<sup>146</sup> For purposes of a comprehensive review, ERAU assessed LPCADF's compliance with the medical care, safety, and security standards within ICE NDS 2000, referred to the requirements outlined in the ORSA, and identified 23 areas of concern. These findings are noted for informational purposes only and should not be construed as contributory to the detainee's death.

1. LPCADF Detention Officer (b)(6); (b)(7)(C) was the first LPCADF staff member to discover SINGH's suicide, and (b)(6); (b)(7)(C) was a first responder. However, Officer (b)(6); (b)(7)(C) was not CPR-certified, and LPCADF was unable to provide a CPR certification card for (b)(6); (b)(7)(C). Moreover, (b)(6); (b)(7)(C) an LPCSO Patrol Sgt. who did not work for the facility but happened to be in the building at the time of the medical emergency, was the only individual who accompanied EMS the entire time they were at LPCADF, escorted them to the ambulance, and performed multiple rounds of CPR on SINGH, but also did not have a current CPR certification.

Relevant NDS 2000 component: *Medical Care*, Section (III)(H)(2): "Detention staff will be trained... this training will be provided by a responsible medical authority in cooperation with the Officer In Charge and will include the following: ... (2) The administration of first aid and CPR...."

2. LPCADF could not produce documentation demonstrating periodic refresher training occurred and did not produce curricula or lesson plans demonstrating that its initial training included the required topics. LPCADF security personnel reported they only received suicide prevention and intervention training during initial training, while LPCADF nursing staff reported they had never received suicide prevention and intervention training. Furthermore, Officer (b)(6); (b)(7)(C) had not yet received training prior to when she discovered SINGH.

Applicable ORSA component: *Suicide Prevention and Intervention*, Section (1): "Every new staff member receives suicide-prevention training. Suicide-prevention training occurs during the employee orientation program."

Relevant NDS 2000 component: *Suicide Prevention and Intervention*, Section (III)(A): "All staff will receive training, during orientation and periodically, in the following: recognizing signs of suicidal thinking, including suspect behavior; facility referral procedures; suicide-prevention techniques; and responding to an in-progress suicide attempt. All training will include the identification of suicide risk factors and the psychological profile of a suicidal detainee."

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<sup>144</sup> See U.S. DOJ, USMS Modification of Intergovernmental Agreement, dated June 4, 2002. This modification officially authorized ICE as a federal user agency on the USMS IGA contract with LPCADF.

<sup>145</sup> See Exhibit 5: LPCADF 2018 ORSA, dated September 13, 2018.

<sup>146</sup> The highest-ranking facility official, CDR (b)(6); (b)(7)(C) completed LPCADF's 2018 ORSA and found the facility fully compliant with all 29 of the 29 standards the ORSA covers. However, during ERAU's on-site review, he indicated he had never heard of the ICE NDS 2000.



3. Despite SINGH's inability to speak more than a few words of English, at no time did LPCADF staff utilize interpretation services. On April 30, 2019, LPCADF security staff did not document SINGH's primary language or the reason they did not complete SINGH's intake process. Additionally, (b)(6); (b)(7)(C) who conducted SINGH's initial assessment, was unable to complete the assessment due to the language barrier; nevertheless, she did not document the language barrier issue in SINGH's medical record until after his death. (b)(6); (b)(7)(C) also stated she was unaware LPCADF had a telephonic interpretation service until after SINGH's death. Furthermore, nursing staff, including the facility's longest tenured nurse, (b)(6); (b)(7)(C) said he had never used, nor was he aware that LPCADF had access to interpretation services.

Applicable facility policy: Receiving Screening/Assessment: "The receiving screening form is available in English and Spanish. Other language needs will utilize the language line."

Relevant NDS 2000 component: Medical Care, Section (III)(D): "If language difficulties prevent the health provider/officer from sufficiently communicating with the detainee for purposes of completing the medical screening, the officer shall obtain translation assistance. Such assistance may be provided by another officer or by a professional service, such as a telephone translation service."

4. During SINGH's initial assessment on April 30, 2019, (b)(6); (b)(7)(C) did not complete SINGH's medical and mental health screening or assess his suicide risk. Additionally, on May 2, 2019, two days after SINGH's admission to LPCADF, Officer (b)(6); (b)(7)(C) contacted individuals SINGH pointed out from his address book to interpret. During one phone conversation between SINGH, (b)(6); (b)(7)(C) and SINGH's English-speaking associate (b)(6); (b)(7)(C) did not take the opportunity to inquire about any known medical or mental health history, or possible suicidal ideation. Pursuant to the conversation, LPN (b)(6); (b)(7)(C) entered a task order for a vegetarian diet but did not enter a chart note about the encounter until May 7, 2019, after SINGH's death.

Applicable ORSA components:

*Admission and Release, Section 2:* "Medical screenings are performed by medical staff or persons who have received specialized training for the purpose of conducting an initial health screening."

*Medical Care, Section 2:* "The facility's in-processing procedures for arriving detainees include medical screening."

Applicable facility policies:

*Receiving Screening/Assessment:* "The receiving screening will be preformed [sic] immediately upon inmates' arrival into the booking area."

*Suicide Prevention & Intervention, Identification*, Section 5.2.1.2: “Every arrival into this facility shall be evaluated for risk indicators.” Risk indicators according to Section 5.2.1.3 are: “additional charges, sentencing, receiving bad news, embarrassing or very serious charges.”

Relevant NDS 2000 components:

*Medical Care*, Section (III)(D): “All new arrivals shall receive initial medical and mental health screening immediately upon their arrival by a health care provider or an officer trained to perform this function. This screening shall include observation and interview items related to the detainee’s potential suicide risk and possible mental disabilities, including mental illness and mental retardation”

*Suicide Prevention and Intervention*, Section (III)(B): “Suicide potential will be an element of the initial health screening of a new detainee, conducted by either the health care provider or a specially trained officer.”

5. On April 30, 2019, during (b)(6); (b)(7)(C) initial assessment of SINGH, she took vitals and scheduled SINGH’s TB testing for seven days following his arrival.

Applicable ORSA component: *Access to Medical Care*, Section 5: “Medical screening includes a Tuberculosis (TB) test.”

Relevant NDS 2000 component: *Medical Care*, Section (III)(D): “All new arrivals shall receive TB screening by PPD (mantoux method) or chest x-ray... If the initial screening is negative, the detainee will be allowed to join the general population.”

6. SINGH did not sign a general consent for medical treatment at any point during his detention at LPCADF.

Relevant NDS 2000 component: *Medical Care*, Section (III)(L): “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.”

7. LPCADF’s single-room medical clinic does not have a curtained area for patient privacy. MCSO detectives, who investigated SINGH’s death, interviewed an inmate worker who reported overhearing medical information being exchanged in the clinic as the laundry room, staffed by inmate workers, is right beside the clinic.

Relevant NDS 2000 component: *Medical Care*, Section (III)(M): “All medical providers shall protect the privacy of detainees’ medical information to the extent possible while permitting the exchange of health information required to fulfill program responsibilities and to provide for the well-being of detainees.”

8. According to CDR (b)(6); (b)(7)(C) LPCADF has not maintained post orders since 2010 or 2011.



Relevant NDS 2000 component: *Post Orders*, Section (III)(A) and (D): “Written orders shall specify the duties of each post in the facility, along with the procedures to be followed in carrying out those duties.”; and “Post orders will be kept current at all times. Post orders will be reviewed and updated yearly or sooner when deemed necessary.”

9. CDR (b)(6); (b)(7)(C) confirmed that LPCADF does not have a formal orientation process for detainees. Additionally, the LPCADF local handbook, geared mostly towards inmates, was only available in English on kiosks located in the facility housing units, not in the cell where SINGH was located. Due to the language barrier, SINGH had no access to information about facility operations, including how to access healthcare. Moreover, the facility had neither electronic nor physical copies of the ICE National Detainee Handbook in any of the 11 available languages, including Punjabi, the language SINGH spoke.

Applicable ORSA components:

*Admission and Release*, Section (1): “In-processing includes an orientation of the facility.”

*Detainee Handbook*, Section (1): “The detainee handbook is written in English and translated into Spanish, or into the next most-prevalent language(s).”

Relevant NDS 2000 components:

*Admission and Release*, Section (III)(A)(1) and (K): “The orientation process supported by a video (INS) and handbook shall inform new arrivals about facility operations, programs, and services;” and, “Upon admission every detainee will receive a detainee handbook. It will fully describe all policies, procedures, and rules in effect at the facility, in accordance with the Detainee Handbook standard.”

*Detainee Handbook*, Section (E): “The handbook will be written in English and translated into Spanish and, if appropriate, into the next most-prevalent language(s) among the facility’s detainees. The OIC will provide translation assistance to detainees exhibiting literacy or language problems and those who request it. This may involve translators from the private sector or from the detainee population.”

10. There is no record (b)(6); (b)(7)(C) issued SINGH clothing, bed linens, towels or hygiene items upon his arrival to LPCADF.

Applicable ORSA components:

*Admission and Release*, Sections (8) and (9): “(8) Detainees are issued appropriate and sufficient clothing and bedding for climatic conditions; and (9) The facility provides and replenished personal hygiene items as needed.”

*Issuance and Exchange of Clothing, Bedding, and Towels*, Sections (1) and (2): “(1) All new detainees are issued clean, temperature-appropriate, presentable clothing during in-processing; and (2) New detainees are issued clean bedding, linens, and a towel.”

Relevant NDS 2000 components:

*Admission and Release*, Section (III)(A)(2): “Staff will issue arriving detainees personal hygiene items, clothing, sheets and blankets appropriate for local weather conditions.”

*Issuance and Exchange of Clothing, Bedding, and Towels*, Sections (B) and (C): “(B) All new detainees shall be issued clean, temperature-appropriate, presentable clothing during in-processing; and (C) All new detainees shall be issued clean bedding, linens and towels.”

11. LPCADF personnel did not document SINGH’s assignment to the juvenile cell during or following booking, including when or why they placed him in that cell, nor was supervisory approval documented. According to CDR (b)(6); (b)(7)(C) LPCADF placed SINGH in the juvenile cell for protective custody purposes due to his sexual assault charge; however, LPCADF staff did not complete a segregated housing order for protective custody until two days following his intake, May 2, 2019. The staff member assigned SINGH to the H Pod the morning of SINGH’s death, not the juvenile cell he was housed in. Additionally, the protective custody segregated housing order completed by Officer (b)(6); (b)(7)(C) was not approved by a supervisor; CDR (b)(6); (b)(7)(C) stated LPCADF does not require supervisory approval of administrative segregation placement as a matter of routine.

Applicable ORSA component: *Special Management Unit, Administrative Segregation*, Section 2, “In exigent circumstances, staff may place a detainee in the SMU (administrative) before a written order has been approved. A copy of the order given to the detainee within 24 hours.”

Applicable facility policy: *Special Management Inmates, Segregation Placement and Review*, Section 2.6.3.4: “Initial placement into segregation shall be documented on the Segregated Housing Order... If a change in the type of confinement occurs, a new Segregated Housing Order shall be generated identifying the circumstances and type of segregation. The shift supervisor must sign all segregated housing orders.”

Relevant NDS component: *Special Management Unit, Administrative Segregation*, Section (III)(B): “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.”

12. When LPCADF officers placed SINGH in the juvenile cell for segregation, they did not initiate a log to record activities and privileges, including meals, recreation, time out of cell, or staff rounds. Between his assignment to the cell at an unknown time on April 30, 2019, and the medical emergency shortly before 6:00 p.m. on May 2, 2019, security personnel only recorded one round, on May 1, 2019 at 8:39 p.m. Moreover, nurses made no rounds, reportedly because LPCADF officers did not notify them SINGH was in the juvenile cell. If additional rounds were completed by LPCADF staff, there was no documentation provided to support it. According to (b)(6); (b)(7)(C) at the time of SINGH’s housing at LPCADF, medical staff conducted segregation rounds every three days for



inmates/detainees pursuant to facility policy *Special Management Inmates*, Chapter 200, Section 2.6; however, after SINGH's death they changed medical segregation rounds to occur daily.

Applicable ORSA components:

*Security Inspections*, Sections (2) and (11): (2) "Every officer is required to conduct a security check of his/her assigned area. The results are documented;" and, (11) "Every search of the SMU and other housing units is documented."

*Special Management Unit (SMU), Administrative Segregation*, Sections (10) and (11): (10) "The SMU maintains a permanent log of detainee-related activity, e.g., meals served, recreation, visitors etc.; and (11) Staff record whether the detainee ate, showered, exercised... during every shift."

Applicable facility policy: *Special Management Inmates*, Documentation, Section 2.6.4.3 and 2.6.4.5: "Documentation of each inmate/detainee placed into segregation shall be maintained. At a minimum, the documentation shall include: (2.6.4.3.5) Spillman Jail Log (logging any/all activities/problems/incidents relating to segregated inmates)."

Relevant NDS 2000 component: *Special Management Unit, Administrative Segregation*, Section (III)(E): "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."

13. On May 2, 2019, LPCADF staff classified SINGH, two days after admission. Although ICE NDS 2000 and LPCADF policy require an initial classification to occur at intake, one was not completed. Moreover, although the facility attempted to conduct a Formal Classification Assessment within 24 to 72 hours in accordance with their own policy, no interpretation services were used; consequently, questions were answered based solely on SINGH's criminal history. Furthermore, a supervisor never reviewed or approved the classification. Per CDR (b)(6), (b)(7)(C) supervisors do not routinely review classification decisions and the facility policy does not require they do so.

Applicable facility policies:

*Inmate Classification, Pre-Classification Assessment (TRIAGE)*, Section 3.3.2: "The LPCSO-ADF shall conduct a Pre-Classification Assessment (TRIAGE) of incoming arrestees, commitments and other inmates booked into the facility... The Triage should begin immediately after accepting custody of an inmate."

*Inmate Classification, Classification Assessment*, Section 3.3.3: "Within 24 to 72 hours, the Disciplinary & Classification Officer (D&C Officer) will complete the Formal Classification Assessment in Spillman, utilizing additional information not readily available to Booking Staff."

Relevant NDS 2000 components:

*Detainee Classification System*, Section (III)(A)(1): “The classification system ensures: All detainees are classified upon arrival, before being admitted into the general population.”

*Detainee Classification System*, Section (III)(A)(3): “The first-line supervisor will review and approve each detainee’s classification.”

14. (b)(6); (b)(7)(C) used a knife rather than a cut-down tool to cut SINGH from the bunk bed. After asking for a seatbelt cutter with a negative response from LPCADF staff, (b)(6); (b)(7)(C) also used a knife to cut through SINGH’s shirt and remove the ligature from his neck, placing SINGH at risk for further injury.

Applicable ORSA component: *Contraband*, Section (1): “The facility follows a written procedure for handling illegal contraband. Staff inventory, hold, and report it when necessary to the proper authority for action/possible seizure.”

Applicable facility policies:

*Searches and Contraband Control, Weapons*, Section 2.9.8.9.3: “All contraband identified as criminal in accordance with ARS 13-2501 shall be properly secured maintaining an accurate chain of custody log.”

*Searches and Contraband Control, Disposition of Contraband Not Used as Criminal Evidence*, Section 2.9.9.5: “Contraband, excluding nuisance contraband, shall be disposed of by the Shift Supervisor.”

Relevant NDS 2000 components:

*Contraband*, Section (I): “Detention staff will handle and properly dispose of contraband in accordance with the standard operating procedures of the facility. Contraband will be destroyed in the presence of at least one official observer, and those involved will document every instance of contraband-destruction.”

*Contraband*, Section (III)(A): “Hard contraband includes any item that is inherently dangerous as a weapon or tool of violence; e.g., a knife, explosives, a ‘zipgun’, brass knuckles, etc.”

15. LPCADF did not maintain continuous supervision of SINGH after EMS departed the facility. An LPCADF supervisor did not dispatch (b)(6); (b)(7)(C) to LPRH until approximately 6:30 p.m., after SINGH arrived at the hospital. At approximately 8:00 p.m., LPCADF dispatched (b)(6); (b)(7)(C) to AWC hospital, as LPRH was preparing to transfer SINGH to AWC for a higher level of care. At approximately 9:08 p.m., once the Native Air flight left LPRH for AWC hospital, Deputy (b)(6); (b)(7)(C) hospital vigil duties ended. As neither Deputy (b)(6); (b)(7)(C) nor Officer (b)(6); (b)(7)(C) maintained a log of events during their respective hospital watches, ERAU was unable to determine how long SINGH remained unaccompanied at both LPRH and AWC.



Applicable facility policies:

Hospitalization of Detainee's [sic], *Responsibility*, Section 5.6.1.1: "The assigned escorting officer (s) shall not leave a detainee unattended for any reason while outside of the secure LPCSO-ADF."

Hospitalization of Detainee's [sic], *Hospital Log*, Section 5.6.2.1: "Escorting officers shall maintain a Hospital Log throughout the duration of the detainees [sic] medical stay."

16. According to CDR (b)(6);  
(b)(7)(C) all inmates and detainees admitted to LPCADF are strip searched.

Applicable ORSA component: *Admission and Release*, Section (4): "Detainees are stripped searched only when cause has been established and not as routine policy. Non-criminal detainees are not strip-searched but are patted down, unless reasonable suspicion is established."

Relevant ICE Change Notice, *Admission and Release – National Detention Standard Strip Search Policy*, dated October 15, 2007, "Facilities are reminded that strip searches, cavity searches... and other required exposure of the private parts of a detainee's body for the purpose of searching for contraband are prohibited, absent reasonable suspicion of contraband possession."

17. The only documented admission process (b)(6); (b)(7)(C) completed was an inventory of SINGH's funds and property on April 30, 2019. SINGH's signature does not appear on the inventory, nor does an address book later found by Office (b)(6);  
(b)(7)(C) in SINGH's backpack. No other contents of SINGH's backpack were inventoried.

Applicable ORSA component: *Admission and Release*, Section (5): "... Staff prepares a complete inventory of each detainee's possessions. The detainee receives a copy."

18. There is no backup RN to oversee the LPNs when (b)(6); (b)(7)(C) who also serves as the facility's HSA, is unavailable. During their interviews with ERAU, nurses reported overwhelming workloads and long hours.

Relevant NDS 2000 component: *Medical Care*, Section (III)(A): "All facilities will employ, at a minimum, a medical staff large enough to perform basic exams and treatments for all detainees."

19. On April 30, 2019, (b)(6); (b)(7)(C) documented SINGH had an elevated blood pressure and pulse during his initial assessment. At no other point during SINGH's detention at LPCADF did medical staff re-check his blood pressure.

20. After (b)(6); (b)(7)(C) radioed for (b)(6); (b)(7)(C) to respond to the medical emergency, RN (b)(6); (b)(7)(C) did not respond with any medical equipment. She reported that this was because (b)(6); (b)(7)(C)'s radio call asking for medical assistance was unclear. She also did not enter a note into the medical record detailing the medical emergency until May 7, 2019, after SINGH's death.
21. LPCADF allowed Officer (b)(6); (b)(7)(C) to perform limited Detention Officer duties on an unsupervised basis before she completed formal training of any kind. Having not been trained, she was unable to take appropriate action when she discovered SINGH's suicide attempt.
22. When (b)(6); (b)(7)(C) responded to SINGH's cell, he did not immediately call a medical emergency over the radio and did not enter the cell to lift SINGH upward pending the arrival of additional staff.
23. LPCSO turned over the investigation of SINGH's suicide to the MCSO. Although not documented by LPCADF, the MCSO report suggests SINGH's cell was treated as a crime scene in accordance with facility policy 5.3.3, Inmate Death. The MCSO report did not offer any conclusions within its scope, and LPCSO did not conduct an internal after-action review to identify any internal policy violations.

## **EXHIBITS**

1. Creative Corrections Healthcare and Security Compliance Analysis.
2. State of Arizona Certificate of Death 102-2019-031160, certified May 4, 2019.
3. Maricopa County Forensic Science Center: Record of Admission, dated May 3, 2019.
4. Maricopa County Medical Examiner Report, case 19-03827, signed July 31, 2019.
5. LPCADF 2018 ORSA, dated September 13, 2018.





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)  
Division Chief, Inspections and Detention Oversight

SUBJECT: Detainee Death Review Findings – Simratpal SINGH  
JICMS #201906742

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 Simratpal SINGH, a 20-year-old citizen of India, who died on May 3, 2019, while in ICE custody at the Abrazo West Campus hospital (AWC) in Goodyear, Arizona (AZ). The Maricopa County Office of the Medical Examiner documented SINGH's cause of death as hanging and the manner of death as suicide.

#### Abbreviated Chronology<sup>1</sup>

On February 5, 2019, U.S. Customs and Border Protection (CBP) arrested SINGH immediately upon his illegal entry into the United States near Otay Mesa, California (CA), and on February 12, 2019, transferred him to the custody of the ICE Office of Enforcement and Removal Operations (ERO) at the San Luis Regional Detention Center (SLRDC) in San Luis, AZ.

On February 20, 2019, ERO Phoenix transferred SINGH to the La Palma Correctional Center (LPCC) in Eloy, AZ, pending a credible fear interview.

On April 17, 2019, ERO Phoenix set SINGH's bond at \$73,500, which SINGH posted on April 29, 2019. ERO Phoenix released SINGH from ICE custody at that time.

On April 30, 2019, at approximately 1:07 p.m., a La Paz County Sheriff's Office (LPCSO) Deputy arrested SINGH on criminal charges for an alleged assault and sexual assault. On this same date,

<sup>1</sup> See accompanying Detainee Death Review for complete chronology.

LPCSO booked SINGH into the La Paz County Adult Detention Facility (LPCADF) located in Parker, AZ.

On May 1, 2019, ERO Phoenix lodged an initial Immigration Detainer – Notice of Action, Form I-247A, against SINGH with the facility. On the same date, the Quartzsite Justice Court in Quartzsite, AZ, granted SINGH bond in the amount of \$5,000.

On May 2, 2019, LPCADF processed SINGH's bond. At approximately 4:27 p.m., LPCADF permitted SINGH a non-contact visit to speak with two individuals who came to the facility to post his bond, which lasted approximately 36 minutes.

At 4:39 p.m., SINGH entered into ICE custody at LPCADF.

At approximately 5:13 p.m., an LPCADF staff member escorted SINGH back to his cell from visitation. On the way back to his cell, SINGH asked the staff member for a pair of socks he saw located on the intake clothing rack, which were provided at that time.

At approximately 5:50 p.m., an LPCADF staff member discovered SINGH unresponsive in his cell; SINGH had socks tied around his neck attached to linens which were wrapped around the upper bunk of his bed post. Shortly thereafter, three other LPCADF staff members responded and coordinated efforts to cut his body down and begin the administration of cardiopulmonary resuscitation (CPR).

At 5:58 p.m., LPCADF personnel contacted the emergency medical services (EMS).

At 6:01 p.m., EMS and Parker Fire Department (PFD) personnel arrived, and at 6:26 p.m., EMS personnel transported SINGH by ambulance to the La Paz Regional Hospital (LPRH) in Parker, AZ.

At 9:08 p.m., SINGH was airlifted to AWC for a higher level of care. When SINGH arrived at AWC, he was in a comatose state with a pulse and heartbeat. Shortly after arrival, SINGH experienced several sudden cardiac arrest events which required life-saving measures. Ultimately, despite the best efforts of medical staff, they were unable to resuscitate SINGH.

On May 3, 2019, at 1:58 a.m., an AWC physician pronounced SINGH's death.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care LPCADF provided SINGH, as well as their efforts to ensure he was safe and secure while detained at the facility, during the (approximate) one hour he was in ICE custody. ICE currently utilizes LPCADF as an under 72-hours facility pursuant to a rider contract on a U.S. Marshals Service Inter Governmental Agreement. Consequently, the contract does not expressly identify which set of ICE standards LPCADF is required to comply with. However, the facility is required to conduct a yearly Operational Review Self-Assessment



(ORSA)<sup>2</sup> designed to assess the facility's compliance with certain requirements of the ICE National Detention Standards (NDS) 2000. In the attached report, ERAU assessed LPCADF's compliance with the ICE NDS 2000 standards and documented these 23 findings as areas of concern. The areas of concern are noted for informational purposes only and should not be construed as contributory to the detainee's death.

If you have any questions, please contact me or have a member of your staff contact ERAU Unit Chief [REDACTED] at (202) 731-[REDACTED]

*Enclosure*

SINGH Detainee Death Review Report

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<sup>2</sup> During his interview, the highest-ranking facility official, Commander (CDR) Rico Suffle indicated that he had never heard of the ICE National Detention Standards (NDS) 2000. Additionally, another Lieutenant (LT) stated he believed the facility was required to adhere to U.S. Marshals Service (USMS) standards, as ICE is under a USMS rider contract with LPCADF. CDR Suffle completed LPCADF's 2018 ORSA and found the facility fully compliant with 29 of the 29 requirements the ORSA covers.

# Nursing Documentation Pathway

## Hypertension



Patient Name:

ID No:

|                                                                                                                              |                                                          |
|------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="radio"/> Emergent                                                                                               | <input type="radio"/> Not Emergent – evaluate for Urgent |
| Immediate evaluation by the HCP; if not available activate EMS. Notify HCP after activation of EMS.                          |                                                          |
| Time Provider Notified _____ Time EMS Activated _____                                                                        |                                                          |
| <input type="checkbox"/> Severe distress with unstable vital signs and with acute coronary syndrome or altered mental status |                                                          |
| <input type="radio"/> Urgent                                                                                                 | <input type="radio"/> Not Urgent – evaluate for Routine  |
| If condition deteriorates consider upgrade to emergent                                                                       |                                                          |
| <input type="checkbox"/> DBP >100 with cardiac history/symptoms<br><input type="checkbox"/> History of recent chest injury   |                                                          |
| <input type="radio"/> Routine                                                                                                |                                                          |
| Data collection that does not trigger emergent/urgent intervention.                                                          |                                                          |
| If condition deteriorates consider upgrade to urgent or emergent.                                                            |                                                          |
| <input type="checkbox"/> No acute distress vital signs within normal limits                                                  |                                                          |

| <input type="radio"/> Emergent Interventions                                                                                                                                                                                                                                                                                                                                 | <input type="radio"/> Urgent Interventions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="radio"/> Routine Interventions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Immediate evaluation by the HCP.<br><input type="checkbox"/> If EMS activated reassess every 5 Minutes until EMS arrival.<br><input type="checkbox"/> Additional interventions as Ordered<br><br>Consider:<br><input type="checkbox"/> Oxygen<br><input type="checkbox"/> IV Fluids<br><input type="checkbox"/> CPR<br><input type="checkbox"/> AED | <input type="checkbox"/> Contact HCP using SBAR format<br><br>Consider:<br><input type="checkbox"/> Oxygen<br><input type="checkbox"/> IV Fluids<br><br><input type="checkbox"/> Additional interventions as ordered<br><input type="checkbox"/> Instruct per Education Fact Sheet<br><input type="checkbox"/> Instructed to contact medical if symptoms reoccur<br><input type="checkbox"/> Reassure patient<br><input type="checkbox"/> Patient verbalized understanding of self-care, symptoms to report & when to return for follow-up | <input type="checkbox"/> <b>Known Hypertensive</b><br><input type="checkbox"/> If BP within normal range reassure patient and inform patient that chronic care clinic visit is scheduled<br><input type="checkbox"/> BP normal to high with history of hypertension and currently on medication schedule for HCP follow up within 7 days<br><br><input type="checkbox"/> <b>Unknown Hypertensive</b><br><input type="checkbox"/> BP >140/90 but <180/110- schedule for HCP follow up within 7 days<br><input type="checkbox"/> Schedule for BP checks daily until seen by HCP and provide HCP with results<br><input type="checkbox"/> Instruct per Education Fact Sheet<br><input type="checkbox"/> Instructed to contact medical if symptoms reoccur<br><input type="checkbox"/> Reassure patient<br><input type="checkbox"/> Patient verbalized understanding of self-care, symptoms to report & when to return for follow-up |

| Scheduled Follow-up                            |                                            |                                                  |
|------------------------------------------------|--------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> None required/reason: | <input type="checkbox"/> Behavioral Health | <input type="checkbox"/> Referral to             |
| <input type="checkbox"/> Provider              | <input type="checkbox"/> Nursing           | <input type="checkbox"/> Other (provide detail): |

| Refusals                                     |                                          |                                                     |
|----------------------------------------------|------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> refusal form signed | <input type="checkbox"/> referred to HCP | <input type="checkbox"/> no further action required |

|                    |                       |        |       |       |
|--------------------|-----------------------|--------|-------|-------|
| Nurse's Signature: | Printed Name (Stamp): | Title: | Date: | Time: |
|--------------------|-----------------------|--------|-------|-------|

Form Number: PW119UN0000ACCEB080114

Page 2 of 2

This pathway is not meant to be applicable to every patient nor to take the place of sound medical judgment; when in doubt, please contact a medical provider

Use Progress Note for additional documentation



# Nursing Documentation Pathway

## Hypertension



|                        |                |                |                                                                          |        |
|------------------------|----------------|----------------|--------------------------------------------------------------------------|--------|
| Patient Name:          |                |                |                                                                          | ID No: |
| Date of Visit:         | Time of Visit: | Date of Birth: | Gender:<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Race:  |
| Allergies:             |                |                |                                                                          |        |
| Current Medication(s): |                |                |                                                                          |        |

| SUBJECTIVE                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Date of Onset:                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Time of Onset:                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> New Onset                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Chronic Complaint<br>Duration:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Medical History</b><br><input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Surgical History</b><br><input type="checkbox"/> None                                                                                                                                                                                                                                                                         | <b>Social History</b><br><input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <b>Symptoms</b><br><input type="checkbox"/> None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| <input type="checkbox"/> Hypertension:<br>Age of onset: _____<br><input type="checkbox"/> Hospitalizations<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Past MI<br>When: _____<br><input type="checkbox"/> Stents<br><input type="checkbox"/> Physical inactivity<br><input type="checkbox"/> Sleep apnea<br><input type="checkbox"/> High dietary salt intake<br><input type="checkbox"/> Last Medication Dose<br>What: _____<br>When: _____ | <input type="checkbox"/> CABG<br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Cholecystectomy<br><input type="checkbox"/> Hernia Repair<br><input type="checkbox"/> Bowel Resection<br><input type="checkbox"/> C-Section<br><input type="checkbox"/> Hysterectomy<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Tobacco Use:<br>Years: _____<br>Amount: _____<br><input type="checkbox"/> Drug Use<br>Years: _____<br>Amount: _____<br>Last Use: _____<br><input type="checkbox"/> Alcohol Use<br>Years: _____<br>Amount: _____<br>Last Use: _____<br><br><b>Family History</b><br><input type="checkbox"/> None<br><input type="checkbox"/> Hypertension<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Heart Disease<br><input type="checkbox"/> Gallstones<br><input type="checkbox"/> Kidney stones | <input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Pain Rating: _____/10<br>Location: _____<br><input type="checkbox"/> Symptoms w/Exertion<br><input type="checkbox"/> Dyspnea on exertion<br><input type="checkbox"/> Shortness of breath<br><input type="checkbox"/> Headache<br><input type="checkbox"/> Fatigue<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Nausea/vomiting<br><input type="checkbox"/> Blurred vision<br><input type="checkbox"/> Extremity swelling<br><input type="checkbox"/> Vision Changes<br>Describe: _____ |

| OBJECTIVE                                                                                            |                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |       |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|
| <b>Vital Signs:</b>                                                                                  | Temp:                                                                                                                                                                                                                                                                 | Pulse:                                                                 | Resp.:                                                                                                  | B/P:                                                                                                                                                                                                                                                                                                                                                                                                | Weight:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | SPO2: |
| AVPU:                                                                                                |                                                                                                                                                                                                                                                                       | <input type="radio"/> Alert                                            | <input type="radio"/> Responds to Voice                                                                 | <input type="radio"/> Responds to Pain                                                                                                                                                                                                                                                                                                                                                              | <input type="radio"/> Unresponsive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |       |
| <b>Color</b>                                                                                         | <b>Skin</b>                                                                                                                                                                                                                                                           | <b>Pulse (apical)</b>                                                  | <b>Cardiac Sounds</b>                                                                                   | <b>Peripheral Pulses</b>                                                                                                                                                                                                                                                                                                                                                                            | <b>Edema</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |       |
| <input type="checkbox"/> Pink<br><input type="checkbox"/> Pallor<br><input type="checkbox"/> Flushed | <input type="checkbox"/> Warm<br><input type="checkbox"/> Dry<br><input type="checkbox"/> Cool<br><input type="checkbox"/> Moist/Clammy<br><input type="checkbox"/> Diaphoretic<br><br>Skin Turgor<br><input type="radio"/> Normal<br><input type="radio"/> Decreased | <input type="checkbox"/> Regular<br><input type="checkbox"/> Irregular | <input type="checkbox"/> Normal<br><input type="checkbox"/> Abnormal<br><input type="checkbox"/> Murmur | <input type="checkbox"/> Present<br><input type="checkbox"/> Right Upper<br><input type="checkbox"/> Left Upper<br><input type="checkbox"/> Right Lower<br><input type="checkbox"/> Left Lower<br><br><input type="checkbox"/> Absent<br><input type="checkbox"/> Right Upper<br><input type="checkbox"/> Left Upper<br><input type="checkbox"/> Right Lower<br><input type="checkbox"/> Left Lower | <input type="checkbox"/> Right Upper<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><input type="checkbox"/> Left Upper<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><input type="checkbox"/> Right Lower<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+<br><input type="checkbox"/> Left Lower<br><input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ |       |

Form Number: PW119UN0000ACCEB080114

Page 1 of 2

This pathway is not meant to be applicable to every patient nor to take the place of sound medical judgment; when in doubt, please contact a medical provider

Use Progress Note for additional documentation

Deputy  
Walt  
385-739-5135



DATE: 11.6.2018 SUBJECT: Nursing Pathways-HTN

READ AND SIGN

| PRINT NAME | SIGNATURE |
|------------|-----------|
|------------|-----------|

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

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## **Blood Pressure Check Training**

**11-06-2018**

Anytime a patient's blood pressure is above 140/90, please follow the instructions on the Nursing Pathways for Hypertension. Below are the instructions:

### **Emergent Intervention:**

Severe distress with unstable vital signs and with acute coronary syndrome or altered mental status.

Immediate evaluation by the HCP: if not available activate EMS. Notify HCP after activation of EMS.

- a. Time Provider Notified
  - b. Time EMS activated
- 
- 1. Immediate evaluation of HCP
  - 2. If EMS activated reassess every 5 minutes until EMS arrives.
  - 3. Neuro assessment every 30 minutes.
  - 4. Additional interventions as ordered.
  - 5. Consider:
    - a. Oxygen
    - b. IV Fluids
    - c. CPR
    - d. AED

### **Urgent Intervention**

DBP > 100 with history of cardiac history/symptoms or, history of recent chest injury.

- 1. Contact HCP using SBAR format.
- 2. Consider
  - a. Oxygen
  - b. IV Fluids
- 3. Additional Interventions as ordered.
- 4. Instruct per Education fact sheet.
- 5. Instruct to contact medical if symptoms reoccur.
- 6. Reassure patient.
- 7. Patient verbalized understanding of self-care, symptoms to report & when to return for follow-up.

Please make sure you are documenting any follow-up blood pressure in the vital signs screen.

NAME: Padron, Wilfredo.  
SEX: Male  
RACE: White  
AGE: 58 years  
DOB: 09/03/1960

CASE NO.: 18-00182  
DATE OF AUTOPSY: November 1st, 2018  
TIME OF AUTOPSY: 16:00  
EXAMINER: (b)(6); (b)(7)(C) MD

|                                   |                                                                                                      |                                      |
|-----------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------|
| <b>Circumstances of Death:</b>    |                                                                                                      | The decedent was found unresponsive. |
| <b>Authorization for Autopsy:</b> |                                                                                                      | Florida Statute 406                  |
| <b>Identification:</b>            | Visually by police.                                                                                  |                                      |
| <b>Cause of Death:</b>            | Thrombosis of the Right Coronary Artery<br><br>due to:<br><br>Atherosclerotic Cardiovascular Disease |                                      |
| <b>Manner of Death</b>            |                                                                                                      | Natural                              |



### **EXTERNAL EXAMINATION**

The body is that of a 67-inch, 197-pound white male, who appears the reported age of 58 years. The body is well preserved and warm. Rigor mortis is present. Livor mortis is posterior, red-purple and blanches to pressure.

The hair is short and grey with male pattern baldness. A medium length grey beard and moustache is on the chin and upper lip. The sclera are non-icteric. The irides are brown with arcus senilis. The conjunctivae are not congested and have no petechiae. The nasal bridge is deviated to the right. The oral mucosa and frenula are intact. The teeth are natural and in poor condition. The external auditory canals are free of blood.

The neck is straight. The chest and back are symmetric. The abdomen is flat. The external genitalia are those of a normal uncircumcised adult male. The external anus is unremarkable.

The arms and legs are normally developed. The fingernails and the toenails are short. A 2-inch hypo pigmented linear scar is in the dorsal surface of the left deltoid. A 6-inch hypo pigmented linear scar is in the dorsal surface of the left triceps.

### **CLOTHING & PERSONAL EFFECTS**

The decedent is clad in blue pants, white boxers, a white sock, a grey sweater, and a blue shirt. A white plastic rosary is around the neck.

### **EVIDENCE OF INJURY**

A 2 x 1-1/4-inch purple bruise is in the ventral surface of the right upper extremity. A 3 x 2-1/2-inch area of circular red-yellow abrasions is in the midchest. Multiple very small punctate healing red abrasions are in all 4 of the extremities. The anterior aspect of the 4<sup>th</sup> through 8<sup>th</sup> left ribs and the anterior aspect of the 5<sup>th</sup> through 6<sup>th</sup> right ribs are fractured.

### **EVIDENCE OF MEDICAL INTERVENTION**

A combi-tube is in the mouth. A white hospital type bracelet is around the left wrist. A properly placed intraosseous catheter is in the left shin.

## **INTERNAL EXAMINATION:**

### **BODY CAVITIES and MUSCULOSKELETAL SYSTEM:**

The body is opened by a Y-shaped incision and the chest plate is removed. The chest wall and the abdominal wall have no abnormalities. The body cavities have no abnormal fluid collections or adhesions. The musculoskeletal system is well developed. The muscles have a normal color and consistency. There are no fractures of the clavicles, pelvis or vertebral column.

**HEAD: (Central Nervous System)**

The calvarium and skull base are intact. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. The epidural and subdural space is free of blood. The leptomeninges are thin and transparent. The subarachnoid space is free of blood and exudates. The brain is 1375 grams. The cerebral and cerebellar hemispheres are symmetric. The cerebral gyri and the sulci are unremarkable. The cingulate gyri, unci, and cerebellar tonsils are not herniated. The cerebral cortex has no contusion. The mammillary bodies and the cranial nerve roots are well formed and symmetric. The blood vessels of the base of the brain, including the circle of Willis are well formed and patent. The gray-white matter demarcations are distinct. The central nuclei are well formed and symmetric. The hippocampi are normally formed. The ventricles are normal in size. The corpus callosum is well formed and intact. The substantia nigra is gray.

**NECK:**

The hyoid bone and thyroid cartilage are intact. The larynx and trachea are lined by intact tan mucosa. The paratracheal lymph nodes are tan and moderately enlarged.

**CARDIOVASCULAR SYSTEM:**

The right dominant heart is 500 grams. The epicardial surface has a normal amount of adipose tissue. The coronary arteries course in a normal fashion from patent and normally oriented ostia. The lumen of the right coronary artery is occluded by a thrombosis. The lumen of the circumflex artery is 60% narrowed by calcific atherosclerosis. The lumen of the left anterior descending coronary artery is 80% narrowed by calcific atherosclerosis. The left ventricular free wall, the interventricular septum, and the right ventricular free wall are 1.4, 1.5, and 0.5 centimeters, respectively. The atria are not dilated and the atrial septum is intact. The endocardial surfaces are smooth. The tricuspid, mitral, pulmonic, and aortic valves are normally formed and have no fusion, vegetation's, or fenestrations. The chordae tendineae are intact and not thickened.

The aorta is normal in course, caliber, and branch pattern. The endothelial surfaces are rough, yellow, and have a moderate amount of atherosclerosis.

**RESPIRATORY SYSTEM:**

The right and left lungs are 740 and 540 grams, respectively. The pleural surfaces are red-purple and have a moderate amount of anthracosis. The parenchyma is red-purple and has no focal lesions. The pulmonary vessels and bronchi are normally formed and patent. The hilar lymph nodes are black and otherwise unremarkable.

**LIVER & BILIARY SYSTEM:**

The 2200-gram liver has a smooth, glistening, intact capsule, covering a tan-brown parenchyma. A 0.9 x 0.9 x 0.5 centimeter dark red lesion with blood exuding from its cut surface is in the liver. The lobular pattern is preserved. The extra and intrahepatic vessels are patent. The gallbladder contains 10 milliliter of yellow bile, but no stones. The mucosa is yellow-green and unremarkable. The biliary tree is patent.



**ALIMENTARY TRACT:**

The esophagus is lined by intact tan mucosa. The stomach does not contain any fluid, food pieces, pills, or pill fragments. The gastric mucosa is unremarkable. The small bowel and colon have no obstruction, perforation, or masses. The rectum is normal and contains soft, brown fecal material. The pancreas is normal in size and has a tan, lobulated parenchyma. The appendix is unremarkable.

**GENITOURINARY SYSTEM:**

The right and left kidneys are 200 and 220 grams, respectively. The renal capsules are smooth, thin, and semi-transparent, covering mildly granular, red-brown cortical surfaces. The renal cortices are sharply delineated from the medullae. The calyces, pelves, and ureters are well formed, not dilated, and drain normally. The urinary bladder contains 60 milliliters of yellow urine. The mucosa is tan and has mild trabeculation.

The testes have no ecchymosis or masses. The prostate gland is tan and unremarkable.

**RETICULOENDOTHELIAL SYSTEM:**

The spleen is 300 grams. It has a gray-purple intact capsule. The parenchyma is dark red-purple. The regional lymph nodes appear normal.

**ENDOCRINE SYSTEM:**

The pituitary, thyroid, and adrenal glands are unremarkable.

**ADDITIONAL PROCEDURES:**

- Documentary photographs are taken by: (b)(6); (b)(7)(C)
- Specimens retained for future testing as needed; Peripheral blood, urine, bile, vitreous, and a DNA spot card.
- Dissected organs are released with the body
- Additional personnel present for the autopsy: None
- Additional specimens retained as evidence: None
- Personal possessions are released with the body.

**AUTOPSY FINDINGS:**

- I. Thrombosis of the right coronary artery, with multifocal atherosclerotic cardiovascular disease and cardiomegaly (500 grams).
- II. Mild bilateral arteriolonephrosclerosis.
- III. Mild bilateral pulmonary congestion and edema.
- IV. Hepato-splenomegaly (2200 and 300 grams) with a hepatic hemangioma.
- V. Bilateral anterior rib fractures consistent with CPR artifact.

**OPINION:**

This 58-year-old, white male, Padron, Wilfredo., died as a result of a Thrombosis of the Right Coronary Artery due to Atherosclerotic Cardiovascular Disease.

The manner of death is determined to be: Natural

*The opinion as to the cause and manner of death is based on the information available at the date of this report. If additional objective, probative information becomes available, this office reserves the right to consider such information, and if appropriate, amend the report, including the cause and manner of death.*

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

\_\_\_\_\_  
Date



**DETAINEE DEATH REVIEW: Wilfredo PADRON, A022776291**  
**Healthcare and Security Compliance Analysis**  
**Monroe County Detention Center**  
**Key West, Florida**

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 Wilfredo PADRON on November 1, 2018 while in the custody of the Monroe County Detention Center (MCDC), Key West, Florida. A site visit was conducted November 27 through 29, 2018 by ERAU staff (b)(6); (b)(7)(C) Management and Program Analyst and team leader, an (b)(6); (b)(7)(C) Section Chief, and Creative Corrections contract personnel (b)(6); (b)(7)(C) Program Manager and Security Subject Matter Expert, and (b)(6); (b)(7)(C) RN, Healthcare Subject Matter Expert. Contractor participation was requested to determine compliance with the ICE 2008 Performance Based National Detention Standards (PBNDS) governing medical care and security operations.

This report includes 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 PADRON's medical record and detention file, tour of the housing unit, medical clinic and sick bay area, interviews of staff, and review of policies, video surveillance recordings, hospital records, and available incident related documentation.

(b)(6); (b)(7)(C) legal counsel for MCDC's healthcare services contractor, was present for interviews of all medical personnel and Captain (b)(6); (b)(7)(C) Operations Commander, Monroe County Sheriff's Office, was present for interviews of all but one security witness. Although Creative Corrections subject matter experts expressed concern that Captain (b)(6); (b)(7)(C) presence may intimidate security witnesses and inhibit frank testimony, (b)(6); (b)(7)(C) General Counsel to the Sheriff, stated that either he or Captain (b)(6); (b)(7)(C) must be present for the interviews. (b)(6); (b)(7)(C) advocated in favor of Captain (b)(6); (b)(7)(C) on grounds that his presence would be less intimidating than his own. ERAU determined that Captain (b)(6); (b)(7)(C) presence would be allowed.

## **SYNOPSIS**

Wilfredo PADRON, 57 years old, was transferred to MCDC from the Krome North Service Processing Center on August 19, 2018. During intake screening and physical examination at Krome, he reported a history of chronic medical conditions that included hypertension, pancreatitis, high cholesterol, and leg pain necessitating use of a wheelchair. Medications for treatment of hypertension, high cholesterol, and pain were started and sent with PADRON to MCDC.

At MCDC, PADRON was classified high custody and placed in general population housing, with wheelchair. The medications started at Krome were continued and the detainee was identified as

a chronic care patient. The facility's physician determined PADRON stable during initial chronic care evaluation and ordered routine follow up.

PADRON submitted multiple healthcare requests and was seen at nursing sick call for complaints that included cold symptoms, foot fungus, constipation, and chest pain. On five occasions, PADRON was taken to the medical unit on an urgent basis, four for complaints of chest pain in the six days preceding his death. The first resulted in transport to the emergency room when his blood pressure was found to be 196/98, qualifying as crisis hypertension per American Heart Association (AHA) parameters. The emergency room discharged him in under three hours with a diagnosis of constipation. When seen by MCDC's midlevel provider later the same morning, PADRON's blood pressure was 175/107. He was returned to the housing unit following administration of a medication to treat shoulder pain and a new prescription to treat constipation.

The second urgent escort to medical for chest pain resulted in a nurse's administration of ibuprofen and counseling to follow sick call procedures rather than claiming urgent need. His blood pressure was 148/81. On the third occasion PADRON was brought to medical for chest pain, his blood pressure was again found at crisis level, 196/99, but fell to 157/97 over the course of 20 minutes. Per provider direction but without her assessment, he was maintained in the sick bay area but was returned to the housing unit after approximately ten hours without re-evaluation or authority. PADRON's fourth and final escort to medical for chest pain was the day before his death, October 31, 2018. The encounter was not documented in the medical record. Based on video evidence, a nurse saw PADRON in sick bay and took his vital signs, following which the Director of Nurses spoke with him. A notation on the sick bay roster documents the detainee's blood pressure was 153/89. PADRON was returned to the housing unit within 20 minutes.

At approximately 6:41 a.m. on November 1, 2018, another detainee found PADRON unresponsive when attempting to wake him for breakfast. The housing unit deputy was summonsed, confirmed PADRON was unresponsive, and immediately called medical emergency. Security and medical personnel responded in under two minutes and performed cardio pulmonary resuscitation pending the arrival of emergency medical services personnel approximately 12 minutes later. PADRON was taken to the hospital by ambulance where death was pronounced at 7:17 a.m.

Autopsy results are pending as of the date of this report.

## HEALTHCARE SERVICES

Correct Care Solutions (CCS) provides healthcare services under contract with the Monroe County Sheriff's Office. CCS having recently joined with Correctional Medical Group Companies under new name WellPath, healthcare personnel identified themselves as employees of WellPath during the site visit. Full time positions include the Health Services Administrator (HSA), Director of Nurses (DON), a mental health professional, seven registered nurses (RN), an administrative



assistant, and four licensed practical nurses (LPN). Most full-time nurses work 12 hour shifts. Part-time positions include a nurse practitioner (NP) on site 32 hours per week, five RNs, a psychiatrist, mental health provider, dentist, and dental assistant. The Clinical Director is a physician under independent contract to provide 20 hours of on-site services each week. On call responsibilities are shared by the Clinical Director and NP.

The CorrecTek electronic medical record (EMR) system is used for all encounters, orders, appointment scheduling, and medication administration. CCS protocols, titled Nursing Documentation Pathways specific to common complaints, are used for nursing encounters. Pathways are completed electronically and populate encounter notes. Pathways provided to reviewers call for nurses to document medical history, examination components including full vital signs, and the nursing plan resulting from the assessment.

The MCDC clinic has two examination rooms, a nurses' station, medication room, dental suite, mental health office, radiology room, two holding cells, and administrative offices. An adjacent area, referred to as sick bay, has six cells with total capacity of 20, a shared nurses'/deputy station, and a supply/examination room.

## **DETENTION SUMMARY**

Detainee PADRON was classified high custody. Except for approximately ten hours in sick bay, he was housed in general population for the duration of his detention. He had no disciplinary infractions and filed no grievances. All submitted requests related to healthcare. PADRON made or attempted more than 1900 phone calls, averaging 25 per day. He had no visits.

## **SUMMARY OF EVENTS**

### **August 15 – 18, 2018**

Prior to his transfer to MCDC, PADRON was held at the Krome North Service Processing Center (KNSPC). Per ICE form I-203, Order to Detain or Release Alien, he arrived at 8:45 p.m. on August 15, 2018.

**Note:** The review team did not visit KNSPC; therefore, the below information summarizes information documented in written records, only.

Included in the KNSPC detention file are property records listing clothing and personal items, a cell phone, and two Visa cards; a uniform and linen issue form; a form listing Roman Catholic for religious affiliation; a Limited English Proficient form listing Spanish as his primary language; and what appears to be a signed receipt for the detainee handbook. PADRON also signed a form acknowledging a question and answer session was conducted on various topics, including sexual

assault, the handbook, legal services, and the phone system. The ICE Risk Classification Assessment documents assignment of a rating of high custody based on convictions for drug possession, vehicle theft, and aggravated assault between 1985 and 2010. Also included in the KNSPC detention file is ICE form I-213, Record of Deportable/Inadmissible Alien, documenting for funds in possession, "United States Dollar 1,512.00".

**Note:** A receipt for funds inventoried upon arrival KNSPC was not included in the documentation provided to reviewers, nor was a record of any funds expended or released during his three day detention. However, the detention file includes a transaction receipt and copy of a check in the amount of \$110.52 released with PADRON upon transfer to MCDC. Upon inquiry about the discrepancy between the amount recorded on the I-213 and the amount released with PADRON upon transfer to MCDC, (b)(6); (b)(7)(C) team leader for the death review, was told by a Supervisory Detention and Deportation Officer that the person who completed the I-213 likely made a typographical error.

The I-213 also documents the following: "The subject does not claim good health. Subject claims to take daily medication for hypertension<sup>1</sup>, brain stem stroke syndrome, lacunar syndrome<sup>2</sup> and constipation."

**Note:** The references to brain stem stroke syndrome and lacunar syndrome are noteworthy because of their specificity. They were not repeated in any KNSPC or MCDC medical record entries. As discussed below, PADRON did not report a history of strokes to the KNSPC or MCDC providers.

**Note:** Based on the property inventory and medical record (see below), medications were not received with detainee PADRON.

The medical pre-screening and full intake screening were conducted by RN (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) In her pre-screening entry, RN (b)(6); (b)(7)(C) documented an interpreter was not available and that she speaks Spanish. She also documented that PADRON was transferred from another facility and that she reviewed an accompanying medical transfer summary. Yes was entered for current illness or health problems, and the RN assigned priority two status for full intake screening.

In her intake screening entry, RN (b)(6); (b)(7)(C) documented she speaks English and Spanish and that Nurse (b)(6); (b)(7)(C) provided interpretation assistance. In contradiction with her pre-screening

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<sup>1</sup> Hypertension refers to high blood pressure.

<sup>2</sup> Lacunar stroke syndrome happens when blood flow to one of the small arterial vessels deep within the brain (in this case the stem section of the brain) becomes blocked, and the affected area is deprived of blood supply.

<sup>3</sup> The times the screenings were conducted is not documented. The pre-screening was entered on August 15, 2018; the screening on August 16, 2018.



entry, RN (b)(6); (b)(7)(C) documented a medical transfer summary did not accompany PADRON.

**Note:** Documentation provided to reviewers by ERAU indicates PADRON was not, in fact, transferred from another facility.

(b)(6); (b)(7)(C) wrote that PADRON reported a medical history of hypertension, pancreatitis<sup>4</sup>, and left leg fracture secondary to a motor vehicle accident in 1998. He reported taking medications he did not have in his possession, but could recall the name of only one, lisinopril<sup>5</sup>. His height was 66 inches and his weight was 95 pounds. Vital signs were as follows: temperature normal at 98.2, pulse normal at 69, respirations normal at 16, pulse oxygen normal at 98, and blood pressure elevated at 150/74<sup>6</sup>.

(b)(6); (b)(7)(C) noted PADRON walked with a limp, favoring the right leg, and he was ambulating with a cane. Screening for tuberculosis symptoms, mental health disorders, and substance use were all negative. He was referred to a provider and medically cleared for custody.

A chest X-ray taken and signed the same day found no evidence of tuberculosis. The radiology report notes the detainee's lungs were clear and his heart size was within normal limits. An old fracture of the lateral end of his right clavicle was noted, with nonunion<sup>7</sup>.

**Note:** The finding that the heart was within normal limits is contrary to a history of cardiomegaly<sup>8</sup> reported by PADRON for the first time during the initial physical examination completed at MCDC.

The initial physical examination was conducted the same day, August 16, 2018, by (b)(6); (b)(7)(C) NP. (b)(6); (b)(7)(C) documented an interpreter was not used because he is fluent in Spanish. His entries to the vital signs chart suggest the examination may have been conducted at approximately 9:00 a.m., although (b)(6); (b)(7)(C) entries to the vital signs chart are time stamped 6:06 a.m. the next day. With the exception of a normal oxygen level of 99 percent, the vital signs were unchanged from those taken during the intake screening, including elevated blood pressure of 150/74. PADRON denied shortness of breath, chest pain, dizziness, heart palpitations, headache, malaise, fever, chills, skin rash, nausea/vomiting, muscle aches, or muscle pain. The examination findings were generally normal, including the heart assessment for which regular rate and rhythm and no murmurs were noted; and the musculoskeletal assessment for which (b)(6); (b)(7)(C) entered,

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<sup>4</sup> Pancreatitis is inflammation of the pancreas, the gland which produces insulin and other important enzymes and hormones that help break down food.

<sup>5</sup> Lisinopril is an anti-hypertensive medication.

<sup>6</sup> Blood pressure of 150/74 falls within American Heart Association (AHA) parameters for stage two hypertension.

<sup>7</sup> A nonunion fracture refers to a permanent failure of healing following a broken bone, unless intervention is performed.

<sup>8</sup> Cardiomegaly is a significantly enlarged heart.

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“ambulates without apparent difficulty, able to sit/stand up without difficulty, no deformity to limbs”. The musculoskeletal assessment is consistent with another section of the encounter note where (b)(6); (b)(7)(C) described the detainee’s gait as normal; however, in (b)(6); (b)(7)(C) narrative summary he documented that PADRON used a wheelchair to ambulate. The only abnormal general examination finding was in the extremities category, wherein (b)(6); (b)(7)(C) noted the detainee alleged chronic pain in his left upper leg.

The assessment findings and associated treatment were as follows:

- Essential (primary)<sup>9</sup> hypertension: lisinopril 40 mg, hydrochlorothiazide 12.5 milligram (mg), and amlodipine Besylate 10 mg, each medication to be taken in the morning for 30 days.
- Chronic pancreatitis: no treatment plan documented.
- Pain: pain reliever diclofenac sodium<sup>10</sup>, delayed release, 50 mg twice daily for 30 days.
- Hyperlipidemia<sup>11</sup>: gemfibrozil 600 mg twice daily for 30 days.

(b)(6); (b)(7)(C) ordered all medications on a keep-on-person (KOP)<sup>12</sup> basis. He also ordered laboratory studies, to include a lipid panel<sup>13</sup>, comprehensive metabolic panel<sup>14</sup>, complete blood count with differential and platelets<sup>15</sup>, and urinalysis.

**Note:** Available records do not document whether the order for laboratory studies was processed prior to PADRON’s transfer to MCDC, and there was no evidence a Medical/Psychiatric Alert was placed to block the detainee’s transfer pending receipt of results. As noted below, the transfer summary indicated no lab work was pending.

(b)(6); (b)(7)(C) medically cleared PADRON for custody. (b)(6); (b)(7)(C) MD, co-signed his entry on August 18, 2018 with note, “consider disability list.”

(b)(6); (b)(7)(C) completed a transfer summary on August 17, 2018 documenting PADRON was cleared for travel to MCDC. Responses to questions on the electronic form addressing any

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<sup>9</sup> Essential hypertension is elevated blood pressure that does not have a known secondary cause.

<sup>10</sup> Diclofenac is a medication to treat pain and inflammation.

<sup>11</sup> Hyperlipidemia is a condition in which there are high levels of fat particles in the blood, placing patients at high risk for heart attack or stroke.

<sup>12</sup> When prescribed KOP, detainees are allowed to maintain prescribed medication in their possession for self-administration.

<sup>13</sup> A lipid panel is a test that measures the amount fat elements in the blood, to include triglycerides and cholesterol.

<sup>14</sup> A metabolic panel is a comprehensive test that measures the sugar level, electrolyte and fluid balance, kidney function, and liver function.

<sup>15</sup> A complete blood count with differential and platelets is a blood test used to evaluate overall health and detect a wide range of disorders, including anemia, infection, and leukemia. The differential portion of the test can detect abnormal or immature cells. Platelets are the cells which cause the blood to clot.



restrictions or special equipment required for travel, any scheduled special appointments, and pending lab work were all negative. The listed diagnoses were primary hypertension, chronic pancreatitis, hyperlipidemia, and left leg pain. (b)(6); (b)(7)(C) listed the medications ordered by NP

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

### August 18, 2018

A Monroe County Sheriff's Office Order to Detain Alien documents custody of detainee PADRON was accepted at 12:17 a.m. (b)(6); (b)(7)(C) completed receiving screening at 12:37 a.m. She did not note the detainee's primary language, use of interpretation assistance, or the language in which screening was conducted.

**Note:** The CorrecTek EMR does not include fields mandating entry of the language in which encounters are conducted, or use of interpretation assistance.

Vital signs within normal limits were as follows: temperature 97, pulse 62, respirations 16, and pulse oxygen 98; blood pressure was elevated at 134/81<sup>17</sup>. PADRON's height was 67 inches and his weight was 197 pounds. (b)(6); (b)(7)(C) entered no to the first query on the screening form, "Refusal of Admission until medically cleared."

**Note:** HSA (b)(6); (b)(7)(C) stated MCDC accepts detainees of all acuity levels<sup>18</sup> provided they are cleared for transfer by KNSPC.

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

documented PADRON's history of hypertension, pancreatitis, hyperlipidemia, and leg pain, and medications as listed on the transfer form. She documented the prescriptions for all five medications were filled on August 16, 2018 and each was last taken on August 17, 2018. RN

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

noted PADRON used a cane, and entered a nursing order for a wheelchair due to hip pain and unsteady gait. She also ordered that he be assigned to a bottom bunk on a lower tier.

**Note:** According to all staff interviewed, detainee PADRON was issued and maintained a wheelchair for the full duration of his detention. Reviewers observed the detainee in a wheelchair in video, and noted that a wheelchair was removed from his cell during the emergency response. In addition, reviewers confirmed he was assigned to a bottom bunk on a bottom tier.

Except for smoking history, remaining information obtained during the screening was consistent with that recorded on the KNSPC screening form. At KNSPC, PADRON denied tobacco use; at MCDC, he reported smoking a pack of cigarettes a day for 25 years. His psychiatric, suicide risk, and Prison Rape Elimination Act (PREA) screening were negative. (b)(6); (b)(7)(C) scheduled PADRON for a routine history and physical assessment, assigned chronic care status, and cleared

<sup>16</sup> RN Adams was unavailable for interview during the site visit.

<sup>17</sup> Blood pressure of 134/81 falls within AHA parameters for stage one hypertension.

<sup>18</sup> Acuity levels reflect the intensity of nursing care required by a patient.

him for general population housing. A consent for health services form, in English, was signed at 12:53 a.m. (b)(6); (b)(7)(C) Advanced Registered NP, co-signed the intake screening on Monday, August 20, 2018.

**Note:** The ICE PBNDS 2008, Medical Care, assigns responsibility for review of intake screenings to the Clinical Director. Written delegation of authority to a midlevel provider was requested by reviewers but not produced.

With the exception of classification, detainee PADRON's custody admission processing was completed by Sergeant (b)(6); (b)(7)(C). During interview, Sergeant (b)(6); (b)(7)(C) stated that a deputy provided interpretation assistance. All forms were in English, including the following forms signed by detainee PADRON: property receipt, Collection and Use of Social Security Numbers, and Intake Inmate Phone Call/Interpreter Information form documenting he needed an interpreter and was unable to read. Sergeant (b)(6); (b)(7)(C) informed the review team that the deputy who interpreted during the admission process translated the forms before PADRON's signature was requested.

The Property Report documents that a check in the amount of \$110.52, a shirt, pants, belt, underwear, shoes, socks, wallet, credit cards, cell phone, cane, and five bottles of prescription medications were received with detainee PADRON. During interview of Captain (b)(6); (b)(7)(C) he stated medications received with detainees are provided to medical personnel for review, then are stored with other property items. The review team's inspection of PADRON's personal property confirmed five prescription bottles bearing KNSPC labels were present. The medications and dosages were as prescribed by N (b)(6); (b)(7)(C) during physical examination prior to transfer to MCDC and as listed on the transfer summary and in RN (b)(6); (b)(7)(C) intake screening note.

**Note:** As discussed above (b)(6); (b)(7)(C) ordered the medications on a KOP basis on August 16, 2018. Records from KNSPC do not allow determination of when they were issued to him once filled; however, as noted, (b)(6); (b)(7)(C) documented the prescriptions were filled the same day as ordered and that they were last taken on August 17, 2018. Because RN (b)(6); (b)(7)(C) was not available for interview, reviewers could not verify that the medication bottles themselves were turned over to her for review before they were placed in property. The medication administration record (MAR) documents the five medications were started at MCDC this date, renewed by N (b)(6); (b)(7)(C) and continued without interruption for the term of PADRON's detention.

A Classification Interview Screen form, inexplicably dated August 17, 2018, was signed by a classification officer (signature illegible) and detainee PADRON. The form does not include a classification level; however, both the KNSPC RCA Summary documenting a rating of high custody and the detainee's criminal history were present in the detention file. Captain (b)(6); (b)(7)(C) explained that MCDC applies the classification level determined by ICE, unless review of the criminal history finds a detainee was misclassified and a rating of low custody should have been



applied. He stated that classification errors are rare and that when they occur, return to KNSPC is requested.

The electronic Jail Log Report documents that at 5:21 a.m., detainee PADRON was processed into Delta Unit, the general population housing unit for ICE detainees. The Cellmate History Report shows PADRON and another detainee were assigned to cell 1. PADRON would remain in Delta Unit throughout his detention; the other detainee was moved on September 12, 2018. PADRON remained the sole occupant of cell 1 thereafter. Delta Unit is a direct supervision pod with a total of 48 cells, 24 on the lower tier and 24 on the upper tier. Cell 1 is double occupancy and the first to the right of the unit's entrance door on the lower tier. The bunk beds are affixed to the left and rear walls and are fully visible from the window in the cell door. An affixed stainless steel desk and stool on the right wall are also directly visible from the cell door window. A stainless steel toilet/sink combination fixture is to the left of the door. A long horizontal window is on the back wall of the cell, and a security light fixture is on the right. According to Captain (b)(6); (b)(7)(C) the light is dimmed during overnight hours. Each cell has an intercom that alarms in Main Control.

The dayroom has 15 tables with stools and 12 benches surrounding a post on which two televisions are four closed circuit security cameras are mounted. Footage from the cameras is monitored in Main Control. Toilet, shower, outdoor recreation, law library, and multi-purpose use areas directly adjoin the dayroom. There are two staircases for access to the upper level positioned on either side of the deputy's station, one of which blocks direct visibility of cell 1 by security cameras. To the right of the entry door is a small window through which medications are given. As explained to reviewers, detainees form a queue to receive their medications from nurses at established "pill pass" times. Deputy (b)(6); (b)(7)(C) stated during interview that the housing unit deputy supervises detainees from the dayroom side of the window during pill pass, to include checking their mouths to verify medications are swallowed.

### August 20, 2018

Detainee PADRON was seen twice for sick call, first by RN (b)(6); (b)(7)(C) 11:16 a.m. and then by LPN (b)(6); (b)(7)(C) at 5:32 p.m. RN (b)(6); (b)(7)(C) encounter note indicates the detainee was seen as a walk-in for complaint of runny nose and that she used the Pathway for Cold/Allergy Symptoms for her assessment. She stated during interview that she conducted the encounter in Spanish. With the exception of a mildly elevated blood pressure of 128/71, vital signs were within normal limits, as follows: temperature 97.2, pulse 76, and respirations 18. RN (b)(6); (b)(7)(C) documented PADRON's medical history included previously reported dyslipidemia and hypertension and added his new report of two strokes in 2014 and 2018, and hospitalization January 24 to 31 in Arizona. RN (b)(6); (b)(7)(C) stated during interview that the year of the hospitalization was 2018.

The RN listed PADRON's current medications and although she did not document a complaint of headache, she added that he was given acetaminophen 325 mg.

**Note:** (b)(6); (b)(7)(C) left blank components requiring examination of the throat, ears, and lymph nodes. In addition, although called for by the Pathway, she did not take PADRON's pulse oxygen level.

(b)(6); (b)(7)(C) 5:32 p.m. encounter note documents a sick call visit for PADRON's complaint of runny nose and cough. Because she did not document he was seen as a walk-in as had RN (b)(6); (b)(7)(C) is assumed the visit was scheduled pursuant to a healthcare request dated August 18, 2018 in which PADRON complained of cold symptoms. The request, written in English and triaged by LPN (b)(6); (b)(7)(C) on August 19, 2018, resulted in referral for sick call.

(b)(6); (b)(7)(C) used the Pathways for Cold/Allergy Symptoms for the encounter. During interview, she reported she does not speak Spanish and did not use an interpreter for this and her subsequent encounters with PADRON, stating he spoke and understood English.

**Note:** As noted previously, a form completed during admission processing documents that PADRON required an interpreter.

The detainee's temperature, pulse oxygen and blood pressure were within normal limits at 98.7, 98 percent, and 121/66, respectively.

**Note:** (b)(6); (b)(7)(C) did not record pulse rate and respiration count, both of which are included on the Pathway. (b)(6); (b)(7)(C) Clinical Director, and (b)(6); (b)(7)(C) stated nurses are expected to obtain a full set of vital signs during each nursing encounter.

The nursing assessment found yellow nasal drainage and redness in the throat. Lymph nodes were not swollen and lung sounds were clear. (b)(6); (b)(7)(C) noted PADRON denied pain with pressure to his forehead and cheeks, but she did not conduct a pain assessment using the standardized scale of zero to ten. Asked if pain assessments are routinely completed during encounters (b)(6); (b)(7)(C) stated they are required only when detainees are seen for complaint of pain.

**Note:** The medical record does not document pain assessments during any encounter with detainee PADRON, including those in which he reported pain and when called for by applicable Pathways.

In the Routine Interventions section of the note (b)(6); (b)(7)(C) documented she issued cetirizine<sup>19</sup> 10 mg to be taken one time daily for seven days.

As noted, LPN (b)(6); (b)(7)(C) used the Pathways for Cold/Allergy symptoms to complete the encounter. The Florida Nurse Practice Act<sup>20</sup> authorizes RNs to perform nursing assessments, provide nursing

<sup>19</sup> Cetirizine is an over-the-counter allergy relief medication.

<sup>20</sup> Florida Nurse Practice Act, Chapter 464, Florida Statutes.



diagnoses, and administer medications and treatments as prescribed or authorized by a duly licensed practitioner. The act recognizes that these functions require, “substantial specialized knowledge judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences.” By contrast, the Nurse Practice Act limits the authority of LPNs to perform selected acts, including administration of treatments and medications under the direction of an RN, physician, or dentist. The physician-approved CCS Pathways direct and duly authorize nursing assessments, diagnoses, and issuance of specified medications based on assessment findings, functions that reviewers hold are outside the scope of practice for LPNs. WellPath legal counsel Stefan Cange who as noted, was present for all interviews of medical personnel, stated he interprets the Florida Nurse Practice Act to allow completion of Pathways by LPNs.

**Note:** Regardless of whether or not LPNs act outside their practice by completing Pathways, the Pathway for Cold/Allergy Symptoms does not authorize the issuance of cetirizine, nor did (b)(6); (b)(7)(C) receive an order for its administration from a provider.

### **August 23, 2018**

(b)(6); (b)(7)(C) conducted detainee PADRON’s initial chronic care evaluation at 8:27 a.m. He reported during interview that he conducted the encounter in Spanish and for that reason, could offer no observation regarding PADRON’s English language proficiency. Recorded vital signs were normal pulse of 68, normal respirations of 14, and elevated blood pressure of 145/83<sup>21</sup>. Temperature and pulse oxygen level were not recorded.

(b)(6); (b)(7)(C) noted PADRON’s medical problems consistent with those listed during the intake screening: hypertension, hyperlipidemia, pancreatitis, chronic pain, and difficulty walking due to a previous accident. He noted PADRON walked with a limp and that his left leg appeared shorter than his right; also, that he had been issued a wheelchair. The examination of systems was within normal limits in each category. In his assessment findings, (b)(6); (b)(7)(C) documented PADRON’s clinical status was stable with respect to hypertension, hyperlipidemia, chronic pancreatitis, and chronic pain, and the degree of control for each condition was good. He ordered laboratory studies and a heart-healthy diet, and medications were to continue unchanged. The goals and objectives of the treatment plan were to maintain blood pressure less than 130/90 through medication and diet; meet a total cholesterol count of less than 200 and triglycerides less than 150 through medication and diet; and control chronic pain through medication, diet, and exercise. PADRON’s next chronic care appointment was scheduled to occur between November 21 and 29, 2018.

**Note:** During interview, (b)(6); (b)(7)(C) was asked if in retrospect, he considered detainee PADRON’s acuity level too high to be well managed at MCDC. He stated PADRON was stable when he examined him, and he was not made aware of subsequent elevated blood pressure readings and complaints of chest pain. Asked if he considered ordering blood

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<sup>21</sup> Blood pressure of 145/83 falls within AHA parameters for stage two hypertension.

pressure monitoring, (b)(6); (b)(7)(C) stated he did not, noting nurses are expected to follow protocols and report significantly elevated blood pressure readings to a provider.

### August 28, 2018

The results for laboratory studies ordered by (b)(6); (b)(7)(C) showed a slightly elevated blood glucose level of 101<sup>22</sup>, elevated triglyceride level of 172<sup>23</sup>, and low HDL level of 30<sup>24</sup>. Abnormal results of the complete blood count included high lymphocytes of 3.2<sup>25</sup> and high eosinophils of 0.9<sup>26</sup>. Dr. (b)(6); (b)(7)(C) initialed the lab report on August 31, 2018.

### August 29, 2018

(b)(6); (b)(7)(C) entered an encounter note titled Initial Medical History and Physical Assessment at 9:08 a.m. (b)(6); (b)(7)(C) stated during interview that interpretation assistance was not used during this or her subsequent encounters with PADRON because he spoke English.

**Note:** The ICE 2008 PBNDS, Medical Care, requires an initial health appraisal within 14 days of detainee arrival unless there is an acute or identified chronic condition warranting more immediate attention. PADRON's chronic conditions did, in fact, warrant an expedited health appraisal; therefore, completion of this encounter 11 days following his arrival is, on its face, delayed. However, reviewers conclude that although designated as the initial chronic care visit rather than the initial health appraisal, (b)(6); (b)(7)(C)'s examination of the detainee five days following his arrival was sufficient to meet the standard. Reviewers further note that in fact, because an initial physical examination was completed at KNSPC two days prior to PADRON's transfer to MCDC, the Initial Medical History and Physical Assessment completed this date would not have been required by the Medical Care standard, had the KNSPC physical examination been provided to MCDC and reviewed by the health care provider. (b)(6); (b)(7)(C) informed the review team that as a matter of course, KNSPC forwards a medical transfer summary, only. Consistent with her statement, the MCDC medical record documentation provided to reviewers does not include the physical examination completed by KNSPC NP (b)(6); (b)(7)(C).

Vitals signs within normal limits were temperature 98.7, pulse 74, respirations 14, and pulse oxygen 100 percent. PADRON's blood pressure was elevated at 152/88<sup>27</sup>.

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<sup>22</sup> Normal blood glucose, blood sugar, is 65 to 99.

<sup>23</sup> Triglycerides are the main constituents of body fat in the human body. Normal range is 0 to 149.

<sup>24</sup> HDL stands for high density lipoprotein, also known as good cholesterol, as it helps to remove extra cholesterol and plaque buildup in the arteries. Normal is greater than 39.

<sup>25</sup> Lymphocytes, also known as white blood cells, are a part of the immune system which fights off disease. The lymphocyte levels will be increased in the event of an infection. Normal range is 0.7 to 3.1.

<sup>26</sup> Eosinophils are a type of disease-fighting white blood cell. Levels will increase in parasitic infection, an allergic reaction, or cancer. Normal range is 0.0 to 0.4.

<sup>27</sup> Blood pressure of 152/88 is within AHA parameters for stage two hypertension.



(b)(6); (b)(7)(C) entered yes for the following problems, with elaboration: false teeth in the form of a bridge; a spot on the liver detected years ago by Jackson Memorial Hospital in Miami which resulted in no treatment; heartburn from food; constipation for which fiber is taken; hypertension; and cardiomegaly.

**Note:** As noted previously, the chest X-ray completed at KNSPC showed PADRON's heart was normal size, inconsistent with the report of cardiomegaly.

Regarding tuberculosis, (b)(6); (b)(7)(C) noted that PADRON had a history of a past positive test, vaccination in Cuba when younger<sup>28</sup>, and that the chest X-ray taken at KNSPC was negative. The physical examination summary notes no abnormalities were noted. In comments (b)(6); (b)(7)(C) wrote that PADRON reported he had six strokes in the past and had been taking a baby aspirin<sup>29</sup>; also, that (b)(6); (b)(7)(C) approved aspirin. (b)(6); (b)(7)(C) note indicates she would check with (b)(6); (b)(7)(C) and follow her orders. The note also states she would prescribe fiber. (b)(6); (b)(7)(C) electronically signed (b)(6); (b)(7)(C) note at 9:00 a.m. on August 30, 2018, adding no comments or orders.

**Note:** Absent a Pathway authorizing (b)(6); (b)(7)(C) to start fiber, a provider order would have been required. There is no documentation of an order or that fiber was started until October 26, 2018 following diagnosis of constipation.

During interview, (b)(6); (b)(7)(C) were queried about information in the encounter note. Asked to explain her physical examination summary documenting that no abnormalities were noted, (b)(6); (b)(7)(C) stated she meant there were no abnormal findings other than high blood pressure,. Asked whether she notified (b)(6); (b)(7)(C) of PADRON's request for aspirin, the RN stated she did not recall; likewise, (b)(6); (b)(7)(C) indicated she did not recall receiving the notification. (b)(6); (b)(7)(C) stated that typically, nurses schedule a chart review to request provider follow up.

**Note:** No record of a scheduled chart review was provided to reviewers. As discussed below, aspirin was not prescribed for 15 days following another request by PADRON.

(b)(6); (b)(7)(C) was also queried about (b)(6); (b)(7)(C) encounter note; specifically, about PADRON's reported history of strokes and request for aspirin. (b)(6); (b)(7)(C) stated that had the stroke history been reported to him, he would have prescribed a blood thinner.

**Note:** (b)(6); (b)(7)(C) electronic signature on (b)(6); (b)(7)(C) note certifies his review of the content, including PADRON's reported history of strokes.

<sup>28</sup> In some parts of the world, the Bacille Calmette-Guerin (BCG) vaccination against tuberculosis is given. The BCG may result in positive purified protein derivative skin tests.

<sup>29</sup> Baby aspirin is typically ordered for patients who are at high risk or have a history of heart disease or stroke to prevent formation of blood clots which could block blood flow to the heart or cause the blood vessel to burst and result in internal bleeding. Due to the bleeding risk associated with taking aspirin, however, it is important the provider discuss the risks and benefits with the patient prior to prescribing.

**Note:** The absence of any reference to a history of strokes in (b)(6); (b)(7)(C) August 23, 2018 chronic care examination note supports that detainee PADRON did not report the history to him; likewise, the detainee apparently did not report past strokes at KNSPC or during intake screening at MCDC. His first documented report of strokes was during a sick call encounter on August 20, 2018; the second was this date, August 29, 2018, during physical examination by (b)(6); (b)(7)(C). Review of the problem list in the medical record found a history of strokes was not included among PADRON's medical conditions. (b)(6); (b)(7)(C) stated medical conditions are added to the problem list only when diagnosed or confirmed by a provider. Presumably because PADRON did not report his stroke history to (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) did not note the history documented by (b)(6); (b)(7)(C) when he signed her physical examination encounter entry, it was not added to the problem list. Inclusion of known medical conditions on problem lists supports healthcare staff's awareness of all known medical conditions during encounters.

#### **August 31, 2018**

(b)(6); (b)(7)(C) documented receipt and triage of a healthcare request dated September 3, 2018. In the request, which was written in English, PADRON asked to receive his blood pressure medication at night. (b)(6); (b)(7)(C) wrote on the request that a routine appointment was scheduled for sick call.

**Note:** Based on the documented receipt and triage date of August 31, 2018, reviewers conclude September 3, 2018 was written in error by detainee PADRON.

**Note:** A sick call encounter pursuant to this request was not conducted. As discussed below, (b)(6); (b)(7)(C) reviewed PADRON's medical record on September 6, 2018 and changed the administration time for one of his medications.

#### **September 5, 2018**

(b)(6); (b)(7)(C) documented triage of a healthcare request dated September 4, 2018 in which PADRON complained of cold symptoms, runny nose, and wheezing. The request was written in Spanish. (b)(6); (b)(7)(C) referred him for routine sick call.

**Note:** The next sick call encounter was completed September 10, 2018 for other complaints (see below). The medical record provided does not allow determination of the whether (b)(6); (b)(7)(C) scheduled a sick call appointment prior to that date.



## September 6, 2018

(b)(6); (b)(7)(C) documented a chart review at 11:32 a.m. She listed PADRON's current problems as allergic rhinitis<sup>30</sup>, chronic pain due to trauma, chronic pancreatitis, and hypertension. She did not include hyperlipidemia on the list of diagnoses.

**Note:** Although PADRON complained of cold symptoms in a healthcare request two days earlier and (b)(6); (b)(7)(C) listed allergic rhinitis among current problems, an assessment was not conducted pursuant to the complaint.

In her chart review note, (b)(6); (b)(7)(C) wrote, "Patient would like his amlodipine scheduled at night." She changed administration of the medication to evenings, accordingly.

**Note:** In his September 3, 2018 healthcare request, detainee PADRON asked to have his blood pressure medication given at night. He did not specify which of his three anti-hypertensive medications he wanted changed, or all three. Whereas (b)(6); (b)(7)(C) conducted a chart review only and did not see the patient, it is unclear how she determined amlodipine was the blood pressure medication he wished to take at night.

## September 10, 2018

(b)(6); (b)(7)(C) conducted a sick call encounter at 2:08 p.m. documenting PADRON complained of fungus on feet and requested for aspirin.

**Note:** If precipitated by a healthcare request for these complaints, none was found. In his last healthcare request dated and triaged September 4, 2018, PADRON complained of cold symptoms.

**Note:** (b)(6); (b)(7)(C) did not document use of a Pathway, nor did she document any vital signs.

PADRON reported the foot fungus was very itchy and (b)(6); (b)(7)(C) noted white dry skin was present on the bottom of his feet and in between his toes. She started antifungal medication fluconazole 150 mg, one tablet daily by mouth one time per week for three weeks. The MAR documents the medication was started and given per (b)(6); (b)(7)(C) order.

**Note:** Oral fluconazole is a prescription medication. Reviewers were not provided with documentation supporting that (b)(6); (b)(7)(C) obtained a verbal order from a provider; therefore, based on available documentation, (b)(6); (b)(7)(C) acted outside her scope of practice.

Regarding aspirin, (b)(6); (b)(7)(C) wrote, "Patient request to have his aspirin started since he has a clogged artery in his head." As he had during the initial physical examination, PADRON again told (b)(6); (b)(7)(C) said he would start him on aspirin. She wrote in the encounter note

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<sup>30</sup> Allergic rhinitis is otherwise known as seasonal allergies.

that the request would be placed in the chart for review, and that the detainee would be informed of the outcome.

**Note:** As discussed below, aspirin was started three days later.

### **September 13, 2018**

Detainee PADRON submitted a healthcare request stating his face was swollen and his lips were burning; also, because his gums had “holes” he was unable to wear his dentures. The request was triaged two days later and per the response, he was placed on the dental list. The triage nurse cannot be identified.

**Note:** Documentation the dental evaluation was scheduled was not provided to reviewers. PADRON was evaluated by a dental professional four weeks later, in the course of a sick call encounter during which he complained of soreness in his mouth and other medical symptoms.

### **September 14, 2018**

(b)(6); (b)(7)(C) entered a chart review at 4:15 p.m. listing PADRON’s medical conditions and medications. A note in her entry states, (b)(6); (b)(7)(C) started patient on aspirin.”

**Note:** Documentation of a verbal or written order was not provided to reviewers; however, the MAR documents PADRON was started on aspirin 81 mg, chewable tablet, the previous morning, September 13, 2018. The ordering provider was not specified. Aspirin, which as noted above is a blood thinning agent to prevent stroke or heart attack, was not initiated for more than two weeks after the detainee first reported his history of strokes and was told that his use of aspirin would be referred to a provider.

### **September 24, 2018**

Detainee PADRON submitted a healthcare request complaining of facial swelling and sore throat. The request was triaged (signature/initials illegible) with note added that the detainee would be scheduled for sick call.

**Note:** Documentation the sick call appointment was scheduled was not provided.

### **September 25, 2018**

(b)(6); (b)(7)(C) documented an encounter at 11:07 a.m. noting the nature of the visit was, “Miscellaneous: ‘extremely sick’” and that the encounter type was walk-in. PADRON’s pulse and respirations were normal at 87 and 14, respectively; his blood pressure was elevated at 135/87<sup>31</sup>.

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<sup>31</sup> Blood pressure of 135/87 falls within AHA parameters for stage one hypertension.



**Note:** Temperature and pulse oxygen were not obtained.

In the subjective section of the note (b)(6); (b)(7)(C) wrote PADRON “came down for an ‘urgent’ issue. Then he tells us that it is sickness from pain in his throat and he thinks he has swelling on left side of throat. Complain of congestions, sneezing, watery eyes.” In the objective section, (b)(6); (b)(7)(C) wrote, “Patient is informed that this is not the proper way to come down for sick call. He was informed how to do proper sick call process and will be expected to do this in the future.” Her assessment was that PADRON had a cold, and she gave acetaminophen 325 mg, two tablets to be taken twice daily for seven days as needed, and cetirizine 10 mg once daily for 30 days.

**Note:** (b)(6); (b)(7)(C) encounter note does not reflect that she used a Pathway for cold/allergy symptoms to arrive at her finding, nor does it document a general nursing assessment supporting her determination PADRON had a cold. As noted, the Pathway for cold and allergy symptoms provided to reviewers does not include the issuing of cetirizine; therefore (b)(6); (b)(7)(C) initiation of the medication was without apparent authority.

**Note:** The content of (b)(6); (b)(7)(C) note suggests the encounter was not a scheduled sick call visit. Specifically, she states the detainee came to medical on an urgent basis on report that he was extremely sick; also, that he was instructed to follow proper sick call procedures in the future. The Delta Unit Jail Log Report documents PADRON’s departure for medical at 10:59 a.m. and his return nine minutes later, at 11:08 a.m.; however, the deputy, (b)(6); (b)(7)(C), did not note that departure was other than for routine sick call.

## October 10, 2018

In response to two sick call requests dated October 8, 2018, one in English and one in Spanish, (b)(6); (b)(7)(C) conducted a nurse sick call encounter at 3:42 p.m. to address PADRON’s complaint of sore throat, neck pain, and infection inside his mouth. Normal vital signs were temperature 97.1, pulse 68, and pulse oxygen 98. PADRON’s blood pressure was mildly elevated at 132/78. A respiration count was not documented. PADRON complained of constipation and straining during bowel movements, and stated that when he wakes up in the morning, he coughs and his whole neck hurts and is swollen. He requested antibiotics.

In the objective section of her note, (b)(6); (b)(7)(C) wrote that PADRON’s abdomen was neither distended nor tender to touch, and bowel sounds were normally active in all four quadrants. She noted the detainee was assessed by (b)(6); (b)(7)(C) for his complaint of neck pain, and the determination was made that he was showing signs and symptoms consistent with heartburn/GERD<sup>32</sup>. LPN (b)(6); (b)(7)(C) objective note adds that PADRON also complained of a sore spot in his mouth and that upon assessment by dental (dental professional not specified), it was determined that the detainee had an aphthae ulcer<sup>33</sup> which would heal on its own. (b)(6); (b)(7)(C) documented, “Dental educated

<sup>32</sup> GERD is Gastro-Esophageal Reflux Disease, otherwise known as acid reflux, which causes heartburn.

<sup>33</sup> An aphthae ulcer, also referred to as a canker sore, is a commonly occurring small, shallow sore inside the mouth or at the base of the gums.

patient that he needs to take out his dentures and rest his mouth because this could be causing the ulcer in his mouth and further irritating it”; also, that she instructed him to increase his water intake.

**Note:** Neither (b)(6); (b)(7)(C) nor the dental professional documented their own assessments of detainee PADRON, including findings and education.

In the assessment decision section of the note, (b)(6); (b)(7)(C) wrote that PADRON was placed on a stool softener to resolve constipation and on Zantac<sup>34</sup> for heartburn. The plan was to follow up at a later date to determine if the Zantac was effective. The MAR documents Colace, a stool softener, was started this date and Zantac was started on October 12, 2018. Per the MAR, both were prescribed by (b)(6); (b)(7)(C) and successfully administered over the remaining detention period.

**Note:** Although the MAR documents Colace and Zantac were ordered by (b)(6); (b)(7)(C), the actual orders were not provided to reviewers and as noted, she did not enter an encounter note reflecting her assessment and orders. In addition, she did not co-sign (b)(6); (b)(7)(C) note to confirm its accuracy.

**Note:** The medical record provided does not include documentation of scheduling or completion of the referenced follow up.

#### **October 16, 2018**

(b)(6); (b)(7)(C) (first name and title unknown) completed an ICE Classification Reassessment Scale form documenting there were no disciplinary incidents or adjustment issues warranting a change to PADRON’s custody level. A supervisor approved (b)(6); (b)(7)(C) recommendation that the custody level remain high.

#### **October 24, 2018**

(b)(6); (b)(7)(C) mental health counselor, documented that she saw detainee PADRON in error. When triaging a healthcare request written in Spanish on October 19, 2018, LPN (b)(6); (b)(7)(C) mistakenly read it to state the detainee wished to be seen for depression. As translated for reviewers by ERAU team leader (b)(6); (b)(7)(C) PADRON appeared to be complaining of elevated blood pressure. (b)(6); (b)(7)(C) wrote that PADRON denied submitting the request and any past mental health treatment; also, that he would be seen again as needed.

**Note:** PADRON was not seen for complaint of elevated blood pressure.

#### **October 26, 2018**

Deputy (b)(6); (b)(7)(C) documented in the Delta Unit Jail Log Report that detainee PADRON stated he had chest pain and was sent to medical at 12:49 a.m. Deputy (b)(6); (b)(7)(C) elaborated on the event in

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<sup>34</sup> Zantac (generic name *ranitidine*) is a medication used to treat and prevent heartburn. It can also be used to treat stomach ulcers, gastroesophageal reflux disease, and other conditions that cause too much stomach acid.



an incident report, writing that he was at his desk when he heard knocking coming from PADRON's cell. He opened the door and asked the detainee what was wrong. When PADRON stated he was having chest pain, Deputy (b)(6); (b)(7)(C) radioed for a rover<sup>35</sup> and Sergeant (b)(6); (b)(7)(C) first name unknown) escorted the detainee to medical. The timeline in the incident report documents (b)(6); (b)(7)(C) arrived within three minutes of the radio call.

According to RN (b)(6); (b)(7)(C) she gave the instruction to bring PADRON to medical when notified by the deputy that the detainee reported chest pain. She wrote in her encounter note, entered at 4:32 a.m. that PADRON arrived at 1:00 a.m. and described his chest pain as sharp and radiating to the left arm and back. RN (b)(6); (b)(7)(C) recalled during interview that PADRON spoke "pretty good" English, indicating she seeks assistance from a staff member or uses the Language Line when necessary. PADRON's vital signs within normal limits were temperature 97.9, pulse 78, respirations 20, and pulse oxygen 97 percent. His blood pressure was extremely elevated at 196/98<sup>36</sup>, and he was observed gripping his chest. An electrocardiogram (EKG)<sup>37</sup> showed normal sinus rhythm with depressed ST segment<sup>38</sup>. RN (b)(6); (b)(7)(C) contacted (b)(6); (b)(7)(C) who ordered that the detainee be sent to Lower Keys Medical Center (LKMC). Per the RN's note, Main Control notified emergency medical services (EMS) and the ambulance arrived at 1:30 a.m. Per Deputy (b)(6); (b)(7)(C) incident report, Main Control contacted EMS at 1:10 a.m. and the unit arrived in sick bay at 1:24 a.m., departing the sallyport at 1:35 a.m. When asked, (b)(6); (b)(7)(C) stated she informed the emergency room (ER) of PADRON's condition by telephone and completed the necessary documentation to accompany him. She acknowledged that she failed to make a copy, but recalled with confidence that she reported the hypertensive crisis reading to the ER by phone and on the ER paperwork.

The ER record documents that PADRON arrived at 1:41 a.m. The presenting complaint was as follows: "EMS states [patient] from jail with [abdominal] pain. [Patient] states no [bowel movement] in two days."

**Note:** The ER record makes no reference to receiving notification by phone or in documentation that PADRON was sent to the hospital due to a blood pressure reading of 196/98. It does, however, list his medical conditions and detail each of his medications, suggesting paperwork was received. RN (b)(6); (b)(7)(C) assertion that she informed the ER of the blood pressure reading by phone and in the documentation cannot be verified.

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<sup>35</sup> Rover refers to a deputy assigned to escort duty.

<sup>36</sup> Blood pressure of 196/98 is within AHA parameters for hypertension crisis.

<sup>37</sup> An EKG is the process of recording the electrical activity of the heart using electrodes placed in specific locations on the skin.

<sup>38</sup> ST depression, common in patients with uncontrolled hypertension, is often a sign of myocardial ischemia (lack of oxygen to the heart muscle), of which coronary insufficiency is a major cause.

Vital signs within normal limits were temperature 98.1, pulse 70, respirations 20, and pulse oxygen 99 percent. His blood pressure was 132/75<sup>39</sup>. The review of systems was positive for chest pain, cough, and constipation.

The imaging report for an abdominal X-ray states, "No active disease was found in the chest. Gas scattered throughout nondilated bowel in a nonspecific pattern." An EKG showed non-specific ST abnormality. Administered medications included 30 mg of mineral oil by mouth and 300 milliliters of magnesium citrate liquid<sup>40</sup>, both to treat constipation. In his disposition summary, (b)(6); (b)(7)(C) documented diagnosis of constipation. PADRON's condition was stable and his symptoms were improved. A prescription was written for lactulose solution<sup>41</sup> 30 milliliters once daily by mouth, with follow-up by (b)(6); (b)(7)(C) for continuity of care. PADRON was provided patient education information addressing adult constipation.

(b)(6); (b)(7)(C) documented in her encounter note that detainee PADRON returned from LKMC at 4:20 a.m. The Delta Unit Jail Log Report documents he returned to Delta Unit at 4:34 a.m.

**Note:** During interview, RN (b)(6); (b)(7)(C) remarked that she was surprised the detainee returned from the ER so quickly with only a diagnosis of constipation. She stated she conducted a follow-up nursing assessment upon PADRON's return from the ER, to include taking vital signs. As noted, she documented the time of his return but there is no record of a nursing assessment, vital signs, or notification of a provider before the detainee was returned to the housing unit.

PADRON was seen for follow up by (b)(6); (b)(7)(C) at 9:13 a.m. (b)(6); (b)(7)(C) DON, interpreted for the encounter. Vital signs within normal limits were temperature 98.2, pulse 81, respirations 16, and pulse oxygen normal 99 percent. His blood pressure was significantly elevated at 175/107<sup>42</sup>. PADRON reported he had pain in his left scapula and left arm the night before. He said he was given medication for constipation in the ER and that he had had two bowel movements since that time. His last bowel movement prior to the ER visit was the previous morning. He denied injury to his arm and was uncertain what caused the pain. He was concerned about his elevated blood pressure before going to the ER and that morning, but (b)(6); (b)(7)(C) noted he had yet to receive his morning medication. He said he needed more fiber in his diet and an extra mattress.

The objective section of the note indicates PADRON was moaning but stopped immediately after he was given a stat dose of Toradol<sup>43</sup> 60 mg by injection. There was no sweating or pallor<sup>44</sup>, and

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<sup>39</sup> Blood pressure of 132/75 is within AHA parameters for stage one hypertension.

<sup>40</sup> Magnesium citrate liquid is a salt solution laxative which is thought to work by increasing fluid in the small intestine.

<sup>41</sup> Lactulose solution is a sugar solution used to soften the stools for treatment of constipation.

<sup>42</sup> Blood pressure of 175/107 is within AHA parameters for stage two hypertension.

<sup>43</sup> Toradol (generic *Ketorolac*) is a medication that treats pain.

<sup>44</sup> Pallor refers to an unhealthy pale appearance.



his speech was normal. His lungs were clear, and his heart was regular with no murmur. His abdomen was normally active for bowel sounds, non-tender, non-distended, and free of organomegaly<sup>45</sup>. His left scapular border<sup>46</sup> and biceps showed tenderness to palpation, and mild muscle spasm was noted. No swelling was observed, and he was able to stand without assistance for the injection. The assessment conclusion was muscle pain in the left scapular border and constipation. An extra mattress was authorized, and hydration was encouraged.

**Note:** Reviewers did not observe a second mattress in photographs of PADRON's cell taken following his death.

Medication changes included Fiber Lax 625 mg to be taken one time per day for 90 days to treat constipation, and the one-time Toradol injection. Follow up was to occur as scheduled for chronic care clinic.

During interview, (b)(6); (b)(7)(C) was asked for any retrospective comment on this encounter, including any concern about PADRON's blood pressure of 175/107. She said she focused more on his musculoskeletal complaint and constipation, and was not concerned about the blood pressure reading because he had not yet taken his morning medication. She did not consider ordering blood pressure monitoring.

#### October 28, 2018

PADRON submitted a healthcare request in English complaining of pain in his chest that radiated down his left arm. He added that he had not had a bowel movement since he went to the hospital, and that his pain was bad at night. The request was received and triaged the same day with response by (b)(6); (b)(7)(C) indicating the detainee "will be seen by doctor today again."

**Note:** Based on the seriousness of any report of chest pain (b)(6); (b)(7)(C) should have directed PADRON's immediate transport to medical for assessment. Contrary to the RN's triage response, there is no documentation an encounter with a provider was scheduled or conducted this date. As described below, this request appears to have been disposed by (b)(6); (b)(7)(C) the next day without patient assessment.

Deputy (b)(6); (b)(7)(C) documented the following in the Delta Unit Jail Log Report: "[PADRON] complaining of pain running down his left arm extended to his leg on same side. Face looks flush and developing red marks (blotch like). Notified medical and radioed a rover to escort to sick bay side per medical." The corresponding encounter note was entered by RN (b)(6); (b)(7)(C) 1:28 a.m. as a general SOAPE<sup>47</sup> note. She stated during interview that the detainee spoke "good English" and that when necessary, she uses a deputy or another medical staff person

<sup>45</sup> Organomegaly is the abnormal enlargement of one or more organs.

<sup>46</sup> The scapula is the shoulder bone.

<sup>47</sup> SOAPE refers to documentation which includes Subjective and Objective information, Assessment findings, Plan of care, and patient Education

for interpretation assistance. PADRON's vital signs within normal limits were pulse 78, respirations 22, and pulse oxygen 99 percent. Blood pressure was elevated at 148/81<sup>48</sup>. In the subjective section of the note, (b)(6); (b)(7)(C) documented only the following: "came to medical waving 1 arm states it hurts." In the objective section, she wrote, "nothing ordered for pain, when he talks to staff or when [blood pressure] taken he was quiet, but when left alone for a few seconds he moans again." Her assessment was that PADRON wanted Motrin for pain. For the plan, RN (b)(6); (b)(7)(C) documented the pain was determined non-radiating and reproducible<sup>49</sup>, and that the detainee was given a dose of medication. (b)(6); (b)(7)(C) clarified during interview that detainee was given ibuprofen. By way of education, PADRON was told to alert staff of problems.

**Note:** As detailed, (b)(6); (b)(7)(C) SOAPE note consists of one sentence for each element. Despite the complaint of chest pain, she did not use the Pathway for hypertension. The Pathway is two pages in length and calls for noting whether the patient has a history of hypertension; also, inquiry into 12 listed symptoms, including a rating for pain. For patients with known hypertension currently on medication, the Pathway requires scheduling an appointment with a provider within seven days if blood pressure is normal to high. A range of blood pressure levels meeting this criteria is not specified, nor does the Pathways set a threshold for provider notification. As noted, PADRON's blood pressure this date fell within AHA parameters for stage two hypertension.

#### October 29, 2018

A Nurse Sick Call Visit order by (b)(6); (b)(7)(C) timed 2:31 a.m. documents, "Sick call patient is complaining about chest pain again, he was examined yesterday and day before that, he complains about the same thing, pain is reproducible."

**Note:** There is no encounter note associated with this Nurse Sick Call Visit order. Because the order was not provided in advance of the site visit, reviewers did not have the opportunity to analyze its contents in context of the medical record timeline. Available information leads reviewers to surmise that this order is likely associated with PADRON's October 28, 2019 healthcare request. Reviewers further surmise that (b)(6); (b)(7)(C) noting PADRON was seen the day before and inaccurately stating he was seen the day before that as well, closed the sick call encounter without seeing the detainee. Late production of the order did not allow identification of (b)(6); (b)(7)(C) as a witness; therefore, verification of reviewers' theories and determination of the reason a nursing sick call rather than provider visit was not achieved by way of interview.

At 1:27 p.m., Deputy (b)(6); (b)(7)(C) documented in the Delta Unit Jail Log Report that detainee PADRON complained about pain in his chest and left arm. A nurse was notified and authorized his escort to medical. In a corresponding encounter note timed 1:42 p.m., LP (b)(6); (b)(7)(C)

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<sup>48</sup> Blood pressure of 148/81 is within AHA parameters for stage two hypertension.

<sup>49</sup> Reproducible means causing pain by applying pressure to the area.



documented PADRON was brought to medical for complaint of chest pain. She recorded the following three normal pulse reads and elevated blood pressure levels:

- 1:20 p.m. Pulse 87, blood pressure 196/99<sup>50</sup>
- 1:30 p.m. Pulse 88, blood pressure was 180/100<sup>51</sup>
- 1:40 p.m. Pulse 88, blood pressure 157/97<sup>52</sup>

**Note:** No other vital signs were recorded.

Following the recorded three blood pressure reads, LPN (b)(6); (b)(7)(C) wrote that (b)(6); (b)(7)(C) was consulted and PADRON was moved to sick bay. The Delta Unit Jail Log Report documents the detainee was processed out of the unit and into sick bay at 1:46 p.m.

**Note:** (b)(6); (b)(7)(C) note leaves open the question of whether she notified (b)(6); (b)(7)(C) when PADRON's blood pressure was found to be 196/99 and received instructions to recheck it.

At 2:15 p.m. (b)(6); (b)(7)(C) entered a note repeating that PADRON had been sent to medical for complaint of chest pain. She wrote that after speaking with him and reviewing his vital signs, he told her he was not having pain in his chest but was very worried about his pancreas and requested lab studies to rule out pancreatitis. (b)(6); (b)(7)(C) located him "on his approach to come to medical and nurse explained that stating you have chest pain is considered a medical emergency and should be taken very serious. Patient has now been placed in sick bay for further observation and is scheduled to have labs drawn tonight while patient is fasting."

The review team asked (b)(6); (b)(7)(C) about her encounter note during interview. She stated that when PADRON was brought to medical, he admitted he did not really have chest pains but claimed he did because he wanted lab tests to find out if there was something going on with his pancreas. She did not ask or observe, and PADRON did not specify, any symptoms he was experiencing. (b)(6); (b)(7)(C) said she did not take his blood pressure and did not know of the three blood pressure readings taken by (b)(6); (b)(7)(C).

**Note:** As noted (b)(6); (b)(7)(C) documented that she reviewed PADRON's vital signs. In fact, a full set of vital signs were not taken by either (b)(6); (b)(7)(C).

Asked about the referenced lab studies (b)(6); (b)(7)(C) stated they were verbally ordered by NP (b)(6); (b)(7)(C). The order, provided to the review team during the site visit, was entered by (b)(6); (b)(7)(C) at 2:08 p.m. and set an end date of October 31, 2018 for collection of the blood sample. (b)(6); (b)(7)(C) explained that she set a two day timeframe for collection of the sample consistent with

<sup>50</sup> Blood pressure of 196/99 is within AHA parameters for hypertensive crisis.

<sup>51</sup> Blood pressure of 180/100 is slightly below AHA parameters for hypertensive crisis.

<sup>52</sup> Blood pressure of 157/97 is within AHA parameters for stage two hypertension.

standing practice. Per the LabCorp report documenting findings of the studies<sup>53</sup>, the specimen was collected at midnight on October 31, 2018. (b)(6); (b)(7)(C) stated that midnight is entered for collection of lab specimens as a matter of course but the specimens were actually collected at 3:00 a.m. on October 31, 2018. (b)(6); (b)(7)(C) could not explain why in her note, she documented the labs were to be drawn the night of the encounter, October 29, 2018.

(b)(6); (b)(7)(C) was also asked about her recollection of events this date. She recalled being told by a nurse that PADRON came to medical complaining of chest pain but when he got there, complained of something different. She directed his placement in sick bay so he could be observed and ordered the lab studies. Asked whether placement in sick bay constitutes admission to medical housing, (b)(6); (b)(7)(C) said, "Not really", but indicated that if she directs placement, she expects to be contacted for authorization to return a patient to general population. During interview of HSA (b)(6); (b)(7)(C) she confirmed providers are to determine when a patient may be released from sick bay. Asked about expectations for nurse monitoring of patients in sick bay, she said nurses are to speak to patients and take their vital signs at least once per shift, or as otherwise ordered by the provider.

Per entry in the Delta Unit Jail Log Report by Deputy (b)(6); (b)(7)(C), PADRON was processed back into the unit at 11:19 p.m.

**Note:** The detainee was in sick bay approximately ten and a half hours. There is no documentation of a nursing round or assessment prior to PADRON's release from sick bay, nor is there documentation indicating who directed PADRON's release from sick bay or that provider authorization was obtained.

#### October 30, 2018

(b)(6); (b)(7)(C) entered an encounter note at 11:10 p.m. stating PADRON refused his medications during evening pill pass. He stated he believed the medications were making his blood pressure worse and that he was experiencing chest pains, headaches, and feeling like he was having a stroke as in the past. (b)(6); (b)(7)(C) had him brought to medical for assessment, conducted with interpretation assistance by Deputy (b)(6); (b)(7)(C). PADRON's blood pressure was elevated at 160/98<sup>54</sup>, his pulse was abnormally rapid at 104, and respirations were normal at 18. Temperature and pulse oxygen were not recorded. Asked during interview if she was concerned about the blood pressure level, (b)(6); (b)(7)(C) stated she was not because, "I knew his blood pressures ran high."

(b)(6); (b)(7)(C) documented and stated to the review team that PADRON insisted the amlodipine he takes in the evening is the reason his blood pressure is high and that he wanted the medication he arrived with. After reviewing the list of intake medications, (b)(6); (b)(7)(C) assured him several times they had not changed. PADRON continued to disagree. When she offered to schedule him

<sup>53</sup> Per the LabCorp report, findings were reported November 1, 2018 at 10:12 a.m., following PADRON's death. See Appendix x for results.

<sup>54</sup> Blood pressure of 160/98 is within AHA parameters for stage two hypertension.



to see “medical” the detainee stated he did not want to be seen by anyone other than a doctor. LPN (b)(6); (b)(7)(C) stated during interview that he specifically said he did not want to see the “lady”, presumably referring to (b)(6); (b)(7)(C). Although PADRON continued to maintain that he was not receiving the correct medication, he eventually took his evening doses. (b)(6); (b)(7)(C) deemed him stable, instructed him to alert staff if he experienced chest pain, and had him returned to Delta Unit. Her referral for doctor sick call was changed to provider sick call by (b)(6); (b)(7)(C) the next morning. The sick call appointment was not completed prior to his death.

### October 31, 2018

Reviewers were provided with a video-recorded interview of detainee (b)(6); (b)(7)(C) conducted by a Sheriff’s Office investigator the day of PADRON’s death. The investigator was identified by (b)(6); (b)(7)(C) as Major Crimes Detective (b)(6); (b)(7)(C). During the interview, detainee (b)(6); (b)(7)(C) stated PADRON complained of chest pains during the afternoon this date, the day before PADRON’s death. (b)(6); (b)(7)(C) said the deputy contacted medical and that a nurse eventually responded, but took no action. Instead, she said PADRON complained too much and that he would be seeing the doctor the next day.

Due to his impending deportation, reviewers interviewed (b)(6); (b)(7)(C) by telephone prior to the site visit. He stated he was assigned to cell two, next to PADRON’s, and that he routinely interpreted communications with staff because PADRON spoke very limited English. Regarding events on October 31, 2018, detainee (b)(6); (b)(7)(C) reported information substantially consistent with what he told Detective (b)(6); (b)(7)(C) including that when the nurse arrived in the housing unit, she dismissed the complaint of chest pains, ignoring that PADRON was sweating profusely and holding the left side of his chest. (b)(6); (b)(7)(C) said the nurse left without checking PADRON in any way or giving him anything for pain. He could not identify the nurse, but said a more compassionate nurse spoke to PADRON at evening pill call and said he would be seeing a doctor in the morning.

This incident was not documented in either the Delta Unit log or the medical record; therefore, reviewers sought to identify the staff involved. Before interviewing (b)(6); (b)(7)(C) the deputy assigned to Delta Unit during the day shift, Captain (b)(6); (b)(7)(C) offered that PADRON was, in fact, taken to medical for complaint of chest pain this date. Upon request, he provided video evidence that the detainee was taken from Delta Unit to sick bay and evaluated by medical staff. Deputy (b)(6); (b)(7)(C) confirmed during interview that he called medical when PADRON reported chest pains and received authorization to have him escorted to sick bay. Asked why he did not log the event, Deputy (b)(6); (b)(7)(C) said other duties may have distracted him.

**Note:** Detainee (b)(6); (b)(7)(C) statement that PADRON complained of chest pain during the afternoon is substantiated. However, his statement that a nurse came to the housing unit and took no action is unsubstantiated. Actions taken by medical staff pursuant to PADRON’s complaints are described below.



Video from Delta Unit provided by Captain (b)(6); (b)(7)(C) during the site visit shows PADRON was wheeled to the deputy's station by detainee (b)(6); (b)(7)(C) at 2:24 p.m. Conversation with the Deputy (b)(6); (b)(7)(C) ensued and the deputy made a phone call. At 2:27 p.m. PADRON was wheeled out of Delta and at 2:28 p.m., was wheeled into sick bay by a security staff member identified by Captain (b)(6); (b)(7)(C). PADRON remained positioned away from the nurses' station while a nurse, identified as (b)(6); (b)(7)(C) finished an encounter with another detainee (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) started his assessment of PADRON at the nurses' station at 2:34 p.m. Sergeant (b)(6); (b)(7)(C) stood nearby, stating during interview that he provided interpretation assistance until a Spanish-speaking nurse took over. He recalled PADRON said he was having chest pains.

The video shows PADRON remained at the nurses' station for a total of 18 minutes. RN (b)(6); (b)(7)(C) is seen taking his vital signs early during the encounter, looking at the computer screen, and communicating with PADRON and (b)(6); (b)(7)(C). HSA (b)(6); (b)(7)(C) and two nurses entered the area at various points, ostensibly by happenstance and for reasons unrelated to detainee PADRON. (b)(6); (b)(7)(C) entered as well and spoke with the staff who were present, but did not approach or speak with PADRON before leaving within a minute. After (b)(6); (b)(7)(C) left, Sergeant (b)(6); (b)(7)(C) is seen speaking to the detainee as (b)(6); (b)(7)(C) who had moved behind the nurses' station and closer to PADRON, stood by. As the detainee appeared to grow agitated, gesturing as he spoke, (b)(6); (b)(7)(C) joined the conversation. She sat in a chair and continued to speak with PADRON as (b)(6); (b)(7)(C) diverted his attention to speak with (b)(6); (b)(7)(C) who remained at the other end of the counter. (b)(6); (b)(7)(C) appeared actively involved in communicating with detainee PADRON for approximately three minutes before moving out of view. Within a minute, (b)(6); (b)(7)(C) is seen giving the detainee water and possibly a pill. As that occurred, (b)(6); (b)(7)(C) moved toward PADRON, then toward the exit as the detainee moved himself to his wheelchair and wheeled himself out of camera range, following the sergeant.

(b)(6); (b)(7)(C) were asked about this encounter during interview. Their comments are summarized as follows.

- (b)(6); (b)(7)(C) stated that when notified by the housing unit deputy that PADRON was claiming to have chest pains, he directed that he be brought to medical. He said he took PADRON's vital signs, jotting them on the sick bay roster, and conducted an appropriate assessment. Review of the Sick Bay Shift Report confirmed PADRON's name was handwritten in the top right corner, below which appear the following vital signs: pulse 77, and pulse oxygen 97 percent, both within normal limits, and blood pressure 153/89<sup>55</sup>. (b)(6); (b)(7)(C) acknowledged he did not take PADRON's temperature or respiration count, nor did he complete a pain assessment or use the Hypertension Pathway. He said he reviewed the detainee's chart in the EMR and noted he had a history of chest pain complaints; also, that he was recently sent to the ER. Although PADRON was asymptomatic and showed no signs of distress, (b)(6); (b)(7)(C) went to get N (b)(6); (b)(7)(C).

<sup>55</sup> Blood pressure of 153/89 is within AHA parameters for stage two hypertension.



According to (b)(6); (b)(7)(C) the NP came to sick bay and took over. He said he twice asked her if she wanted him to perform an EKG and both times she said no. (b)(6); (b)(7)(C) also said that at some point during the encounter, he requested (b)(6); (b)(7)(C) assistance in translating. Asked whether he recalls giving PADRON a medication, (b)(6); (b)(7)(C) said the detainee may have been given an aspirin, but that would have been N (b)(6); (b)(7)(C) responsibility to direct and document. Asked why he did not enter an encounter note, RN (b)(6); (b)(7)(C) said that because (b)(6); (b)(7)(C) interpreted, she had a better understanding of communications with detainee PADRON and in fact, told him she would take of the documentation. (b)(6); (b)(7)(C) said the decision to return the detainee to the housing unit was (b)(6); (b)(7)(C)

- (b)(6); (b)(7)(C) who was interviewed before (b)(6); (b)(7)(C), acknowledged that she was present at the time of the encounter but, “didn’t really know what was going on.”
- (b)(6); (b)(7)(C) who also was interviewed before (b)(6); (b)(7)(C) stated she was in sick bay to see another patient and recalled only that she instructed the nurses to tell PADRON he would see a doctor.

**Note** (b)(6); (b)(7)(C) account of events during the encounter is not supported by video evidence or the statements of (b)(6); (b)(7)(C). As noted, video shows (b)(6); (b)(7)(C) entered and exited sick bay within a minute, during which she had no interaction with PADRON. The video shows (b)(6); (b)(7)(C) was more involved than she described; in fact, it appears she was directly involved for approximately three minutes, including one minute where she sat and spoke with PADRON one-to-one. Since she denied recollection of the communication, the content is unknown. Nonetheless, because the encounter was initiated by (b)(6); (b)(7)(C) who, by his own report, assessed the detainee, it was his responsibility to document the encounter, to include any communications translated by (b)(6); (b)(7)(C).

Delta Unit video shows PADRON back in the dayroom, in his wheelchair, at 2:53 p.m. Footage from all six cameras shows that for the next seven minutes, he wheeled himself around with no difficulty or evident distress.

Phone records document that between 7:48 p.m. and 10:42 p.m., PADRON attempted 17 calls to the same number, eight of which were completed. According to ERAU team leader (b)(6); (b)(7)(C), PADRON did not express that he was in medical distress<sup>56</sup>.

Per the Jail Log Report, medications were given at 9:00 p.m. During interview of LPN (b)(6); (b)(7)(C) she confirmed detainee (b)(6); (b)(7)(C) statement that when she gave detainee PADRON his evening medications, she told him he would see the doctor in the morning. She commented that

(b)(6); (b)(7)(C) informed Creative Corrections reviewers that he used interpretation services to determine if any information pertinent to the death review was discussed. He noted interpretation was compromised due to the quality of the audio. More specific information will be provided in ERAU’s report, as determined necessary by Mr. (b)(6);

he appeared stable and in no distress, but was anxious to see the doctor about his medications. Asked about the appointment, (b)(6); (b)(7)(C) said she scheduled it in Correctek and spoke to Dr. (b)(6); (b)(7)(C) about detainee PADRON.

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

At 11:00 p.m., Deputy (b)(6); (b)(7)(C) who assumed the Delta Unit post at 6:00 p.m., documented completion of the face-to-photo count on the MCDC form so titled. Monroe County Sheriff's Office Corrections Bureau Directive 8:021, Population Count Principles and Procedures, states that for the face-to-photo count, detainees in specified housing units, including Delta, "will stand in their cells with their ID's in hand. The deputy will open door and the inmate will present the ID to the deputy for face to photo verification along with the site placement checking for accuracy. Once the inmates have been verified and counted, the cell is re-secured." Although as noted, a staircase largely obstructs view of PADRON's cell, Delta Unit video shows Deputy Pierrilus appears to have stopped at his cell and looked in all other cells, marking a document on a clipboard along the way. He did not open any cell doors during the face-to-photo count. During interview, Deputy (b)(6); (b)(7)(C) stated detainee PADRON presented his ID card at the cell door window. He reported the 11:00 p.m. count was the last time he saw PADRON alive. Per the Jail Log Report, the unit was locked down at 11:14 p.m.

### November 1, 2018 - Day of Death

Deputy Pierrilus documented on the Jail Log Report that throughout the remainder of his shift, he conducted six security rounds at staggered 30 minute intervals as required by Directive 8:020, Observation of General Population and Special Inmates. He also documented two physical counts which, per Directive 8:021, Population Count Principles and Procedures, requires that deputies "be positive they see a living human body before counting an inmate present", judiciously using flashlights as necessary during night counts. Deputy Pierrilus stated during interview that he noted nothing unusual when he looked in PADRON's cell during rounds, and that the detainee appeared to be sleeping. The deputy's entries document the following:

| Time      | Action                            |
|-----------|-----------------------------------|
| 3:20 a.m. | Security round                    |
| 3:49 a.m. | Security round                    |
| 4:18 a.m. | Security round and physical count |
| 4:47 a.m. | Security round                    |
| 5:16 a.m. | Security round                    |
| 5:45 a.m. | Security round and physical count |

To confirm completion of the documented rounds and count, the review team requested video from the security camera directed toward PADRON's cell from midnight through the end of the shift at 6:00 a.m. Video was provided for three of the requested six hours, from 3:00 a.m. to 6:00 a.m.



Analysis of the video found [REDACTED] made a total of four rounds in camera range rather than the six documented. He is seen making rounds at 3:16 a.m., 4:19 a.m., 5:02 a.m., and 5:46 a.m., and only during the 5:02 a.m. and 5:46 a.m. rounds is he seen going to PADRON's cell. He does not use a flashlight and does not appear to take the time necessary to verify cell occupants are alive.

[REDACTED] assumed responsibility for the post at 6:00 a.m. He logged his first round at 6:04 a.m. and his second at 6:28 a.m., both corroborated by video evidence. During interview, Deputy [REDACTED] said PADRON appeared to be sleeping both times he looked in the cell. He said he next went to the cell when another detainee informed him PADRON would not wake up. That detainee was identified by [REDACTED]. Video shows [REDACTED] walking across the dayroom to PADRON's cell at 6:41 a.m., approximately ten seconds after another detainee, identified by [REDACTED] as [REDACTED] went to the cell door. During interview of [REDACTED], he said he typically wheeled PADRON to get his breakfast tray so when he arrived and MENOCAL told him PADRON was sleeping, he said, "I got this" and entered the cell. [REDACTED] said that as soon he saw PADRON, he knew he was dead. He called for the officer, who responded right away. Video evidence shows [REDACTED] did, in fact, respond and enter the cell immediately after [REDACTED] is seen returning to the cell doorway, then exited approximately five seconds later as other detainees approached. During interview, Deputy [REDACTED] said that when he entered the cell he attempted to rouse PADRON, describing his body as cold and blue. Finding no pulse, he called Code Blue, medical emergency. Per entry to the Main Control log by Sergeant A [REDACTED] Code Blue was called at 6:42 a.m.

Based on analysis of the video, the timeline was as follows:

| Time         | Event                                                                                       |
|--------------|---------------------------------------------------------------------------------------------|
| 6:41:00 a.m. | Detainee [REDACTED] arrived at PADRON's closed cell door, followed by detainee [REDACTED]   |
| 6:41:12 a.m. | [REDACTED] opened the door and entered the cell as [REDACTED] moved away.                   |
| 6:41:30 a.m. | [REDACTED] moved into view outside the cell doorway, presumably summoning Deputy [REDACTED] |
| 6:41:44 a.m. | [REDACTED] entered the cell as other detainees approached.                                  |
| 6:41:50 a.m. | [REDACTED] exited the cell and remained nearby, directing the other detainees away.         |
| 6:42:27 a.m. | The first security responders arrived on the unit.                                          |
| 6:43:38 a.m. | Two nurses arrived with cart.                                                               |

**Note:** After the Code Blue call, Security responders arrived in less than a minute and medical responders arrived in less than two minutes.

First to enter PADRON's cell in response to the Code Blue was Deputy (b)(6); (b)(7)(C) followed quickly by Sergeant (b)(6); (b)(7)(C) Deputy (b)(6); (b)(7)(C) said during interview that the detainee was on his back on his bunk, that his body was "chilly", and that he had no pulse and was not breathing. (b)(6); (b)(7)(C) reported (b)(6); (b)(7)(C) was taking PADRON's pulse when she entered. Per their verbal statements and written reports, they immediately moved him to the floor and started cardio pulmonary resuscitation (CPR), (b)(6); (b)(7)(C) giving rescue breaths with mask and Sergeant (b)(6); (b)(7)(C) performing chest compressions. Upon arrival of two nurses, identified as (b)(6); (b)(7)(C) used the sheers maintained on the trauma cart to cut PADRON's shirt for application of the automated external defibrillator (AED) pads by the nurses. (b)(6); (b)(7)(C) medical record entry describing the emergency response confirmed PADRON had no pulse and was "lifeless" when she and (b)(6); (b)(7)(C) arrived; also, that CPR was already underway. She documented the AED noted no rhythm, after which CPR resumed. According to the written reports of (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) assisted with CPR rotations. Per his own report and those of (b)(6); (b)(7)(C) Sergeant (b)(6); (b)(7)(C) also assisted with CPR.

An entry in the Main Control log documents EMS was called at 6:43 a.m., a minute after the Code Blue was logged. Direction to call EMS is not documented in any written reports; however, (b)(6); (b)(7)(C) stated during interview that it came from Sergeant (b)(6); (b)(7)(C). In his written report and verbal statement to the review team, Sergeant (b)(6); (b)(7)(C) stated that when he responded to the Code Blue, he first assisted in locking down the unit and instructed Deputies (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) to prepare for the hospital transport, then assisted with CPR. Because he was interviewed before Sergeant (b)(6); (b)(7)(C) was not asked to verify that he directed the call to EMS.

**Note:** The EMS report was requested in advance of and during the site visit. By email dated December 19, 2019 from Supervisory and Detention and Deportation Office (b)(6); (b)(7)(C) to ERAU team leader (b)(6); (b)(7)(C) the City of Key West refused to provide the report without a subpoena. Without the report, reviewers are unable to verify the time EMS was called and dispatched, and describe the care rendered by the EMS responders.

Per Main Control log entry, "EMS arrived and took over screen and CPR" at 6:49 a.m. Video shows EMS responders did not enter Delta Unit until 6:54 a.m.

**Note:** During interview, Sergeant (b)(6); (b)(7)(C) stated he wrote on paper the times and events reported to him by the staff on scene, later entering them in the computer. He did not record the time the ambulance is seen entering the vehicle sallyport, if observed.

In her medical record entry, RN (b)(6); (b)(7)(C) stated she gave EMS responders a copy of PADRON's history and physical and copy of his medications. The EMS responders are seen on video exiting Delta Unit at 7:03 a.m. with detainee PADRON on a gurney. Video from seven other cameras shows the responders' passage from the unit to the vehicle sallyport and placement in the



ambulance at 7:07 a.m. The vehicle exited through the secure gate at 7:10 a.m. en route to LKMC. Sergeant (b)(6); (b)(7)(C) written report states both Deputies (b)(6); (b)(7)(C) were on board the ambulance.

Per Sergeant (b)(6); (b)(7)(C) report, at 7:20 a.m. Deputy (b)(6); (b)(7)(C) notified him PADRON's death was pronounced at 7:17 a.m. The ER report confirms pronouncement of death at this time by Dr. (b)(6); (b)(7)(C) and differential diagnoses<sup>57</sup> of cardiac arrest and respiratory arrest.

Sergeant (b)(6); (b)(7)(C) documented that one deputy was directed to remain at the hospital until ICE arrived. During interview, he clarified that Major (b)(6); (b)(7)(C) directed that Deputy (b)(6); (b)(7)(C) remain and Deputy (b)(6); (b)(7)(C) return to the facility.

**Note:** Neither Deputy (b)(6); (b)(7)(C) nor Deputy (b)(6); (b)(7)(C) wrote reports. Captain (b)(6); (b)(7)(C) informed the review team that only personnel directly involved in an emergency response are required to write reports. Because Deputy (b)(6); (b)(7)(C) returned to the facility and could offer no information on events at the hospital following PADRON's death, he was not interviewed. Deputy (b)(6); (b)(7)(C) was not available for interview during the site visit, nor was Major (b)(6); (b)(7)(C). According to Captain (b)(6); (b)(7)(C) directed all actions following the death and handled notification of ICE ERO.

The following summarizes documented and/or reported actions following PADRON's death.

- (b)(6); (b)(7)(C) stated during interview that she secured and placed crime scene tape over PADRON's cell as soon as EMS left. She later escorted Major Crimes detectives to the cell, at which time the cell was unsealed and photographs were taken. Notably, one of the photographs provided to reviewers showed English-language paperback novels and multiple pills/tablets. (b)(6); (b)(7)(C) informed the review team that (b)(6); (b)(7)(C) as called to the unit to identify the medications, after which they were confiscated by the detective (b)(6); (b)(7)(C) told reviewers that the medications were antacids and ibuprofen and as she recalled, Mobic for arthritis pain and a medication for urinary incontinence, neither of which were prescribed for PADRON. His own prescription medications were not found among the pills.
- (b)(6); (b)(7)(C) Special Agent Supervisor, Florida Department of Law Enforcement (FDLE), informed the review team that Major Age notified him of PADRON's death on November 1, 2018. He explained that pursuant to a 2014 Memorandum of Understanding between the FDLE and Sheriff's Office, FLDE investigates all in-custody deaths. Agent (b)(6); (b)(7)(C) stated the Sheriff's Office detectives handled all internal matters, including preservation of the cell and its contents. He indicated his investigation is ongoing and will not be concluded until the medical examiner's report is available.

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<sup>57</sup> Differential diagnoses refers to two or more conditions that share similar signs or symptoms.

- On November 5, 2018, Captain (b)(6); (b)(7)(C) chaired a Death After Action meeting attended by (b)(6); (b)(7)(C) and security and medical personnel who responded to the Code Blue; specifically, (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) Meeting minutes reflect that each of the responding security staff members reported their recollections of the medical emergency consistent with what they reported to the review team and documented in incident reports. (b)(6); (b)(7)(C) complemented staff on a job well done.

**Note:** Deputy (b)(6); (b)(7)(C) as likely among the multiple security staff who are seen on video responding to the Code Blue; however, he did not submit an incident report and was not mentioned in reports of other staff. Meeting minutes indicate he reported that when he arrived, CPR was being performed by deputies. He assisted locking down the unit as other detainees yelled, “he been telling medical and that there is a death in Delta.”

Captain (b)(6); (b)(7)(C) summarized the after action review in a memorandum to Major (b)(6); (b)(7)(C) also dated November 5, 2018. He included the names of additional security responders who did not write incident reports, including Deputy (b)(6); (b)(7)(C) and probationary officers (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) (first names not provided).

**Note:** Deputy (b)(6); (b)(7)(C) and the probationary officers did not write incident reports but were likely among the security responders.

Captain (b)(6); (b)(7)(C) memorandum accurately states CPR was continued by MCDC responders until paramedics arrived, referencing 6:49 a.m. as the time this occurred.

**Note:** The time of 6:49 a.m. was also documented in the Main Control log; however, as noted, video evidence shows EMS responders did not enter the unit until 6:54 a.m.

The memorandum does not provide a statement summarizing the after action review team’s conclusions; however, it notes that staffing in Main Control during the incident was discussed. Captain (b)(6); (b)(7)(C) and Sergeant (b)(6); (b)(7)(C) both stated during interview that the discussion centered on the fact that the staffing plan assigns one deputy to Main Control overnight, with a second deputy starting at 7:30 a.m. Sergeant (b)(6); (b)(7)(C) said that because all movement was stopped and the facility was locked down during the PADRON emergency, he was able to handle added responsibilities related to the Code Blue; however, given the responsibilities and activity level in Main Control, assignment of second deputy is desirable. Captain (b)(6); (b)(7)(C) stated during interview that the issue will be addressed, but



underscored that staffing in Main Control had no bearing on the emergency response in PADRON's case.

**Note:** Given the speed of responders' arrival, reviewers concur staffing in Main Control did not impede the emergency response.

- All security personnel interviewed confirmed they were informed employee assistance resources were available. Detainee (b)(6); (b)(7)(C) said detainees in Delta Unit were not offered supportive counseling.
- Upon inquiry, the review team was told PADRON's funds balance of \$68.86 and personal property had not been released pending completion of the FDLE and Sheriff's Office investigations. FDLE Special Agent (b)(6); (b)(7)(C) stated he deferred a decision on release of PADRON's property and funds to the Sheriff's Office; according to Captain (b)(6); (b)(7)(C) the Sheriff's Office will not release the funds and property pending completion of its investigation. He said the investigation will not be completed until the medical examiner's report is available, possibly three to six months following the death.
- The last entry in PADRON's medical record was (b)(6); (b)(7)(C) pte documenting the emergency response. During interview, (b)(6); (b)(7)(C) stated he was not asked to write a medical summary. WellPath legal counsel (b)(6); (b)(7)(C) indicated the corporate mortality review was still in progress. Pending completion of the mortality review, nurses were re-trained in the Hypertension Pathways. An outline of the training and attendee roster were provided to reviewers.

## CONCLUSIONS

### Medical

Detainee PADRON reported multiple chronic medical conditions to healthcare providers at KNSPC, including hypertension, hyperlipidemia, pancreatitis, and leg pain. Upon physical examination, a provider prescribed medications for all but pancreatitis and cleared him for transfer to MCDC. A medical transfer summary listing the diagnoses and medications was forwarded to MCDC; the physical examination was not.

At MCDC, the nurse who conducted the intake screening started the medications the same day and approved a wheelchair due to PADRON's mobility limitations. He maintained the wheelchair throughout his detention. Identified by the nurse as a chronic care patient, he was seen by Dr. (b)(6); (b)(7)(C) for chronic care clinic the fifth day following arrival. The physician determined PADRON was stable and ordered continuation of the medication regimen and routine chronic care follow up

in 90 days. PADRON died weeks before the next scheduled appointment. I (b)(6); (b)(7)(C) had no encounters with the detainee following the first and only chronic care evaluation and was not notified of subsequent nursing encounters or events.

An initial physical examination was conducted by an RN 11 days following PADRON's arrival. The examination was technically not required because PADRON had already been evaluated by (b)(6); (b)(7)(C) and although not known by MCDC, by a provider at KNSPC. During the examination PADRON reported a history of strokes he had not reported to (b)(6); (b)(7)(C) or to the KNSPC provider. The history was, however, noted with great specificity on the I-213 form completed by an ICE Enforcement and Removal Operations officer prior to his placement in detention, leaving open the question of why PADRON did not report past strokes to medical providers. (b)(6); (b)(7)(C) signed the physical examination, apparently not noticing the stroke history for which PADRON requested aspirin as a preventative. The nurse did not refer the request to a provider. Aspirin was not started for another two weeks following a second request. Because PADRON's history of strokes was not noted or diagnosed by a provider, it was not added to the problem list.

Detainee PADRON was seen by nurses for sick call in response to multiple healthcare requests. Although the requests were triaged promptly, sick call appointments referenced in responses did not consistently occur. During sick call, nurses did not conduct pain assessments, take a full set of vital signs, or consistently use or fully complete applicable Pathways. In addition, on three occasions medications were given without apparent authority. Some nurses used interpretation assistance during encounters with PADRON; others stated his English language proficiency was adequate.

All prescribed medications were administered consistent with provider orders. PADRON's compliance was excellent until two days before his death, October 30, 2018, when he claimed anti-hypertensive amlodipine was making his blood pressure worse. The nurse having successfully coaxed PADRON into taking his medication, his compliance was 100 percent during the course of detention, demonstrating that he was an informed patient who understood his medical conditions. This was further evidenced by submission of a healthcare request on October 19, 2018 in which he stated he believed his blood pressure was elevated, and verbal request for laboratory studies on October 29, 2018 on grounds he was experiencing symptoms of he believed consistent with past pancreatitis.

Based on AHA parameters, PADRON's blood pressure was never normal. It was elevated twice and fell within parameters for stage one hypertension three times, stage two six times, borderline stage two/hypertension crisis once, and hypertension crisis level twice. Reviewers acknowledge that the CCS Pathways, which are approved by a physician at the corporate level, do not direct nursing interventions based on AHA parameters. PADRON's complaints related to hypertension started on October 19, 2018 when he submitted a request asserting his blood pressure was elevated. The triage nurse misinterpreted the request to state he was depressed, resulting in a referral to a mental health provider. He was not seen by a medical professional after the mental health provider



determined there were no mental health issues. On October 26, 2018 following urgent escort to medical for complaint of chest pain, PADRON's blood pressure was found to be 196/98 and an EKG was abnormal. The RN appropriately notified the NP who ordered that the detainee be sent to the ER by ambulance. The ER record does not document that hospital personnel were notified of the reason for PADRON's transport, but does list PADRON's medical conditions and medications. When he returned to MCDC approximately four hours later with diagnosis of constipation, the RN authorized his return to the housing unit without documenting an assessment notification of a provider. PADRON's blood pressure was 175/107 approximately five hours later when evaluated by the NP. She prescribed a stool softener based on the ER diagnosis and returned him to the housing unit. She did not order blood pressure monitoring or follow up in advance of the scheduled chronic care evaluation.

Two days later, October 28, 2018, the RN who triaged a healthcare request in which PADRON complained of chest pain and constipation did not have him brought to medical for assessment, noting he was to be seen by the provider the same day. An appointment was neither scheduled nor conducted. Later in the day, the detainee was escorted to medical for urgent complaint of chest pain. He returned to the housing unit following limited assessment by an RN in which his blood pressure was found to be 148/81 and Motrin was administered for pain.

On October 29, 2018, PADRON was again brought to medical on an urgent basis for complaint of chest pain. He was not assessed but was placed in sick bay upon verbal order by (b)(6); (b)(7)(C) following three blood pressure readings within 20 minutes, the first 196/98; the second 180/100; the third 157/97. PADRON was not monitored while there and was returned to sick bay after approximately ten hours, without assessment, blood pressure check or provider authorization.

The next evening, October 30, 2018, a medication nurse exercised due diligence by having him brought to medical after he refused anti-hypertensive medication amlodipine, incorrectly claiming it was not the medication he arrived with and made his blood pressure worse. His blood pressure was 160/98. The nurse succeeded in coaxing PADRON to take his dose of amlodipine, assuring him he would be seen by the physician. An RN amended the note from doctor to provider sick call the next morning. The detainee was not seen by a provider before his death.

During the afternoon of October 31, 2018, PADRON was again brought to medical for complaint of chest pain. The encounter was not documented in the medical record and was known to the review team only because (b)(6); (b)(7)(C) indicated it occurred, information supported by video evidence provided on site. PADRON was in medical for 18 minutes, during which an RN took his vital signs, reviewed his medical record and spoke with him with interpretation assistance provided first by a security sergeant, then by the DON. The only recorded vital signs were normal pulse and pulse oxygen, and elevated blood pressure of 153/89, hand-written on the sick-bay roster. The video shows (b)(6); (b)(7)(C) was in sick bay very briefly, speaking with staff but not with detainee PADRON.

After PADRON returned to the housing unit, he moved around the unit in his wheelchair without apparent difficulty. The MAR documents he received his evening medications and according to the medication nurse, who was unaware her referral to the doctor had been changed, she again assured him he would be seen by (b)(6); (b)(7)(C). PADRON was last seen alive by the housing unit deputy during the 11:00 p.m. count.

Code Blue was called at approximately 6:41 a.m. on November 1, 2018 when PADRON was found in his cell, pulseless and cold to the touch. Response by security and medical personnel was immediate, EMS was called swiftly, and CPR was performed collaboratively by deputies and the nurses until EMS responders arrived and took over. PADRON's death was pronounced at the hospital approximately 45 minutes after the Code Blue call. Autopsy results remain pending.

## Compliance Findings

Creative Corrections cites the following deficiencies in the ICE 2008 PBNDS, Medical Care.

**Expected Outcomes, section (II)(2)**, which states, "Health care needs will be met in a timely and efficient manner."

- PADRON requested aspirin due to his history of strokes on August 29, 2018 and again on September 10, 2018. The first request was not referred to a provider; the second resulted initiation of aspirin on September 13, 2018, more than two weeks after first request.
- Pursuant to detainee PADRON's report that he took fiber for constipation during physical examination on August 29, 2018, (b)(6); (b)(7)(C) noted it would be prescribed. She did not refer the request for provider review. Fiber was not prescribed until October 26, 2018 following PADRON's return to the hospital with diagnosis of constipation.

**Expected Outcomes, section (II)(5)**, which states, "Detainees will receive timely follow up to their health care requests."

- On September 4, 2018, PADRON submitted a request in which he complained of cold symptoms. He was seen six days later, September 11, 2018, for other complaints.
- On September 13, 2018, PADRON submitted a request complaining of facial swelling, mouth sores and difficulty wearing dentures. He was referred to the dentist and seen four weeks later when he again complained a mouth sore during a medical encounter.
- A request dated October 19, 2018 related elevated blood pressure was misinterpreted, resulting in a referral to mental health rather than to medical. When the error was discovered, he was not referred for sick call.
- By request dated October 28, 2018, PADRON complained of constipation and chest pain radiating down his left arm. The nurse who triaged the request did not have him brought to medical for assessment, instead responding by saying the detainee would be seen by a doctor that same day. There is no documentation he was scheduled to see the doctor or midlevel provider.



**Expected Outcomes, section (II)(20)**, which states, “Health care services will be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are verifiably licensed, certified, credentialed, and/or registered in compliance with applicable and state and federal requirements.”

- On August 20, 2018, (b)(6); (b)(7)(C) independently assessed detainee PADRON using the Pathway for Cold/Allergy Symptoms. By doing so, she acted outside the scope of her practice. Per the Florida Nurse Practice Act Statutes, RNs are authorized to provide “assessment, nursing diagnosis, planning, intervention, and evaluation of care” consistent with their “substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences.” The act states LPNs may perform selected acts, including administration of treatments and medications under the direction of an RN or provider.

**Expected Practices, section (V)(F)**, which requires, “Accountability for administering or distributing medications in a timely manner and according to provider orders.”

- On August 20, 2018, (b)(6); (b)(7)(C) administered cetirizine without a provider order.
- On September 10, 2018, (b)(6); (b)(7)(C) administered prescription fluconazole without a provider order.
- On September 25, 2018, (b)(6); (b)(7)(C) issued over-the-counter medication cetirizine upon assessment the detainee had a cold. The Pathway for Cold/Allergy Symptoms, which she did not use, does not authorize this medication. If authorized by another Pathway, it was not provided to reviewers.

**Expected Practices, section (V)(I)**, which states, “The clinical medical authority shall be responsible for review of all health screening forms within 24 hours or next business day to assess the priority for treatment (for example, Urgent, Today, or Routine).”

- The intake screening was co-signed by (b)(6); (b)(7)(C). Delegation of authority by the Clinical Director to perform this function was not provided to reviewers.

**Expected Practices, section (V)(I)**, which states, “Non-English speaking detainees and detainees who are deaf or hard of hearing will be provided interpretation or translation services or other assistance as needed for medical care activities.”

- Positive determination of PADRON’s English language proficiency cannot be made. The Intake Inmate Phone Call/Interpretation Information form completed upon admission to MCDC documents he needed an interpreter, information confirmed by detainee (b)(6); (b)(7)(C) who stated PADRON’s ability to speak English was very limited. Many of PADRON’s healthcare requests were in English; however, verification he wrote them himself is not possible. Of eight non-Spanish speaking healthcare professionals who had encounters with PADRON, three requested staff assistance to interpret; five said PADRON’s English language proficiency was adequate and interpretation assistance was not needed. Contributing to the uncertainty about his English language proficiency is the fact that books with English titles were found in his cell following his death. Nonetheless,

in consideration of the importance of clear communications during medical encounters, reviewers hold there is sufficient evidence to cite deficiency.

**Expected Practices, section (V)(U)**, which states, “The administrative health authority shall maintain a complete health record on each detainee that is organized uniformly in accordance with recognized medical records standards; available to all practitioners and used by them for health care documentation; and properly maintained and safeguarded in a securely locked area within the medical unit.”

- An urgent encounter conducted on October 31, 2018 to address the detainee’s complaint of chest pain was not documented in the medical record.
- (b)(6); (b)(7)(C) October 10, 2018 encounter note indicates (b)(6); (b)(7)(C) and a dental professional assessed detainee PADRON and documents their findings. Neither provider entered their own encounter note and did not co-sign the LPN’s to authenticate the information.

### Areas of Concern

Creative Corrections notes the following additional concerns not addressed in the detention standards.

- ICE form I-213 completed by ERO prior to PADRON’s entry into detention documents a history of brain stem stroke syndrome and lacunar stroke syndrome. The detainee did not report a history of strokes to the KNSPC provider or (b)(6); (b)(7)(C). He did, however, report the history to the RN who conducted the initial physical examination at MCDC following the chronic care evaluation by (b)(6); (b)(7)(C). The history of strokes was not noted by Dr. (b)(6); (b)(7)(C) when he reviewed the physical examination; consequently, he did not add the detainee’s stroke history to the problem list (b)(6); (b)(7)(C) who later ordered aspirin as a preventative based on a chart review, also did not add PADRON’s history of strokes to the problem list. Inclusion of known medical conditions on problem lists serves the purpose of assuring the information is readily available to healthcare staff during encounters.
- (b)(6); (b)(7)(C) changed the administration time for anti-hypertensive medication amlodipine and started aspirin based on review of PADRON’s chart, only. Because she did not see him in person, subjective and objective information related to the changes was not documented, nor was patient education. Regarding aspirin, had (b)(6); (b)(7)(C) seen PADRON in person she may have noted his history of strokes and added it to the problem list. Regarding amlodipine, seeing PADRON to discuss his request may have resulted in documentation of why the provider chose to change the administration time for amlodipine rather than the other prescribed anti-hypertensive medications. An in-person encounter that included patient education may also have avoided PADRON’s later claims that amlodipine was not his correct medication.



- With the exception of intake screening and initial physical examination, documentation of nursing encounters was generally inadequate in content. Subjective and objective information was limited; nurses did not consistently take a full set of vital signs; at no time were PADRON's complaints of pain assessed using the standardized pain scale; and applicable Pathways were not followed. In fact, the Pathway for hypertension was never used to assess the detainee's complaints of chest pain. Had the Hypertension Pathways been followed, nurses would at least have been prompted to obtain a pain rating and inquire about other listed symptoms. The Pathways does, not, however, provide clear guidance based on blood pressure readings of patients with known hypertension. It refers to normal to high range without definition, and is silent on non-emergent or urgent interventions other than scheduling the patient for provider appointment within seven days. EKGs and RN-directed blood pressure monitoring are not addressed. Reviewers recommend corporate review of the CCS Hypertension Pathway to ensure it provides clear guidance that supports optimal nursing care.
- Detainee PADRON was brought to medical on five of the six days preceding his death, four on an urgent basis. Observations and concerns related to the encounters are summarized as follows.

#### **First Urgent Encounter, October 26, 2018**

(b)(6); (b)(7)(C) appropriately notified (b)(6); (b)(7)(C) upon finding PADRON's blood pressure was 196/98, resulting in his transport to the ER. However, (b)(6); (b)(7)(C) did not document assessment of detainee PADRON upon his return from the ER four hours later, or notification of a provider before directing his return to the housing unit. Both would have been prudent nursing practice given the reason the detainee was sent to the ER. When evaluated by (b)(6); (b)(7)(C) approximately five hours after his return, PADRON's blood pressure was 175/107. She did not order blood pressure monitoring because he had not yet received his morning medications, nor did she order follow up in advance of the next scheduled chronic care appointment a month later. Because (b)(6); (b)(7)(C) decision falls within the province of provider judgment, reviewers are not qualified to comment but offer the information for consideration in the context of preceding and subsequent events.

#### **Second Urgent Encounter, October 28, 2018**

(b)(6); (b)(7)(C) encounter note consisted of one sentence for each SOAPE element. The RN did not use the Hypertension Pathway as appropriate given the complaint and the detainee's history.

#### **Third Urgent Encounter, October 29, 2018**

PADRON's blood pressure was critically high at 196/99 when first checked by LPN (b)(6); (b)(7)(C). It was rechecked twice in 20 minutes, lowering only to 157/97. The LPN did not document whether she notified (b)(6); (b)(7)(C) of the first blood pressure reading as appropriate and

received instruction to re-check it. Following the blood pressure readings, LPN (b)(6); (b)(7)(C) documented only that PADRON was moved to sick bay after consultation with NP (b)(6); (b)(7)(C). In her own encounter note (b)(6); (b)(7)(C) reiterated that the detainee was sent to medical for complaint of chest pain and that she reviewed his vital signs. In fact, only blood pressure readings taken by (b)(6); (b)(7)(C) were recorded, readings (b)(6); (b)(7)(C) denied awareness of during interview. The (b)(6); (b)(7)(C) further documented that PADRON informed her he was not having chest pains and instead, wanted to have lab tests to rule out pancreatitis. Her note states the detainee was in sick bay for observation, and to fast pending lab tests. She did not conduct an assessment; in fact, despite his elevated blood pressure and history, PADRON was not assessed by any healthcare professional pursuant to his complaint of chest pain and three elevated blood pressure readings this date. PADRON remained in a sick bay cell for approximately ten hours, during which no monitoring checks were documented. He was returned to the housing unit by direction of an unknown staff member, without recheck of his blood pressure and provider authority. The lab studies were not drawn for another 48 hours.

#### **Encounter Following Medication Refusal, October 30, 2018**

(b)(6); (b)(7)(C) exercised due diligence by having PADRON brought to medical after he refused his medication, successfully coaxing him to take it and scheduling him to see the doctor. However, she did not notify a provider or consult an RN when his blood pressure was found to be 160/98. Despite PADRON's history and events in the preceding days, an RN removed him from the doctor's sick call list.

#### **Fourth Urgent Encounter, October 31, 2018**

(b)(6); (b)(7)(C) saw PADRON in sick bay but did not enter an encounter note. The only written documentation of the encounter was a handwritten note on the sick bay roster indicating the detainee's blood pressure was 153/89 and his pulse and pulse oxygen were normal. (b)(6); (b)(7)(C) statement that (b)(6); (b)(7)(C) took over the encounter is not substantiated by video evidence. In fact, she was briefly present but left the area without interacting with PADRON. (b)(6); (b)(7)(C) did interact with him, but denied involvement in the encounter. The absence of entry in the medical record documenting assessment of PADRON is an egregious omission.

In sum, medical encounters during the six days preceding PADRON's death were poorly documented and reflect general inattentiveness to patient care.

## **Security**

On four occasions, deputies assigned to detainee PADRON's housing unit took necessary and appropriate action by notifying medical staff when he reported chest pain. The deputies made log entries documenting the incidents and PADRON's escort to medical on three of the four occasions.



The missed entry was on October 31, 2018, the day before his death. Because medical staff did not document assessment of the detainee in his chart, no written record of the event exists.

PADRON was last seen alive at 11:00 p.m. on October 31, 2018 during the nightly face-to-photo count. Video evidence supports that the count was conducted at cell windows, including PADRON's, but cell doors were not opened as required by policy. In addition, video evidence does not support security rounds documented by the deputy between 3:00 a.m. and 6:00 a.m. on November 1, 2018. Although the deputy logged six rounds during this timeframe, he is seen making a round past detainee PADRON's cell only twice, at 5:02 a.m. and 5:46 a.m.

When alerted by another detainee that PADRON would not wake up, (b)(6); (b)(7)(C) immediately responded to the cell and upon confirming he was unresponsive, called Code Blue. The first security responders arrived in under a minute and started CPR, followed within the next minute by additional security staff and two nurses. Per the direction of one of the first arriving sergeants, EMS was called. Security and medical collaboratively performed and continued CPR until taken over by EMS responders. Egress into and out of the facility was facilitated efficiently.

Detainee PADRON's cell was sealed by a sergeant following departure of the EMS responders and remained sealed until Sheriff's Office detectives arrived to inspect it following his death. Pills found in the cell were confiscated by the detectives after they were reviewed by (b)(6); (b)(7)(C) They included over-the-counter and two medications not prescribed to PADRON.

Security personnel involved in the emergency response were offered supportive counseling. An after action review was conducted four days following PADRON's death. Meeting participants included Major (b)(6); (b)(7)(C) Captain (b)(6); (b)(7)(C) the HSA, DON, and medical and security personnel who responded to the Code Blue. Included among the participants were two deputies and two probationary officers who responded but did not write incident reports.

According to Captain (b)(6); (b)(7)(C) PADRON's personal property and funds totaling \$68.86 will remain at MCDC pending completion of the Sheriff's investigation. He stated the investigation will not be completed until the medical examiner's report is issued, possibly three to six months following PADRON's death.

## Compliance Findings

Creative Corrections found no deficiencies in the ICE 2008 PBNDS governing safety and security. However, the reviewer cites the following violations of MCDC directives.

**Bureau Directive 8:020, Observation of General Population and Special Inmates**, which states, "The deputy will continuously move about the housing dorm/unit so that a personal visual observation of each inmate is made at least once every 30 minutes on an irregular schedule to

ensure their state of well-being (i.e., that they are alive, free from injury or assault, and that their needs are being tended to).”

- Video shows (b)(6); (b)(7)(C) conducted a round past PADRON’s cell only twice between 3:00 a.m. and 6:00 a.m. on November 1, 2018; specifically, at 5:02 a.m. and 5:46 a.m. At 3:16 a.m. and 4:19 a.m., he appears to make rounds but does not approach PADRON’s cell. A round documented at 3:49 a.m. was not made at all. During his rounds, Deputy (b)(6); (b)(7)(C) does not appear to take the time necessary to verify detainees’ well-being.

**Bureau Directive 8:021, Population Count Principles and Procedures, General Principles of Counts**, which states, “Unit A1, B, B1, C, D, KV/PK ISO cells: For the face to photo count, the inmates will stand in their cells with their ID’s in hand. The deputy will open door and the inmate will present the ID to the deputy for face to photo verification along with the site placement checking for accuracy. Once the inmates have been verified and counted, the cell is re-secured.”

- During the face-to-photo count on October 31, 2018, (b)(6); (b)(7)(C) did not open detainee PADRON’s cell door, or other cell doors within camera view.

**Bureau Directive 8:021, Population Count Principles and Procedures, General Principles of Counts**, which states, “Deputies must be positive they see a living human body before counting an inmate as present”; also, “When making night counts, flashlights shall be used judiciously, but enough light should be thrown on the inmate to ensure that a dummy is not being counted. Rather than count an inmate present on the basis of the sight of hair, shoes, or parts of clothing the deputy must be certain he or she is seeing human flesh and/or movement.”

- (b)(6); (b)(7)(C) logged a physical headcount at 4:18 a.m. on November 1, 2018. Video evidence shows he did not approach PADRON’s cell during the count.





## Detainee Death Review Report

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# Wilfredo Padron

Date of Death: November 1, 2018

Alien File Number: 022 776 291

Joint Integrity Case Management System (JICMS) (b)(6); (b)(7)(C); (b)(7)(E)

January 31, 2020

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

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## **DETAILS OF REVIEW**

From November 27 to 29, 2018, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Monroe County Detention Center (MCDC) to review the facts and circumstances surrounding Wilfredo PADRON's detention and 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 consulting firm.<sup>1</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to PADRON, in addition to conducting in-person interviews of individuals employed by MCDC, Correct Care Solutions (CCS), and the ICE Office of Enforcement and Removal Operation (ERO) Miami field office. On August 18, 2018, ICE transferred PADRON from Krome North Service Processing Center (KNSPC) to MCDC, where he remained until his death.

## **FACILITY PROFILE**

MCDC is owned and operated by the Monroe County Sheriff's Office (MCSO) under an Intergovernmental Service Agreement (IGSA), which requires the facility to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2008. CCS, now known as Wellpath, provides medical care.<sup>2</sup> ICE ERO began housing detainees at MCDC in 1995, under the oversight of the ERO Field Office Director (FOD) in Miami, FL. MCDC can house male detainees for periods longer than 72 hours and has an ICE detainee bed capacity of 72; the average ICE detainee population is 63.<sup>3</sup> At the time of PADRON's death, MCDC housed approximately 54 ICE male detainees.<sup>4</sup>

## **IMMIGRATION AND CRIMINAL HISTORY**

On May 16, 1980, the United States Immigration and Naturalization Service (INS) encountered PADRON in the United States near Key West, FL, during the "Mariel Boatlift" mass emigration of Cubans.<sup>5</sup>

On an unknown date, PADRON was placed at the Fort Chaffee Cuban Refugee Center, located in Fort Chaffee, Arkansas.<sup>6</sup>

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<sup>1</sup> See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis.

<sup>2</sup> For the purpose of this report, Wellpath will be referred to as CCS as medical documentation pertaining to PADRON was marked with the CCS name.

<sup>3</sup> ERO Facility List Report as of November 26, 2018.

<sup>4</sup> See Information Request Background Information table, undated.

<sup>5</sup> See Form I-556, Cuban Boat Lift Processing Worksheet, dated May 28, 1980; see also Mariel Nomination Package email from Deportation Officer (DO) I (b)(6); (b)(7)(C) to ICE Removal and International Operations (RIO), dated August 18, 2018.

<sup>6</sup> See Form I-556, dated May 28, 1980; see also PADRON ICE Significant Incident Report (SIR), dated November 2, 2018.

On March 10, 1994, PADRON filed an Application to Register Permanent Residence or Adjust Status (Form I-485) with the INS<sup>7</sup>, and on August 16, 1995, INS adjusted PADRON's status to that of a lawful permanent resident retroactive to October 10, 1992.<sup>8</sup>

On July 17, 2000, INS arrested<sup>9</sup> PADRON at the Florida Department of Corrections Probation Office in Miami, FL, and on July 20, 2000, issued him a Notice to Appear<sup>10</sup> charging him as removable pursuant to Section 237(a)(2)(A)(ii) of the Immigration and Nationality Act (INA), as an alien convicted of two crimes involving moral turpitude after admission.<sup>11</sup>

On November 15, 2000, the Miami INS Office of District Counsel filed additional charges of removability pursuant to Section 237(a)(1)(A) of the INA, as an alien inadmissible at the time of entry and or procuring by fraud a visa or admission into the United States, and Section 237(a)(2)(A)(i) of the INA, as an alien convicted of a crime involving moral turpitude within five years after admission or adjustment.<sup>12</sup>

On November 29, 2001, an immigration judge in Miami, FL, ordered PADRON removed from the United States to Cuba.<sup>13</sup>

On May 15, 2002, INS in Miami, FL, released PADRON on an Order of Supervision (OSUP) with orders to report the second week of May each year to the Miami INS office.<sup>14</sup>

Between May 15, 2002, and March 22, 2018, PADRON reported on OSUP to the INS (ICE ERO after March 1, 2003) Miami office as required.<sup>15</sup> On March 22, 2018, ERO Miami scheduled PADRON's next report date for August 15, 2018.<sup>16</sup>

On August 15, 2018, ERO Miami took PADRON into custody at the ERO Miami, Miramar Sub-Office due to his significant likelihood of removal, revoked his OSUP,<sup>17</sup> and detained him at KNSPC.<sup>18</sup>

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<sup>7</sup> See Form I-485, dated March 10, 1994.

<sup>8</sup> See Form I-181, Memorandum of Creation of Record of Lawful Permanent Residence, dated August 16, 1995.

<sup>9</sup> See Form I-200, Warrant for Arrest, dated July 17, 2000.

<sup>10</sup> See Form I-862, Notice to Appear, dated July 20, 2000.

<sup>11</sup> PADRON's convictions are listed in the Appendix of this report.

<sup>12</sup> See Form I-261, Additional Charges of Inadmissibility/Deportability, dated November 15, 2000.

<sup>13</sup> See Order of the Immigration Judge, dated November 29, 2001.

<sup>14</sup> See Form I-220B, Order of Supervision, dated May 15, 2002. *Note:* On a separate copy of the Form I-220B, an unknown ICE official scratched out the May reporting requirement with December and June annually.

<sup>15</sup> See PADRON ICE SIR, dated November 2, 2018.

<sup>16</sup> *Ibid.*

<sup>17</sup> See Form I-203, Order to Detain or Release Alien, dated August 15, 2018; *see also* Notice of Revocation of Release, dated August 15, 2018.

<sup>18</sup> See ERO Miami AOR (Area of Responsibility) Bed Space Request Form, dated August 15, 2018.



On August 18, 2018, ERO Miami submitted a package to ICE ERO headquarters for presentation to the Cuban Embassy to facilitate PADRON's repatriation to Cuba.<sup>19</sup> ERO Miami also transferred PADRON to MCDC in Key West, FL.<sup>20</sup>

On August 31, 2018, ERO engaged the Government of Cuba regarding PADRON's repatriation.<sup>21</sup>

While present in the United States, PADRON was convicted of ten criminal offenses, listed in Table 1 of the Appendix in this report.

## **CHRONOLOGY OF EVENTS**

### **August 15, 2018**

At approximately 8:45 p.m., Detention Officer (b)(6); (b)(7)(C) booked PADRON into KNSPC.<sup>22</sup> Staff also deposited PADRON's cash, in the amount of \$112.00.<sup>23</sup>

At 9:50 p.m.,<sup>24</sup> Registered Nurse (RN) RN (b)(6); (b)(7)(C) signed off on PADRON's intake pre-screening and documented the following:<sup>25</sup>

- PADRON had a medical transfer summary from another facility.<sup>26</sup>
- PADRON spoke Spanish but no interpreter was available during his pre-screening.<sup>27</sup>
- PADRON took medications for health problems.
- PADRON's intake pre-screening disposition was a priority two.<sup>28</sup>

<sup>19</sup> See Mariel Nomination email, dated August 18, 2018.

<sup>20</sup> See ICE Detainee Transfer Notification form, dated August 17, 2018; *see also* Monroe County Sheriff's Office Order to Detain Alien, dated August 18, 2018.

<sup>21</sup> See PADRON ICE SIR, dated November 2, 2018.

<sup>22</sup> See eClinicalWorks (eCW) Pre-Screening appointment Arrival Time, dated August 15, 2018; *see also* Department of Homeland Security (DHS) Detainee Personal Property Record and Record of Search, dated August 15, 2018.

<sup>23</sup> See KNSPC Resident Account Summary (RAS) entry, dated August 15, 2018. ERAU notes that DHS Form I-213 documented PADRON had \$1,512 in his possession at the time of his apprehension. As staff booked PADRON out of KNSPC with a balance of only \$110.52, Supervisory Detention and Deportation Officer (SDDO) (b)(6); (b)(7)(C) from the ERO Miami Field Office told ERAU on November 13, 2018, that he believed the \$1,512 to be a typographic error. As no officer's name is listed beside the entry on the RAS form, ERAU could not interview staff to confirm if this was a typographic error. While housed at MCDC, PADRON submitted no complaint that he was missing money.

<sup>24</sup> Medical encounter times are documented using the following order of precedence, dependent upon available information: the recorded time a patient is seen; the recorded time a patient's vital signs are taken; and the time medical staff sign off on an encounter note.

<sup>25</sup> See eCW Pre-Screening appointment, dated August 15, 2018.

<sup>26</sup> Despite this annotation in the medical record, PADRON was not transferred from another facility prior to arriving at KNSPC. As mentioned above, on August 15, 2018, ERO revoked PADRON's OSUP to repatriate him to Cuba, took him into custody at the Miami sub-office that time, and transferred him to KNSPC the same day.

<sup>27</sup> See DHS KNSPC Limited English Proficient (LEP) form, dated August 18, 2018. This form identified PADRON as a Spanish-speaking LEP individual. It is unclear why this document was filled out on August 18, 2018, as his intake at KNSPC was on August 15, 2018.

<sup>28</sup> Priority-2 (PRI-2) indicates a detainee has a non-time sensitive medical condition requiring timely, but not emergent, care or intervention.

**August 16, 2018**

At approximately 6:52 a.m., (b)(6); (b)(7)(C) conducted PADRON's intake screening and documented the following:<sup>29</sup>

- Although PADRON spoke both Spanish and English, (b)(6); (b)(7)(C) first name unknown) provided interpretation during PADRON's intake screening.
- A medical transfer summary did not accompany PADRON to KNSPC.
- PADRON reported a history of hypertension, pancreatitis,<sup>30</sup> and left leg fracture secondary to a motor vehicle accident in 1998.
- PADRON reported taking medications he did not have in his possession but could only recall the name of one: Lisinopril.<sup>31</sup>
- PADRON walked with a limp favoring his right leg; his left leg was shorter than his right.
- PADRON's vital signs were all within normal limits except for an elevated blood pressure of 150/74.<sup>32</sup> He reported 0 out of 10 pain.
- PADRON's screening for tuberculosis (TB) symptoms, mental health disorders, and substance use were all negative.

The RN noted PADRON's intake screening was abnormal, referred him to a provider, and medically cleared him for custody. PADRON signed an ICE Health Service Corps (IHSC) medical consent form (IHSC Form 793).<sup>33</sup>

At 8:42 a.m. (b)(6); (b)(7)(C) read the results of PADRON's TB chest X-ray from earlier that morning and confirmed there was no radiographic evidence of TB. The radiology report also noted PADRON's lungs were clear, his heart size was within normal limits, and that there was no evidence of atherosclerotic disease of the aorta.<sup>34</sup> An old fracture of the lateral end of his right clavicle with nonunion was further noted.<sup>35</sup>

At approximately 9:05 a.m., Nurse Practitioner (NP) (b)(6); (b)(7)(C) conducted PADRON's initial physical exam and documented the following:<sup>36</sup>

<sup>29</sup> See eCW Intake Screening appointment, dated August 16, 2018.

<sup>30</sup> Pancreatitis is inflammation of the pancreas, the gland that produces insulin and other important enzymes and hormones that help break down food.

<sup>31</sup> Lisinopril is an anti-hypertensive medication.

<sup>32</sup> 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 less than 120/80. 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; this blood pressure falls within AHA parameters for stage two hypertension. Stage two hypertension is characterized by a systolic reading of at least 140 or a diastolic reading of at least 90.

<sup>33</sup> See IHSC Form 793, dated August 16, 2018.

<sup>34</sup> ERAU notes that during PADRON's initial physical examination at MCDC on August 29, 2018, he reported a history of cardiomegaly, a significantly enlarged heart. Additionally, the Medical Examiner documented one of his findings as cardiomegaly.

<sup>35</sup> A nonunion fracture refers to a permanent failure of healing following a broken bone, unless intervention is performed.

<sup>36</sup> See eCW PE – Initial screening appointment, dated August 16, 2018. (b)(6); (b)(7)(C) documented in the encounter notes he was fluent in Spanish.



- PADRON denied shortness of breath, chest pain at rest, dizziness, heart palpitations, headache, malaise, fever, chills, skin rash, nausea/vomiting, muscle aches, or muscle pain.
- PADRON had 20/50 vision in both eyes but did not have glasses.<sup>37</sup>
- Although NP Lewis documented that PADRON had been using a wheelchair to ambulate, he further noted that PADRON ambulated without apparent difficulty, was able to sit and stand without difficulty, had no deformity to his limbs, and had a normal gait.
- PADRON reported chronic pain in his left upper leg.
- PADRON's vital signs remained unchanged from his intake screening, apart from a pulse oxygen reading of 99%.<sup>38</sup>

(b)(6); (b)(7)(C) assessment findings and prescribed treatment included:

- Essential (primary) hypertension:<sup>39</sup> Lisinopril (40 mg), hydrochlorothiazide (HCTZ) (12.5 mg), and amlodipine besylate (10 mg), all to be taken in the morning for 30 days, keep-on-person (KOP);<sup>40</sup>
- Pain, unspecified: diclofenac sodium<sup>41</sup> delayed release (50 mg) twice a day for 30 days, KOP;
- Hyperlipidemia:<sup>42</sup> gemfibrozil (600 mg) to be taken twice a day for 30 days, KOP; and
- Chronic pancreatitis.

(b)(6); (b)(7)(C) ordered laboratory studies, to include a lipid panel (LP),<sup>43</sup> comprehensive metabolic panel (CMP),<sup>44</sup> a complete blood count (CBC/D/PLT) with differential and platelets,<sup>45</sup> and a urinalysis.<sup>46</sup> (b)(6); (b)(7)(C) medically cleared PADRON for custody. (b)(6); (b)(7)(C) also signed the encounter notes and noted a disability list should be considered for PADRON.

<sup>37</sup> According to the American Optometric Association, 20/20 vision is a term used to express normal visual acuity (the clarity or sharpness of vision) measured at a distance of 20 feet. If one has 20/20 vision, he or she can see clearly at 20 feet what should normally be seen at that distance. If one has 20/100 vision, it means that he or she must be as close as 20 feet to see what a person with normal vision can see at 100 feet. If vision is not 20/20, corrective lenses may be necessary.

<sup>38</sup> (b)(6); (b)(7)(C) took PADRON's vital signs on August 17, 2018, at 6:06 a.m. These vitals were recorded in NP (b)(6); physical exam screening from the previous day, August 16, 2018.

<sup>39</sup> Essential hypertension is elevated blood pressure that does not have a known secondary cause.

<sup>40</sup> When prescribed a KOP medication, detainees may maintain prescribed medication in their possession for self-administration. Lisinopril, hydrochlorothiazide, and amlodipine besylate are anti-hypertensive medications.

<sup>41</sup> Diclofenac is a medication used to treat pain and inflammation.

<sup>42</sup> Hyperlipidemia is a condition in which there are high levels of fat particles in the blood, placing patients at high risk for heart attack or stroke.

<sup>43</sup> A lipid panel is a test that measures the amount of fat elements in the blood, to include triglycerides and cholesterol.

<sup>44</sup> A metabolic panel is a comprehensive test that measures blood sugar levels, electrolyte and fluid balance, kidney function, and liver function.

<sup>45</sup> A complete blood count with differential and platelets is a blood test used to evaluate overall health and detect a wide range of disorders, including anemia, infection, and leukemia. The differential portion of the test can detect abnormal or immature cells. Platelets are the cells that cause blood to clot.

<sup>46</sup> Records provided do not document whether the order for the laboratory studies was completed prior to PADRON's transfer to MCDC or the results of the lab work. However, the transfer summary from KNSPC to MCDC, dated August 17, 2018, indicates no lab work was pending at the time of transfer.

At 2:29 p.m., a KNSPC staff member processed PADRON's property withdraw check in the amount of \$110.52.<sup>47</sup>

### August 17, 2018

At 5:19 p.m., RN (b)(6); (b)(7)(C) signed off on PADRON's Transfer Summary for MCDC and documented the following:<sup>48</sup>

- PADRON had a history of hypertension, chronic pancreatitis, left leg pain due to a motor vehicle accident, and hyperlipidemia.
- PADRON's prescriptions were listed as Lisinopril (40 mg), HCTZ (12.5 mg), amlodipine besylate (10 mg), diclofenac sodium delayed release (50 mg), and gemfibrozil (600 mg).
- PADRON was negative for TB and cleared for travel.

### August 18, 2018

At approximately 12:17 a.m., a Monroe County Booking Deputy booked PADRON into MCDC.<sup>49</sup> Security staff appropriately assigned PADRON a high classification level based on ICE's classification assessment.<sup>50</sup> Sergeant (Sgt.) (b)(6); (b)(7)(C) completed a form that indicated PADRON required a Spanish interpreter.<sup>51</sup>

At 12:37 a.m., RN (b)(6); (b)(7)(C) conducted PADRON's intake screening and documented the following:<sup>52</sup>

- PADRON's vital signs were within normal limits except for an elevated blood pressure of 134/81.<sup>53</sup>
- PADRON had a history of hypertension, pancreatitis, hyperlipidemia, and leg pain, and was taking five medications listed on the KNSPC Transfer Summary note.<sup>54</sup> PADRON reported last taking his medication the day before.

(b)(6); (b)(7)(C) did not note PADRON's primary language, the use of interpretation assistance, or the language in which she conducted the screening.<sup>55</sup> (b)(6); (b)(7)(C) submitted a special needs/accommodation request for a wheelchair due to PADRON's hip pain and unsteady gait; he

<sup>47</sup> See KNSPC Resident Transaction Receipt, dated August 16, 2018. ERAU was unable to confirm the identity of the KNSPC staff member due to an illegible signature on the receipt.

<sup>48</sup> See eCW Transfer Summary, dated August 17, 2018.

<sup>49</sup> See MCSO Order to Detain Alien, dated August 18, 2018.

<sup>50</sup> Although the MCDC Classification Interview Screen form, dated August 17, 2018, does not provide a classification level, Captain (b)(6); (b)(7)(C) explained to ERAU during his interview on November 27, 2018, that MCDC always classifies detainees according to ICE's suggested classification level.

<sup>51</sup> See Intake Inmate Phone Call/Interpreter Information form, dated August 18, 2018.

<sup>52</sup> See Receiving Screening encounter note, dated August 18, 2018.

<sup>53</sup> According to the 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.

<sup>54</sup> ERAU confirmed that upon admission to MCDC, all five of PADRON's KOP medications prescribed by (b)(6); (b)(7)(C) at KNSPC were relinquished and stored with PADRON's property.

<sup>55</sup> ERAU notes the CorrecTek electronic medical record (EMR) system used by MCDC medical staff does not include fields mandating entry of the language in which encounters are conducted or use of interpretation assistance.



usually walked with a cane. She also cleared PADRON for a bottom bunk on a lower tier. RN (b)(6); (b)(7)(C) scheduled PADRON for a routine history physical visit and a chronic care visit, then cleared him for housing in general population. Advanced Registered Nurse Practitioner (ARNP), (b)(6); (b)(7)(C) co-signed the intake screening on August 20, 2018.

At 12:53 a.m., PADRON signed a Consent for Health Services form.<sup>56</sup> ARNP (b)(6); (b)(7)(C) also prescribed PADRON the same five medications listed on his KNSPC transfer form.<sup>57</sup>

At 5:21 a.m., MCDC Officer (b)(6); (b)(7)(C) processed PADRON into a general population dorm, Delta Unit, where he remained during his detention at MCDC.<sup>58</sup>

## August 19, 2018

At 4:19 p.m., an unidentified nurse triaged PADRON's Healthcare Request, written in English, which PADRON dated August 18, 2018.<sup>59</sup> PADRON stated he had a cold, a fever, and that something [illegible word] hurt.

## August 20, 2018

At 11:16 a.m., RN (b)(6); (b)(7)(C) conducted a walk-in sick call appointment for PADRON's complaints of a runny nose and coughing.<sup>60</sup> During this encounter, PADRON added he had history of a stroke in 2014 and 2018, with his last hospitalization being in January.<sup>61</sup> Apart from an elevated blood pressure of 128/71, his other vital signs were within normal limits. RN (b)(6); (b)(7)(C) gave PADRON Tylenol (325 mg) for a headache as directed by the Headache Pathway.<sup>62</sup> In her encounter note, RN (b)(6); (b)(7)(C) left blank the components requiring examination of the throat, ears, and lymph nodes as directed by the Pathway. In addition, although called for by the Pathway, she did not take PADRON's pulse oxygen level.

<sup>56</sup> See Receiving Screening health services consent form, dated August 18, 2018. Although most intake forms were in English, during his interview with ERAU, (b)(6); (b)(7)(C) stated that onsite staff who spoke Spanish were used to interpret.

<sup>57</sup> See prescription orders for amlodipine, diclofenac sodium, gemfibrozil, HCTZ, and Lisinopril, dated August 18, 2018.

<sup>58</sup> See Jail Log Report, entry dated August 18, 2018. PADRON had one roommate until September 12, 2018, after which time he resided in his cell without a roommate.

<sup>59</sup> See Healthcare Request received August 19, 2018; the MCDC triaging nurse's signature and initials are illegible.

<sup>60</sup> See (b)(6); (b)(7)(C) encounter note dated August 20, 2018, at 11:16 a.m. ERAU cannot determine what language this encounter was conducted in as there is no documentation whether or not interpretation services were provided. During her interview with ERAU on November 28, 2018, (b)(6); (b)(7)(C) stated PADRON could speak enough English to understand her. (b)(6); (b)(7)(C) also entered a separate one-page encounter note at 11:14 a.m. with PADRON's current medications and vital signs, which were the same as those in her 11:16 a.m. encounter note.

<sup>61</sup> PADRON did not provide the year of his hospitalization, only that it occurred around January 24 – 31 in Arizona.

<sup>62</sup> See PADRON's MCDC Medical Administration Record (MAR). ERAU notes that although the MAR documented that (b)(6); (b)(7)(C) administered PADRON Tylenol (325 mg), (b)(6); (b)(7)(C) encounter note stated she administered Tylenol (650 mg). Although documentation is inconsistent, the Headache Pathway authorizes acetaminophen (650 mg) or allergy Ibuprofen (200 mg) by mouth once. Acetaminophen is the generic name for the brand name medication Tylenol.

At 5:32 p.m., Licensed Practical Nurse (LPN) (b)(6); (b)(7)(C) conducted a sick call appointment for PADRON's complaints of a runny nose and coughing and documented the following.<sup>63</sup>

- LPN (b)(6); (b)(7)(C) used the Pathway for Cold/Allergy Symptoms for the encounter but did not utilize interpretation services for the encounter.<sup>64</sup>
- PADRON's vital signs were within normal limits except for an elevated blood pressure of 121/66.<sup>65</sup>
- PADRON had yellow nasal drainage and redness in his throat; however, his lymph nodes were not swollen and his lung sounds were clear. (b)(6); (b)(7)(C) further noted PADRON denied pain with pressure to his forehead and cheeks.
- (b)(6); (b)(7)(C) provided PADRON with an over-the-counter medication, cetirizine (10 mg), for allergy relief.<sup>66</sup>

### August 23, 2018

At 8:27 a.m., (b)(6); (b)(7)(C) conducted PADRON's initial chronic care evaluation in Spanish<sup>67</sup> and documented the following:<sup>68</sup>

- PADRON's medical problems were hypertension, hyperlipidemia, chronic pancreatitis, and chronic pain, and that PADRON was clinically stable for each.
- PADRON's vital signs were all within normal limits except for an elevated blood pressure of 145/83.<sup>69</sup>
- PADRON had difficulty walking due to a previous accident, he walked with a limp, and his left leg appeared shorter than the right leg. To address this issue, medical staff gave PADRON a wheelchair.

(b)(6); (b)(7)(C) treatment plan for PADRON was for him to: maintain a blood pressure of less than 130/90 through medication and diet; to meet a total cholesterol count of less than 200 and triglycerides less than 150 through medication and diet; and to control chronic pain through medication, diet, and exercise. (b)(6); (b)(7)(C) scheduled PADRON for his next chronic care appointment between November 21 and 29, 2018. He ordered laboratory studies, to include a

<sup>63</sup> See (b)(6); (b)(7)(C) Cold/Allergy Symptoms encounter note, dated August 20, 2018.

<sup>64</sup> During her interview with ERAU on November 28, 2018, (b)(6); (b)(7)(C) confirmed that she does not speak Spanish, nor were interpretation services used for this encounter. She further stated PADRON spoke English well enough to understand her.

<sup>65</sup> The LPN did not take a full set of vitals, to include PADRON's pulse and respiratory rate.

<sup>66</sup> The Pathway for Cold/Allergy Symptoms does not authorize the issuance of cetirizine, nor did a provider direct (b)(6); (b)(7)(C) to administer the medication.

<sup>67</sup> ERAU confirmed during its interview with (b)(6); on November 29, 2018 that he speaks Spanish fluently.

<sup>68</sup> See Initial Visit for Multiple Medical Problems Visit encounter note, dated August 23, 2018.

<sup>69</sup> (b)(6); did not document PADRON's temperature and pulse oxygen level.



CMP, CBC/D/PLT, LP, and a hemoglobin A1c,<sup>70</sup> as well as a heart-healthy diet, and advised medications were to continue unchanged. He also prescribed PADRON Zantac<sup>71</sup> for reflux.<sup>72</sup>

*Note:* During his interview, ERAU asked (b)(6); (b)(7)(C) if, in retrospect, he considered PADRON's acuity level too high to be well managed at MCDC.<sup>73</sup> He stated PADRON was stable when he examined him and he was not made aware of any subsequent elevated blood pressure readings or complaints of chest pain. (b)(6); (b)(7)(C) further added he would have prescribed PADRON a blood thinner or aspirin at the time had he known about PADRON's stroke history. When asked if he considered ordering blood pressure monitoring (b)(6); (b)(7)(C) stated he did not, noting that nurses are expected to follow protocols and report significantly elevated blood pressure readings to a provider. He also stated providers generally cannot decide on blood pressure monitoring after one visit as there are various factors that can affect patients' blood pressure, including adjusting to a new facility. He added that nurses should have performed an electrocardiogram (EKG)<sup>74</sup> and taken a full set of vitals every time PADRON complained of chest pain.

### August 28, 2018

At approximately 10:11 a.m., MCDC medical staff received the results from the laboratory studies (b)(6); (b)(7)(C) ordered and (b)(6); (b)(7)(C) Siegfried collected on August 23, 2018.<sup>75</sup> The results showed a slightly elevated blood glucose level of 101,<sup>76</sup> an elevated triglyceride level of 172,<sup>77</sup> and a low high-density lipoprotein (HDL) level of 30.<sup>78</sup> Abnormal results of the CBC included high lymphocytes of 3.2<sup>79</sup> and high eosinophils of 0.9.<sup>80</sup> (b)(6); (b)(7)(C) initialed the lab report on August 31, 2018.

### August 29, 2018

At 9:08 a.m., RN (b)(6); (b)(7)(C) conducted PADRON's initial medical history and physical assessment and documented the following:<sup>81</sup>

<sup>70</sup> A hemoglobin A1c test reflects one's average blood sugar level for the past two to three months. Specifically, this test measures what percentage of one's hemoglobin, a protein in red blood cells that carries oxygen, is coated with sugar.

<sup>71</sup> Zantac, generic name ranitidine, is a medication used to treat and prevent heartburn. It can also be used to treat stomach ulcers, Gastro-Esophageal Reflux Disease (GERD, otherwise known as acid reflux, which causes heartburn), and other conditions that cause excessive stomach acid.

<sup>72</sup> See Chronic Care appointment order, dated August 23, 2018.

<sup>73</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>74</sup> An EKG is the process of recording the electrical activity of the heart using electrodes placed in specific locations on the skin.

<sup>75</sup> See LabCorp Patient Report for Wilfredo PADRON, dated August 28, 2018; see also PADRON's MAR/TAR report, entry dated August 23, 2018.

<sup>76</sup> The normal reference interval for blood glucose is 65 to 99.

<sup>77</sup> Triglycerides are the main constituents of body fat in the human body. The normal interval range is 0 to 149.

<sup>78</sup> HDL, also known as good cholesterol, helps remove extra cholesterol and plaque buildup in the arteries. The normal reference interval is greater than 39.

<sup>79</sup> Lymphocytes, also known as white blood cells, are a part of the immune system that fights off disease. Lymphocyte levels may increase in the event of an infection. The normal interval range is 0.7 to 3.1.

<sup>80</sup> Eosinophils are a type of disease-fighting white blood cell. Eosinophils levels may indicate the presence of a parasitic infection, an allergic reaction, or cancer. The normal reference interval range is 0.0 to 0.4.

<sup>81</sup> See (b)(6); (b)(7)(C) Initial Medical History and Physical Assessment encounter note dated August 29, 2018, at 9:08 a.m.

- PADRON's vital signs were within normal limits except for an elevated blood pressure of 152/88.
- PADRON had false teeth in the form of a bridge.
- PADRON reported having hypertension, cardiomegaly, heartburn from food, taking fiber for difficulty defecating, and a spot on his liver detected at Jackson Memorial Hospital in Miami years prior, for which no treatment was provided at the time.
- PADRON reported a history of six strokes and taking baby aspirin.<sup>82</sup> He stated (b)(6); (b)(7)(C) had approved aspirin during their encounter on August 23, 2018, to which (b)(6); (b)(7)(C) documented she would follow up with ARNP (b)(6); (b)(7)(C) about the aspirin and follow her orders.<sup>83</sup>
- Medical staff would prescribe PADRON fiber.<sup>84</sup>
- The physical exam summary stated no abnormalities were noted<sup>85</sup> and (b)(6); (b)(7)(C) electronically signed the encounter note at 9:00 a.m. on August 30, 2018.<sup>86</sup>

### August 31, 2018

At 12:30 p.m., LPN (b)(6); (b)(7)(C) triaged<sup>87</sup> PADRON's Healthcare Request, written in English.<sup>88</sup> PADRON stated he should receive blood pressure medication at night but was not receiving it.<sup>89</sup> He asked for medical to see him so they could update all his medications.

<sup>82</sup> Baby aspirin (one common brand name: Bayer Children's Aspirin) is typically ordered for patients who are at high risk for or have a history of heart disease or stroke to prevent formation of blood clots that could block blood flow to the heart or cause the blood vessel to burst and result in internal bleeding. Due to the bleeding risk associated with taking aspirin, however, it is important the provider discuss the risks and benefits with the patient prior to prescribing. PADRON's stroke history was not added to his medical Problem List, the point of which is to support healthcare staff's awareness of all known medical conditions during their encounters with the patient. Health Services Administrator (HSA) (b)(6); (b)(7)(C) stated during her interview with ERAU that conditions are only added to the Problem List when diagnosed or confirmed by a provider.

<sup>83</sup> ERAU notes (b)(6); (b)(7)(C) made no mention of aspirin in his August 23, 2018 encounter note.

<sup>84</sup> MCDC did not prescribe PADRON fiber until 58 days later, on October 26, 2018, once he returned from a hospital visit during which he was diagnosed with constipation. Furthermore, absent a Pathway authorizing RN Tyler to start PADRON on fiber, a provider order would have been required; neither a Pathway authorizing fiber nor a provider order was present in PADRON's medical record.

<sup>85</sup> During her interview with ERAU, RN (b)(6); (b)(7)(C) stated that she usually notes there are no abnormalities unless there is something else she feels necessary to include that was not already documented within her notes.

<sup>86</sup> Despite signing off on the encounter note, during his interview with ERAU on November 29, 2018, (b)(6); (b)(7)(C) stated that had medical staff made him aware of PADRON's history of multiple strokes, he would have prescribed a blood thinner.

<sup>87</sup> When a detainee submits a Healthcare Request at MCDC, medical staff triage each request and mark the request as either Emergent, Urgent, or Routine, and respond to the patient by notifying them what action will be taken.

<sup>88</sup> See Healthcare Request, received August 31, 2018. Although medical staff documented they received PADRON's request on August 31, 2018, PADRON dated the document September 3, 2018.

<sup>89</sup> Per PADRON's MCDC MAR, medical staff administered PADRON all three of his blood pressure medications in the morning. ERAU is uncertain if PADRON was referring to medication he may have taken the evening prior to his ICE detention.



## September 5, 2018

At 5:00 p.m., (b)(6); (b)(7)(C) triaged PADRON's Healthcare Request, written in English, which PADRON dated September 4, 2018. PADRON stated he had cold symptoms and a runny nose, and was wheezing.<sup>90</sup> (b)(6); (b)(7)(C) scheduled PADRON for a sick call appointment with (b)(6); (b)(7)(C) with a Request Start Date and End Date for the same day.<sup>91</sup>

## September 6, 2018

At 11:32 a.m., ARNP (b)(6); (b)(7)(C) conducted a chart review related to PADRON's August 31, 2018, Healthcare Request.<sup>92</sup> She documented PADRON's current diagnoses as allergic rhinitis,<sup>93</sup> chronic pain due to trauma, chronic pancreatitis, and hypertension.<sup>94</sup> ARNP (b)(6); (b)(7)(C) documented that PADRON wished to have his amlodipine scheduled at night and changed its administration time to the evening.<sup>95</sup>

## September 7-10, 2018

On September 7, 2018, at 12:39 p.m., (b)(6); (b)(7)(C) discontinued the sick call appointment (b)(6); (b)(7)(C) scheduled on September 5, 2018, and re-scheduled PADRON for a new medical appointment on September 8, 2018. Nevertheless, medical did not see PADRON on September 8, 2018, as RN (b)(6); (b)(7)(C) had scheduled. (b)(6); (b)(7)(C) later documented within her September 7, 2018 medical appointment order that medical saw PADRON for these concerns on September 10, 2018. However, PADRON's medical encounter dated September 10, 2018 (*see below*), documented nothing related to PADRON's sick call concerns about cold symptoms, a runny nose, and wheezing. Although medical scheduled PADRON for an appointment related to his September 4, 2018, Healthcare Request on two separate occasions, MCDC was unable to provide ERAU with documentation confirming medical staff assessed PADRON for these specific sick call concerns triaged on September 5, 2018.

On September 10, 2018, at 2:08 p.m., (b)(6); (b)(7)(C) conducted a sick call encounter in PADRON's housing unit and documented the following regarding his concerns:<sup>96</sup>

- PADRON complained of fungus on his feet, which were itchy and had dry white skin on the bottom and in between his toes.
- PADRON requested aspirin as he stated he had "a clogged artery in his head."

<sup>90</sup> See Healthcare Request, received September 5, 2018.

<sup>91</sup> At MCDC, medical appointments are scheduled with a time frame (Requested Start Date and End Date) within which medical should see a patient. There is no documentation that a provider or (b)(6); (b)(7)(C) saw PADRON on September 5, 2018.

<sup>92</sup> See Chart Review, dated September 6, 2018.

<sup>93</sup> Allergic rhinitis is otherwise known as seasonal allergies.

<sup>94</sup> Although part of medical's original intake assessment findings on August 18, 2018, (b)(6); (b)(7)(C) did not list hyperlipidemia as one of PADRON's current diagnoses.

<sup>95</sup> As PADRON specified in his August 31, 2018 Healthcare Request that he wanted all his medication updated, it is unclear how ARNP (b)(6); (b)(7)(C) made the determination that PADRON only wished to have his amlodipine scheduled at night without seeing him.

<sup>96</sup> See Provider Visit – Sick Call Encounter, dated September 10, 2018. It is unclear if this encounter was based on a Healthcare Request, as no request submitted before this date relates to issues with PADRON's feet.

- PADRON again noted that the last time he saw (b)(6); (b)(7)(C) on August 23, 2018, (b)(6); (b)(7)(C) said he would start PADRON on aspirin (81 mg). (b)(6); (b)(7)(C) noted she added this to PADRON's chart for review and that medical would send (b)(6); (b)(7)(C) a note asking him if they could start PADRON on aspirin.
- (b)(6); (b)(7)(C) noted PADRON was ordered fluconazole (150 mg), one tablet per week for three weeks.<sup>97</sup>

### September 12, 2018

At an unknown time (b)(6); (b)(7)(C) documented that PADRON refused his evening doses of diclofenac sodium (50 mg), gemfibrozil (600 mg), and amlodipine (10 mg).<sup>98</sup> Medical staff explained to PADRON that refusal of his medication could result in worsening of his medical conditions.

### September 13, 2018

At 8:19 a.m., (b)(6); (b)(7)(C) ordered PADRON Bayer Children's Aspirin (81 mg), 21 days after his initial alleged request.<sup>99</sup> PADRON received his first dose on this date.

### September 14, 2018

At 4:15 p.m., ARNP (b)(6); (b)(7)(C) conducted a chart review, which listed PADRON's current diagnoses, excluding hyperlipemia, and PADRON's nine medications. The only note ARNP (b)(6); (b)(7)(C) made was that (b)(6); (b)(7)(C) started PADRON on aspirin.

### September 15, 2018

At 4:00 a.m., an unidentified nurse<sup>100</sup> triaged PADRON's Healthcare Request, written in English, which PADRON dated September 13, 2018.<sup>101</sup> PADRON stated he had a swollen face, that his lips were burning, and that he had holes on his gums and was not able to use his dentures. The unidentified nurse wrote in the "Response to Patient/Comments" area of the Healthcare Request form that she placed PADRON on the dental list. However, MCDC provided no documentation to ERAU demonstrating that medical staff scheduled PADRON for a dental evaluation pursuant to this request.

<sup>97</sup> MCDC was unable to provide ERAU documentation evidencing (b)(6); (b)(7)(C) obtained a verbal order from a provider for fluconazole, which medical staff thrice administered to PADRON throughout his detention at MCDC.

<sup>98</sup> See CCS Refusal of Treatment form, dated September 12, 2018. PADRON did not sign the form; however, two illegible staff signatures are present on the form. Medical staff documented that PADRON told them, "I don't want to take it." This is the only date besides October 30, 2018 that PADRON refused any of his medication.

<sup>99</sup> See aspirin prescription, dated September 13, 2018.

<sup>100</sup> During ERAU's onsite review, MCDC medical staff was unable to identify the individual's signature on PADRON's September 15, 2018 Healthcare Request.

<sup>101</sup> See Healthcare Request, received September 15, 2018.



**September 25, 2018**

At 2:29 a.m., (b)(6); (b)(7)(C) entered a sick call appointment order for PADRON, which she documented being completed the same day.<sup>102</sup> A note in the instructions area of the sick call appointment order sheet stated the sick call was related to a fever, body aches, facial swelling, and pain, as well as a possible infection.

At approximately 10:20 a.m., an unidentified nurse<sup>103</sup> triaged PADRON's Healthcare Request, written in Spanish, which PADRON dated September 24, 2018.<sup>104</sup> PADRON stated he had a swollen face, sore throat, and a fever. He added this was the second request he had sent medical staff.<sup>105</sup> The nurse noted medical staff would see PADRON the same day.

At 11:07 a.m., (b)(6); (b)(7)(C) conducted a sick call appointment for PADRON after he walked into the clinic stating he was extremely sick and documented the following:<sup>106</sup>

- PADRON's vital signs were within normal limits, except for an elevated blood pressure of 135/87.<sup>107</sup>
- PADRON stated he had pain in his throat, swelling on the left side of his throat, congestion, sneezing, and watery eyes.
- (b)(6); (b)(7)(C) discussed with PADRON that this was not the proper way to come down for sick call, and he would be expected to follow the correct process in the future.<sup>108</sup>

(b)(6); (b)(7)(C) diagnosed PADRON with a cold and gave him acetaminophen (325 mg), two tablets to be taken twice daily for seven days as needed, and cetirizine (10 mg) once daily for 30 days. RN (b)(6); (b)(7)(C) encounter note does not reflect that she used a Pathway for cold or allergy symptoms to arrive at her finding, nor does it document a general nursing assessment supporting her determination that PADRON had a cold. Furthermore, the CCS Pathway for cold and allergy symptoms provided to ERAU did not include the issuance of cetirizine. MCDC provided no documentation of another Pathway for cold and allergy symptoms that would have authorized the administration of these medications.

<sup>102</sup> See sick call appointment order, dated September 25, 2018. ERAU notes it is unclear why the sick call appointment order was entered into the system at 2:29 a.m., before the Healthcare Request was triaged at 10:20 a.m.

<sup>103</sup> The staff signature and date fields were empty and other nursing staff entries were either completely or partially illegible. It appears the staff initials printed on the form were AF. (b)(6); (b)(7)(C) is the only member of the MCDC medical staff with those initials. During her interview with ERAU, (b)(6); (b)(7)(C) confirmed she spoke Spanish.

<sup>104</sup> See Healthcare Request, dated September 25, 2018.

<sup>105</sup> MCDC was unable to provide ERAU a Healthcare Request or other complaint before this date related to facial swelling, a sore throat, or a fever.

<sup>106</sup> See RN (b)(6); (b)(7)(C) encounter note, dated September 25, 2018.

<sup>107</sup> RN (b)(6); (b)(7)(C) did not take PADRON's temperature or pulse oxygen readings.

<sup>108</sup> ERAU notes although (b)(6); (b)(7)(C) told PADRON he did not follow proper sick call procedures, PADRON submitted a sick call related to cold symptoms on September 4, 2018, which medical staff did not see him for until this encounter.

## October 9, 2018

At 12:44 a.m., (b)(6); (b)(7)(C) entered a sick call appointment order that noted PADRON stated he had a fever, swelling, and soreness on the left side of his throat.<sup>109</sup> She further documented PADRON noted the problem had been ongoing and had gotten worse.

At 12:45 a.m., (b)(6); (b)(7)(C) triaged PADRON's Healthcare Request, written in Spanish, which PADRON dated October 8, 2018.<sup>110</sup> PADRON stated his glands were inflamed, his face was swollen, he was having issues with his mouth, and needed antibiotics for the infection. LPN (b)(6); (b)(7)(C) noted she scheduled an appointment for PADRON.

At 1:55 a.m., (b)(6); (b)(7)(C) triaged PADRON's Healthcare Request, written in English, which PADRON dated October 8, 2018.<sup>111</sup> PADRON stated that his throat hurt, he had a little dot on his face, pain in his neck, and an infection in his mouth. He also stated he had previously "requested one" on September 25, 2018. (b)(6); (b)(7)(C) noted she scheduled PADRON for an appointment to see the doctor.

## October 10, 2018

At 3:42 p.m., (b)(6); (b)(7)(C) signed off on PADRON's sick call appointment screening and documented the following:<sup>112</sup>

- PADRON's vital signs were within normal limits except for an elevated blood pressure reading of 132/78.<sup>113</sup>
- PADRON stated he was constipated and strained during bowel movements. He added that he woke up coughing every morning and that his whole neck hurt and was swollen. He reiterated his need for antibiotics.
- PADRON's abdomen was not distended or tender to the touch and his bowels sounded normoactive<sup>114</sup> in all four quadrants.
- ARNP (b)(6); (b)(7)(C) had assessed PADRON's concerns about his neck and determined he was showing signs and symptoms consistent with heartburn/GERD. (b)(6); (b)(7)(C) had stated she would start PADRON on Zantac.<sup>115</sup>

<sup>109</sup> See MCDC sick call appointment order b (b)(6); (b)(7)(C) dated September 9, 2018.

<sup>110</sup> See Healthcare Request, received October 9, 2018 (12:45 a.m.).

<sup>111</sup> See Healthcare Request, received October 9, 2018 (1:55 a.m.).

<sup>112</sup> See LPN (b)(6); (b)(7)(C) encounter note, dated October 10, 2018.

<sup>113</sup> LPN (b)(6); (b)(7)(C) did not document PADRON's respiratory rate.

<sup>114</sup> Normoactive refers to normal activity or sound in the bowels.

<sup>115</sup> As ERAU previously mentioned, following his August 23, 2018, appointment with PADRON (b)(6); (b)(7)(C) noted he would start PADRON on Zantac for acid reflux; however, there is no documentation to support any provider at MCDC prescribed PADRON Zantac until this date (October 10, 2018), following PADRON's sick call appointment encounter with ARNP (b)(6); (b)(7)(C). Furthermore, MCDC did not administer the medication until October 12, 2018.



- PADRON complained of a sore spot in his mouth. Dental assessed him and determined that it was an aphthae ulcer<sup>116</sup> that would heal on its own.<sup>117</sup>
- (b)(6); (b)(7)(C) documented PADRON would be started on Zantac for heartburn issues and stool softener for his constipation. She noted she scheduled follow-up with a provider to assess PADRON at a later date to determine if Zantac was effective.<sup>118</sup>
- (b)(6); (b)(7)(C) documented dental educated PADRON on removing his dentures and resting his mouth as that could be causing the ulcer and irritation in his mouth. She told PADRON he should increase his water intake.

On this date, (b)(6); (b)(7)(C) ordered PADRON Colace<sup>119</sup> (100 mg) capsules, orally twice a day as needed, and ranitidine (150 mg) tablets, twice daily.<sup>120</sup>

### October 16, 2018

Deputy (b)(6); (b)(7)(C) completed PADRON's ICE Classification Reassessment and documented PADRON had no disciplinary incidents, minor infraction warnings, or issues with overall adjustment since his last classification. A supervisor approved Deputy Major's recommendation that PADRON's custody level remain high.

### October 19, 2018

At 5:00 a.m., (b)(6); (b)(7)(C) triaged another Healthcare Request from PADRON written in Spanish and dated October 18, 2018.<sup>121</sup> PADRON stated he needed his blood pressure checked, that he took medication in the morning and at night, and that he noticed his blood pressure was high. Using Google Translate to respond to PADRON in Spanish because she did not speak Spanish, LPN (b)(6); (b)(7)(C) noted in the "Response to Patient/Comments" field of the Healthcare Request form that she placed PADRON on the mental health list.<sup>122</sup>

### October 24, 2018

MCDC Mental Health Counselor (MHC) (b)(6); (b)(7)(C) saw PADRON pursuant to his placement on the mental health list by LPN (b)(6); (b)(7)(C) and noted the Healthcare Request was in error; however, per LPN (b)(6); (b)(7)(C) MHC Swain did not notify her of the error.<sup>123</sup> PADRON denied submitting a

<sup>116</sup> An aphthae ulcer, also referred to as a canker sore, is a commonly occurring small, shallow sore inside the mouth or at the base of the gums.

<sup>117</sup> MCDC was unable to provide an encounter note for the dental visit (b)(6); (b)(7)(C) discussed in her encounter note. Neither (b)(6); (b)(7)(C) nor the dental professional documented their own assessments of detainee PADRON, including findings and education. (b)(6); (b)(7)(C) did not co-sign (b)(6); (b)(7)(C) encounter note to confirm its accuracy.

<sup>118</sup> MCDC provided no documentation confirming medical staff scheduled a follow-up appointment.

<sup>119</sup> Colace, also known as docusate sodium, is a stool softener.

<sup>120</sup> ERAU notes medical staff did not begin administration of ranitidine until October 12, 2018.

<sup>121</sup> See Healthcare Request, received October 19, 2018.

<sup>122</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018. ERAU notes (b)(6); (b)(7)(C) entered the Spanish word "depresión" into Google Translate, which means depression in English, instead of what PADRON wrote, "de presión," which refers to blood pressure.

<sup>123</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018.

sick call for mental health treatment and denied past mental health treatment. Consequently, medical did not see PADRON for his complaints of high blood pressure.

## October 26, 2018

At 12:49 a.m., after PADRON complained of chest pain to Deputy (b)(6); (b)(7)(C) Sgt. A (b)(6); (b)(7)(C) escorted him to medical.<sup>124</sup> (b)(6); (b)(7)(C) documented that from his desk he heard PADRON knocking on his cell door.<sup>125</sup> When he walked over and looked in PADRON's cell, he saw PADRON sitting in his wheelchair and opened the door to ask PADRON what was wrong. PADRON stated he was having chest pain, and Deputy (b)(6); (b)(7)(C) dialed for a rover.

In her encounter note, time stamped 4:32 a.m., (b)(6); (b)(7)(C) Lake assessed PADRON and documented the following:<sup>126</sup>

- Security staff brought PADRON down from Delta Unit at 1:00 a.m. with complaints of chest pain. PADRON described his pain as sharp, radiating to his left arm and back and was gripping his chest.
- PADRON's vital signs were within normal limits except for an elevated blood pressure of 196/98.<sup>127</sup>
- (b)(6); (b)(7)(C) performed an EKG, which showed normal sinus with depressed ST segment.<sup>128</sup>
- (b)(6); (b)(7)(C) contacted ARNP (b)(6); (b)(7)(C) who ordered staff to send PADRON to Lower Keys Medical Center (LKMC). (b)(6); (b)(7)(C) documented staff notified Main Control, who then contacted EMS.

*Note:* During her interview with ERAU, (b)(6); (b)(7)(C) explained she informed the LKMC Emergency Department (ED) of PADRON's sharp chest pain and normal EKG results by telephone and completed the necessary documentation to accompany him to the hospital. (b)(6); (b)(7)(C) went on to state this documentation usually included medications and patient medical history.<sup>129</sup> (b)(6); (b)(7)(C) explained that she could not provide the documentation to ERAU for review as she forgot to make a copy of the documents before sending them with PADRON to the hospital. (b)(6); (b)(7)(C) informed ERAU she was certain she reported his hypertensive crisis reading to the ED by phone and through paperwork. The hospital documented PADRON's past medical history was obtained from the EMS, which included his medical history and medications.<sup>130</sup>

<sup>124</sup> See MCSO Jail Log Report, entry dated October 26, 2018.

<sup>125</sup> See MCSO Incident Report, entry dated October 26, 2018. Rover refers to a deputy assigned to escort duty.

<sup>126</sup> See (b)(6); (b)(7)(C) encounter note, dated October 26, 2018.

<sup>127</sup> During his interview with ERAU on November 29, 2018, (b)(6); (b)(7)(C) stated staff did not make him aware of PADRON's hypertensive crisis vital sign reading.

<sup>128</sup> ST depression, common in patients with uncontrolled hypertension, is often a sign of myocardial ischemia (lack of oxygen to the heart muscle), of which coronary insufficiency is a major cause.

<sup>129</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>130</sup> See LKMC Nurse's Notes and Physician Documentation, dated October 26, 2018. The hospital documented PADRON's past medical history as high cholesterol, GERD, hypertension, and constipation. Additionally, eight of PADRON's medications were included.



The timeline of events below is based on (b)(6); (b)(7)(C) incident report.<sup>131</sup>

- At 1:10 a.m., Main Control contacted EMS.
- At 1:20 a.m., EMS arrived to MCDC.
- At 1:24 a.m., EMS arrived at the sick bay.
- At 1:35 a.m., EMS left the sally port.
- Detention Deputies (b)(6); (b)(7)(C) escorted PADRON in the ambulance to the hospital.<sup>132</sup>

At 1:41 a.m., PADRON arrived at the LKMC ED. Hospital medical staff documented the following:<sup>133</sup>

- PADRON spoke a little English but his preferred language was Spanish.<sup>134</sup>
- EMS personnel notified hospital staff that PADRON had abdominal pain and had no bowel movement in two days.
- PADRON's admitting diagnosis read, "constipation, unspecified."
- PADRON's vital signs were within normal limits except for an elevated blood pressure of 132/75.
- PADRON was positive for chest pain, a cough, and constipation. His palpitations were normal and he appeared alert, awake, and comfortable.
- The X-ray imaging report noted no active disease was found in PADRON's chest but showed gas scattered throughout nondilated bowel in a nonspecific pattern. PADRON's EKG showed normal sinus rhythm and a non-specific ST abnormality.
- Medications administered were mineral oil (30 mg) by mouth and magnesium citrate liquid<sup>135</sup> (300 ml), both to treat constipation.
- (b)(6); (b)(7)(C) documented PADRON's diagnosis as constipation. His condition was stable and his symptoms were improved. Staff provided PADRON educational information about addressing adult constipation.
- (b)(6); (b)(7)(C) wrote a prescription for lactulose solution<sup>136</sup> (30 ml) once daily by mouth, requesting patient follow-up with MCDC's (b)(6); (b)(7)(C) for continuity of care that day.
- PADRON signed his discharge instructions.

At 4:20 a.m., (b)(6); (b)(7)(C) documented PADRON returned from LKMC.<sup>137</sup>

<sup>131</sup> See MCSO Incident Report, entry dated October 26, 2018. ERAU notes these times vary slightly from the MCSO Jail Log Report.

<sup>132</sup> See EMS Report email from (b)(6); (b)(7)(C) dated December 19, 2018. After numerous requests, Monroe County EMS refused to provide ICE with EMS records related to both this incident and the EMS response on the day of PADRON's death, November 1, 2018. A month and a half after the records were originally requested, (b)(6); (b)(7)(C) notified ICE that Chief (b)(6); (b)(7)(C) from Monroe County EMS refused to release the EMS records without a subpoena.

<sup>133</sup> See LKMC Nurse's Notes and Physician Documentation, dated October 26, 2018.

<sup>134</sup> ERAU was unable to determine in what language the hospital encounter occurred.

<sup>135</sup> Magnesium citrate liquid is a salt solution laxative that is thought to work by increasing fluid in the small intestine.

<sup>136</sup> Lactulose solution is a sugar solution used to soften the stools for treatment of constipation.

<sup>137</sup> See (b)(6); (b)(7)(C) encounter note, dated October 26, 2018. During her interview with ERAU on November 29, 2018, (b)(6); (b)(7)(C) stated she was surprised PADRON returned from the ED so quickly with only a diagnosis of constipation. Although (b)(6); (b)(7)(C) stated she assessed PADRON upon his return from the ED, she did not document the follow-up

At 4:34 a.m., PADRON returned to the Delta Unit.<sup>138</sup>

At 9:13 a.m., (b)(6); (b)(7)(C) conducted PADRON's ED visit follow-up assessment and documented the following:<sup>139</sup>

- Director of Nursing (DON) (b)(6); (b)(7)(C) provided interpretation.
- PADRON's vital signs were within normal limits except for an elevated blood pressure of 175/107.
- PADRON had two bowel movements since the ED gave him medication for his constipation.
- PADRON reported he started having pain in his left scapula<sup>140</sup> and arm the previous evening, which hurt with palpation. PADRON denied injury to his arm and stated he was not certain what caused the pain.
- PADRON stated concern about his blood pressure the previous evening and present morning; (b)(6); (b)(7)(C) noted PADRON had not had his morning medication yet.
- PADRON said he needed more fiber in his diet and requested an extra mattress.
- PADRON continued to moan until (b)(6); (b)(7)(C) gave him a dose of Toradol<sup>141</sup> (60 mg) by injection.
- PADRON showed no signs of diaphoresis<sup>142</sup> or pallor<sup>143</sup> and exhibited normal speech.
- PADRON's lungs were clear and his heart was regular with no murmur.
- PADRON's bowel sounds were normoactive and his abdomen was non-tender, non-distended, and free of organomegaly.<sup>144</sup>
- PADRON's left scapular border and biceps showed tenderness to palpation with mild muscle spasms.
- (b)(6); (b)(7)(C) did not observe swelling or erythema.

When asked about this encounter, specifically about PADRON's elevated blood pressure reading of 175/107, (b)(6); (b)(7)(C) said she focused more on his musculoskeletal complaint and constipation rather than his elevated blood pressure reading, especially since he had not yet taken his morning medication.<sup>145</sup> As such, she did not consider ordering blood pressure monitoring.

Therefore, (b)(6); (b)(7)(C) assessment was muscle pain in PADRON's left scapular border and per the ED, constipation. She authorized PADRON to have an extra mattress<sup>146</sup> and encouraged hydration. (b)(6); (b)(7)(C) noted medical would follow up with PADRON during his chronic care

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nursing assessment (to include vitals) or that a provider was contacted before PADRON was returned to his housing unit.

<sup>138</sup> See MCSO Jail Log Report documented PADRON returned to the Delta Unit at 4:34 a.m.

<sup>139</sup> See ARNP Moore's encounter note, dated October 26, 2018.

<sup>140</sup> The scapula is the shoulder bone.

<sup>141</sup> Toradol (generic *Ketorolac*) is a medication that treats pain.

<sup>142</sup> Diaphoresis refers to abnormal sweating.

<sup>143</sup> Pallor refers to an unhealthy pale appearance.

<sup>144</sup> Organomegaly is the abnormal enlargement of one or more organs.

<sup>145</sup> ERAU interview with ARNP (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>146</sup> ERAU notes that although ARNP (b)(6); (b)(7)(C) authorized an additional mattress, photos taken by MCDC staff of PADRON's cell following his death only show one thin mattress.



appointment with (b)(6); (b)(7)(C) scheduled to occur between November 21 and 29, 2018.<sup>147</sup> (b)(6); (b)(7)(C) prescribed PADRON Fiber Lax (625 mg) to be taken once a day for 90 days for constipation.<sup>148</sup>

## October 28, 2018

At 12:53 a.m., Deputy (b)(6); (b)(7)(C) noted in the Delta Unit Jail Log that PADRON complained of pain running down his left arm, which extended to his left leg.<sup>149</sup> (b)(6); (b)(7)(C) remarked in the entry field of the Delta Unit Jail Log that PADRON's face looked flush and was developing red blotch-like marks. (b)(6); (b)(7)(C) then notified medical and radioed for a rover to escort PADRON to the sick bay.

At 1:28 a.m. (b)(6); (b)(7)(C) documented her assessment of PADRON, noting the following:<sup>150</sup>

- PADRON came to medical waiving his arm and stated it hurt.
- PADRON's vital signs were within normal limits except for an elevated blood pressure of 148/81.
- When PADRON talked to staff or they took his blood pressure, he was quiet, but once staff left him alone for a few seconds, he would moan again.
- PADRON requested Motrin for pain. As his pain was non-radiating and reproducible,<sup>151</sup> she gave him one dose of Advil (200 mg).
- (b)(6); (b)(7)(C) told PADRON to alert staff if he had any other issues.

Despite the complaint of chest pain, (b)(6); (b)(7)(C) did not use the Hypertension Pathway, which calls for noting whether the patient has a history of hypertension and prompts inquiry into 12 listed symptoms, including, but not limited to being in pain. For patients with known hypertension currently on medication, the Pathway recommends medical staff schedule an appointment with a provider within seven days if blood pressure is within the normal to high range; however, the Pathway does not specify which blood pressure levels meet this range criterion.

## October 29, 2018

At 2:30 a.m. (b)(6); (b)(7)(C) triaged PADRON's Healthcare Request, written in English, which PADRON dated October 28, 2018.<sup>152</sup> PADRON stated he had pain in his chest radiating down his left arm and had not experienced a bowel movement since he went to the hospital. He added that his pain was bad at night. (b)(6); (b)(7)(C) responded that a doctor would see PADRON the same day.

<sup>147</sup> See chronic care appointment order, dated August 23, 2018.

<sup>148</sup> See Prescription order, dated October 26, 2018.

<sup>149</sup> See MCSO Jail Log Report, entry dated October 28, 2018.

<sup>150</sup> See (b)(6); (b)(7)(C) encounter note, dated October 28, 2018. During her interview with ERAU on October 29, 2018, (b)(6); (b)(7)(C) stated she usually uses a deputy for interpretation when needed but that PADRON spoke good English. She clarified she did not usually document if she used MCDC staff for interpretation assistance. ERAU notes her assessment of PADRON's language skills is contrary to documentation from intake, LKMC, and other nursing staff.

<sup>151</sup> Reproducible refers to the ability to cause pain by applying pressure to the area.

<sup>152</sup> See Healthcare Request, received October 29, 2018.

At 2:31 a.m., (b)(6); (b)(7)(C) scheduled a sick call appointment for the same day.<sup>153</sup> In the instructions area of the appointment order, (b)(6); (b)(7)(C) documented PADRON was again complaining about reproducible chest pain, although he was examined on October 27 and 28, 2018.<sup>154</sup>

At 1:27 p.m. (b)(6); (b)(7)(C) documented PADRON complained about pain in his left arm; therefore, he notified (b)(6); (b)(7)(C)<sup>155</sup> As a result, (b)(6); (b)(7)(C) authorized security staff to escort PADRON from his housing unit to medical.

At 1:42 p.m., LPN (b)(6); (b)(7)(C) entered an encounter note stating security brought PADRON to medical as he complained of chest pain.<sup>156</sup> She also documented his blood pressure was taken at the following times but did not record any other information:

- 1:20 p.m.: Pulse, 87; Blood Pressure, 196/99
- 1:30 p.m.: Pulse, 88; Blood Pressure, 180/100
- 1:40 p.m.: Pulse, 88; Blood Pressure, 157/97

(b)(6); (b)(7)(C) note stated she consulted ARNP (b)(6); (b)(7)(C) and then moved PADRON to the sick bay at approximately 1:46 p.m.<sup>157</sup> During her interview, ARNP (b)(6); (b)(7)(C) recalled a nurse telling her that PADRON came to medical complaining of chest pain but when he got there, he complained of something different.<sup>158</sup> She stated she directed his placement in sick bay so medical staff could observe him and ordered lab studies to rule out pancreatitis.<sup>159</sup>

At 2:08 p.m., ARNP (b)(6); (b)(7)(C) ordered a lab diagnostic panel with a requested start date of October 29, 2018, and a requested end date of October 31, 2018.<sup>160</sup>

At 2:15 p.m. (b)(6); (b)(7)(C) assessed PADRON and documented the following:<sup>161</sup>

- Security brought PADRON from the Delta Unit to medical as he complained of chest pain.

<sup>153</sup> See sick call appointment order, dated October 29, 2018.

<sup>154</sup> Documentation provided indicated medical staff only saw PADRON on October 28, 2018.

<sup>155</sup> See MCSO Jail Log Report, entry dated October 29, 2018.

<sup>156</sup> See LPN (b)(6); (b)(7)(C) encounter note, dated October 29, 2018.

<sup>157</sup> See MCSO Jail Log Report, entry dated October 29, 2018. It is unclear if LPN (b)(6); (b)(7)(C) notified ARNP (b)(6); (b)(7)(C) when PADRON's blood pressure first indicated he was in hypertensive crisis at 1:20 p.m. and received instructions to re-check it.

<sup>158</sup> ERAU interview with ARNP (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>159</sup> See LabCorp Patient Results, dated November 1, 2018. PADRON's Amylase lab results ruled out pancreatitis.

<sup>160</sup> See Lab Diagnostic Panel 2 Order, dated October 29, 2018.

<sup>161</sup> See (b)(6); (b)(7)(C) encounter note, dated October 29, 2018.



- After speaking with PADRON and assessing his vitals,<sup>162</sup> PADRON stated he was not having chest pain but rather was worried about his pancreas and wanted labs drawn to rule out pancreatitis.<sup>163</sup>
- (b)(6); (b)(7)(C) educated PADRON on his approach for medical to assess him and explained chest pain is considered a medical emergency that should be taken very seriously.
- MCDC staff moved PADRON to the sick bay for further observation and scheduled him for labs in the evening while he was fasting.<sup>164</sup>

At 2:32 p.m., ARNP (b)(6); (b)(7)(C) prescribed PADRON acetaminophen (325 mg), twice per day for seven days.<sup>165</sup>

At 11:19 p.m., Deputy (b)(6); (b)(7)(C) processed PADRON back into the Delta Unit.<sup>166</sup>

### October 30, 2018

At an unknown time, LPN (b)(6); (b)(7)(C) documented that PADRON declined to take his morning medications HCTZ (12.5 mg) and aspirin (81 mg), as he said he did not need that medication today.<sup>167</sup> LPN (b)(6); (b)(7)(C) documented she educated PADRON on the potential consequences of not taking his medication and checked the boxes beside “worsening of medical conditions” and “death.” She documented that PADRON refused to sign the form.

At 11:10 p.m., LPN (b)(6); (b)(7)(C) documented the following events related to PADRON:<sup>168</sup>

- Deputy (b)(6); (b)(7)(C) provided interpretation during the sick bay encounter.

<sup>162</sup> During her interview with ERAU on November 28, 2018, (b)(6); (b)(7)(C) did despite documenting the assessment of vitals within her note, she did not take PADRON’s blood pressure nor was she aware of PADRON’s three blood pressure readings. (b)(6); (b)(7)(C) took earlier in the day.

<sup>163</sup> During her interview with ERAU, (b)(6); (b)(7)(C) explained that PADRON did not clarify why he believed he may have pancreatitis nor did she ask. No additional documentation of any related observations or symptoms PADRON was experiencing were provided within her note.

<sup>164</sup> (b)(6); (b)(7)(C) clarified that ARNP (b)(6); (b)(7)(C) gave the labs order verbally and that she set a two-day timeframe for collection of the sample, consistent with standing practice. Although (b)(6); (b)(7)(C) note stated MCDC scheduled for PADRON’s labs to be drawn in the evening while fasting, per the LabCorp report, staff collected PADRON’s specimens during the early morning hours of October 31, 2018. (b)(6); (b)(7)(C) could not explain why she stated this within her encounter note. See LabCorp Patient Results, dated November 1, 2018.

<sup>165</sup> See Prescription order, dated October 29, 2018.

<sup>166</sup> See MCSO Jail Log Report, entry dated October 29, 2018. ERAU notes that although PADRON was in the sick bay for approximately ten and one-half hours, there is no documentation a nursing round occurred or that medical staff conducted an assessment prior to PADRON’s release from sick bay. Moreover, there is no documentation indicating who directed PADRON’s release from sick bay or if staff obtained provider authorization. When asked by ERAU whether placement in sick bay constitutes admission to medical housing, ARNP (b)(6); (b)(7)(C) stated “not really” but indicated that if she directs placement in sick bay, she expects staff to contact her for authorization to return a patient to general population. HSA (b)(6); (b)(7)(C) confirmed during interview that providers are to determine when a patient may be released from sick bay. When asked about expectations for nurse monitoring of patients in sick bay, HSA (b)(6); (b)(7)(C) said nurses are to speak to patients and take their vital signs at least once per shift, or as otherwise ordered by the provider.

<sup>167</sup> See Refusal of Treatment form, dated October 30, 2018. According to HSA (b)(6); (b)(7)(C) no longer worked at the facility; therefore, ERAU was unable to interview her.

<sup>168</sup> See LPN (b)(6); (b)(7)(C) encounter note, dated October 30, 2018.

- During evening pill pass, PADRON refused to take his blood pressure medication because he believed the medications the facility gave him were making his blood pressure worse.<sup>169</sup> PADRON stated he was also experiencing chest pains, a headache, and felt like he was having a stroke like he had before, prior to his detention.
- (b)(6); (b)(7)(C) requested security staff escort PADRON to the sick bay so she could further assess him.<sup>170</sup>
- Upon assessment in the sick bay, PADRON had an elevated blood pressure of 160/98 and a rapid pulse of 104.<sup>171</sup> His respirations remained within normal limits. PADRON stated this high blood pressure was due to the amlodipine prescription he took in the evening and requested to take the medication he arrived to MCDC with.
- After reviewing the medications PADRON came to the facility with, LPN (b)(6); (b)(7)(C) explained to PADRON several times that he was currently taking the same hypertension medications he arrived with. Although PADRON maintained he was not receiving the correct medication, the nurse was eventually able to get PADRON to take his evening dose of hypertension medication.
- (b)(6); (b)(7)(C) offered to schedule PADRON for an appointment with medical; however, PADRON noted he did not want to be seen by anyone other than a doctor. She instructed PADRON to notify staff if he experienced additional chest pain.<sup>172</sup> As (b)(6); (b)(7)(C) assessed PADRON was stable, she had security staff escort him back to the Delta Unit.

During her interview, (b)(6); (b)(7)(C) stated she told PADRON that (b)(6); (b)(7)(C) would see him on November 1, 2018.

## October 31, 2018

At 7:06 a.m., (b)(6); (b)(7)(C) entered an encounter note documenting that she altered LPN (b)(6); (b)(7)(C) referral for a doctor sick call appointment the previous evening to a provider visit.<sup>173</sup> Notwithstanding, the only provider visit scheduled on this date, by ARNP (b)(6); (b)(7)(C) documented a provider was to see PADRON on November 2, 2018, to review PADRON's labs with him and discuss his concern about pancreatitis.

<sup>169</sup> The MAR documents that PADRON took his evening dose of the blood pressure medication amlodipine but he did not take his as-needed medications docusate sodium (100 mg), Fiber Lax (625 mg), and acetaminophen (325 mg). Although the MAR recorded "ESHEEHAN" as the individual who administered PADRON's medication on this evening, (b)(6); (b)(7)(C) clarified during her interview with ERAU on November 28, 2018, that she used the computer in the sick bay that was already logged in to (b)(6); (b)(7)(C) profile and did in fact administer PADRON's evening medication as documented.

<sup>170</sup> During her interview with ERAU on November 28, 2018, (b)(6); (b)(7)(C) stated that when PADRON brought up concerns about his blood pressure medication at pill pass, she requested security staff escort him to the sick bay so she could have someone interpret the encounter.

(b)(6); (b)(7)(C) did not record PADRON's temperature or pulse oxygen levels.

<sup>172</sup> See (b)(6); (b)(7)(C) encounter note, dated October 30, 2018.

<sup>173</sup> During her interview with ERAU on November 29, 2018, ARNP (b)(6); (b)(7)(C) clarified that a provider visit would allow any mid-level provider or doctor at the facility to assess a detainee.



At 10:27 a.m., PADRON made a telephone call.<sup>174</sup> He stated MCDC finally took him to the doctor as he told them he felt bad. PADRON told the recipient he had been taking Lisinopril but that MCDC was giving him something else. He stated he wanted the medicines he had been taking.<sup>175</sup>

At 2:22 p.m., (b)(6); (b)(7)(C), another detainee who was housed in Delta Unit, engaged Deputy (b)(6); (b)(7)(C) at the officers' station to provide interpretation for PADRON, who was complaining of chest pain.<sup>176</sup> In response, at 2:23 p.m., (b)(6); (b)(7)(C) called medical, in addition to calling for a rover to escort PADRON to sick bay.<sup>177</sup> At 2:24 p.m., in response to a hand motion from Deputy (b)(6); (b)(7)(C), (b)(6); (b)(7)(C) pushed PADRON, who was in his wheelchair, over to (b)(6); (b)(7)(C). At 2:27 p.m., (b)(6); (b)(7)(C) arrived and escorted PADRON to the sick bay, where he arrived at 2:28 p.m.

Although the encounter in sick bay was not documented in PADRON's medical record by MCDC medical staff, the surveillance video footage depicted the following:<sup>179</sup>

- At 2:28 p.m., PADRON arrived at the sick bay, escorted by (b)(6); (b)(7)(C).
- At 2:34 p.m., RN (b)(6); (b)(7)(C) began assessing PADRON. (b)(6); (b)(7)(C) stood by and provided interpretation as needed until (b)(6); (b)(7)(C) took over the encounter.<sup>180</sup> PADRON gestured towards his left shoulder and arm.
- At 2:36 p.m., (b)(6); (b)(7)(C) took PADRON's vital signs. (b)(6); (b)(7)(C) annotated PADRON's blood pressure was elevated at 153/89; his pulse and pulse oxygen were within normal limits at 77 and 97%, respectively.<sup>181</sup>
- From 2:41 p.m. until 2:52 p.m., (b)(6); (b)(7)(C) were standing and conversing with each other at the other end of the nurses' station, a few feet from PADRON.
- At 2:48 p.m., ARN (b)(6); (b)(7)(C) entered the sick bay and spoke with (b)(6); (b)(7)(C) and HSA (b)(6); (b)(7)(C). Twenty-six seconds later, (b)(6); (b)(7)(C) looked at PADRON and left the sick bay. (b)(6); (b)(7)(C) then spoke to PADRON as (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) who had moved behind the nurses' station and closer to PADRON, stood by. (b)(6); (b)(7)(C) appeared actively involved in communicating with PADRON for the next three minutes, to include approximately one minute where she sat directly in front of PADRON to speak with him,

<sup>174</sup> See Monroe County Detention Facility Physical Information Form Emergency Contact, dated August 18, 2018; see also Lionbridge transcription of call 77200090, dated October 31, 2018. PADRON made 12 successful calls to three different numbers on this date, between 10:24 a.m. and 10:42 p.m. Based on an initial review of the short audio recordings with an interpreter over the phone, ERAU's translation services provider transcribed three calls from Spanish to English, which PADRON placed at 10:27 a.m., 8:07 p.m., and 10:42 p.m. These calls are further discussed in the report. As the quality of the audio is poor, some of what both parties said was unintelligible.

<sup>175</sup> The MAR shows that ARN (b)(6); (b)(7)(C) prescribed PADRON Lisinopril August 18, 2018, his first day at MCDC, and that medical staff administered PADRON this medication from his first day at MCDC until his last. See PADRON's MCDC MAR.

<sup>176</sup> MCDC Delta Unit Video Surveillance Footage, timed 2:00 p.m. to 2:27 p.m., dated October 31, 2018. During interview with ERAU (b)(6); (b)(7)(C) recalled that he frequently interpreted for PADRON.

<sup>177</sup> ERAU interview with Deputy (b)(6); (b)(7)(C) dated November 28, 2018.

<sup>178</sup> MCDC Delta Unit Video Surveillance Footage, timed 2:00 p.m. to 2:27 p.m., dated October 31, 2018.

<sup>179</sup> MCDC sick bay Video Surveillance Footage, timed 2:28 p.m. to 2:52 p.m., dated October 31, 2018.

<sup>180</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 27, 2018. (b)(6); (b)(7)(C) called PADRON complained of chest pain.

<sup>181</sup> See Sick Bay Shift Report, dated October 31, 2018. (b)(6); (b)(7)(C) wrote PADRON's vital signs in the top right-hand corner of the Sick Bay Shift Report, outside the form fields.



before moving out of view. As (b)(6); (b)(7)(C) walked away, (b)(6); (b)(7)(C) gave PADRON water and possibly a pill.

- At 2:52 p.m., PADRON, in a wheelchair, wheeled himself out of the sick bay with Sgt. (b)(6); (b)(7)(C) leading the way in front of him.

(b)(6); (b)(7)(C) stated that during this encounter, he reviewed PADRON's electronic medical record and noticed PADRON had a history of chest pain complaints and was recently sent to the local ED, but he did not complete a pain assessment or use the Hypertension Pathway.<sup>182</sup> Although RN (b)(6); (b)(7)(C) stated PADRON was asymptomatic and showed no signs of distress, he asserted that he decided to consult ARNP (b)(6); (b)(7)(C). According to (b)(6); (b)(7)(C), (b)(6); (b)(7)(C) came to sick bay and took over the encounter; however, surveillance footage does not support that she took over the encounter as she never spoke directly to PADRON.<sup>183</sup> (b)(6); (b)(7)(C) said he asked (b)(6); (b)(7)(C) twice if she wanted him to perform an EKG on PADRON and she said no both times. (b)(6); (b)(7)(C) also said that at some point during the encounter, he requested (b)(6); (b)(7)(C) assistance in interpreting. Asked whether he recalled giving PADRON medication, (b)(6); (b)(7)(C) said he may have given PADRON an aspirin but that would have been (b)(6); (b)(7)(C) responsibility to direct and document. When asked why he did not enter an encounter note, (b)(6); (b)(7)(C) asserted that because (b)(6); (b)(7)(C) interpreted, she had a better understanding of communications with PADRON and that (b)(6); (b)(7)(C) told him she would take care of the documentation. (b)(6); (b)(7)(C) said it was (b)(6); (b)(7)(C) decision to return PADRON to his housing unit.

(b)(6); (b)(7)(C) acknowledged she was present at the time of the undocumented medical encounter but could not recall what transpired.<sup>184</sup> (b)(6); (b)(7)(C) stated she was in sick bay to see another patient and only recalled instructing the nurses to tell PADRON the doctor would see him.<sup>185</sup>

At 2:53 p.m., PADRON returned to the Delta Unit and began talking to other detainees.<sup>186</sup> For the next seven minutes, PADRON can be seen using his legs, while seated, to move his wheelchair around the unit, with no apparent difficulty or distress.

At 8:07 p.m., PADRON called a contact by telephone and told them that MCDC staff took him to the hospital due to back pain and that a doctor had not seen him in a week. He mentioned he was currently in pain and that he had spoken with a Deportation Officer that same day.<sup>187</sup>

At approximately 9:00 p.m., LPN (b)(6); (b)(7)(C) administered PADRON his seven evening medications. LPN (b)(6); (b)(7)(C) confirmed she told PADRON the doctor would see him in the morning and noted he appeared stable and in no distress but was anxious to see the doctor about his medications. Although no documentation exists, (b)(6); (b)(7)(C) stated she scheduled the appointment in their system and spoke to (b)(6); (b)(7)(C) about PADRON.

<sup>182</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>183</sup> See MCDC sick bay Video Surveillance Footage, timed 2:28 p.m. to 2:52 p.m., dated October 31, 2018.

<sup>184</sup> ERAU interview with DON (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>185</sup> ERAU interview with ARNP (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>186</sup> MCDC Delta Unit Video Surveillance Footage, timed 2:53 p.m. to 2:54 p.m., dated October 31, 2018.

<sup>187</sup> See Lionbridge transcription of call 77204280, dated October 31, 2018.



At 10:42 p.m., PADRON made a telephone call.<sup>188</sup> This was the last documented time PADRON spoke with anyone.

At 11:05 p.m., Deputy (b)(6); (b)(7)(C) assigned to Delta Unit for the 6:00 p.m. to 6:00 a.m. shift, looked into PADRON's cell<sup>189</sup> but did not open the door as required by MCSO policy.<sup>190</sup> Deputy (b)(6); (b)(7)(C) stated PADRON presented his ID card at the cell door window and that this count was the last time he saw PADRON alive.<sup>191</sup> (b)(6); (b)(7)(C) also stated he conducted security rounds throughout the night, every 25 to 30 minutes, which consisted of looking into each detainee's cell to make sure they were sleeping.

### November 1, 2018 – Day of Death

Between 12:00 a.m. and 6:00 a.m., (b)(6); (b)(7)(C) documented conducting 13 security rounds<sup>192</sup> and five physical headcounts.<sup>193</sup> (b)(6); (b)(7)(C) stated he noted nothing unusual when he looked in PADRON's cell during those rounds and that PADRON appeared to be sleeping.<sup>194</sup>

ERAU reviewed video footage covering the 3:00 a.m. to 6:00 a.m. portion of (b)(6); (b)(7)(C) shift on November 1, 2018.<sup>195</sup> ERAU confirmed that of the six rounds logged by (b)(6); (b)(7)(C) during this time frame, only two rounds actually took place in accordance with policy (*see table below*).<sup>196</sup>

<sup>188</sup> See Lionbridge transcription of call 77207610, dated October 31, 2018.

<sup>189</sup> MCDC housed PADRON in Delta Unit's cell 001 in a lower bunk on the ground-level tier from August 18, 2018, until his death. Cell 001 is located immediately behind the stairs that lead to Delta Unit's upper tier. PADRON's cell was the closest to the entrance of the unit. PADRON did not have a roommate at the time of his death; *see* Cellmate History Report, dated August 18, 2018, to November 1, 2018.

<sup>190</sup> See MCDC Face to Photo Count Form, dated October 31, 2018. Although the count was logged at 11:00 p.m. per the MCDC Face to Photo Count Form, video surveillance footage supports completion of the face-to-photo count for all 58 detainees housed in Delta Unit starting at PADRON's cell at 11:05 p.m. and ending at 11:12 p.m.; *see also* MCDC Delta Unit Video Surveillance Footage, timed 11:05:31 p.m. to 11:05:53 p.m., dated October 31, 2018, and four separate surveillance footage clips ending at 11:12:36 p.m. ERAU notes that, per MCSO Corrections Bureau Directive 8:021, *Population Count Principles and Procedures*, a face-to-photo count requires detainees to stand in their cell with their ID in hand. A deputy would then open the cell door and the detainee would present their ID to the deputy for face-to-photo verification. Once the detainee is verified and counted, the cell is then re-secured.

<sup>191</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 28, 2018.

<sup>192</sup> ERAU notes per MCSO Corrections Bureau Directive 8:020, security rounds require deputies to continuously move about the housing dorm/unit so that a personal visual observation of each inmate is made at least once every 30 minutes on an irregular schedule to ensure their state of well-being (i.e., they are alive, free from injury or assault, and that their needs are being tended to).

<sup>193</sup> See MCSO Jail Log Report By Date/Time With Linked Inmates, dated October 31, 2018, to November 1, 2018. ERAU notes per MCSO Corrections Bureau Directive 8:021, physical headcounts require deputies to be positive they see a living human body before counting a detainee present, judiciously using flashlights as necessary during night counts.

<sup>194</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 28, 2018.

<sup>195</sup> See MCDC Video Surveillance Footage, timed 3:00 a.m. to 6:00 a.m., dated November 1, 2018. ERAU notes that, although requested on multiple occasions, MCSO did not provide the Delta Unit video footage covering the entirety of November 1, 2018. As such, ERAU was only able to review and confirm rounds logged by (b)(6); (b)(7)(C) between 3:00 a.m. to 6:00 a.m. on November 1, 2018.

<sup>196</sup> ERAU notified the ICE Joint Intake Center (JIC) of this matter on December 20, 2018, when it became aware of the issue (JICMS case number: 201902698). On September 19, 2019, the ERO Administrative Inquiry Unit (AIU), who OPR referred the case to, closed the investigation with a final determination of substantiated. AIU subsequently informed the appropriate ERO FOD of their findings.



| Logged    | Documented Action                 | Seen in Footage | ERAU Determination                    |
|-----------|-----------------------------------|-----------------|---------------------------------------|
| 3:20 a.m. | Security round                    | 3:16 a.m.       | Deputy seen in footage <sup>197</sup> |
| 3:49 a.m. | Security round                    | Not Seen        | Did not occur                         |
| 4:18 a.m. | Security round and physical count | 4:20 a.m.       | Deputy seen in footage                |
| 4:47 a.m. | Security round                    | Not Seen        | Did not occur                         |
| 5:16 a.m. | Security round                    | 5:02 a.m.       | Occurred                              |
| 5:45 a.m. | Security round and physical count | 5:46 a.m.       | Occurred                              |

At 6:00 a.m., (b)(6); (b)(7)(C) took over for (b)(6); (b)(7)(C). He logged his first round at 6:04 a.m. and his second round at 6:28 a.m., both confirmed through video surveillance review.<sup>198</sup> During his interview with ERAU, (b)(6); (b)(7)(C) said PADRON appeared to be sleeping both times he looked in the cell.<sup>199</sup> (b)(6); (b)(7)(C) said the next time he approached PADRON's cell was after another detainee told him PADRON was not responding.

The following times are based on Delta Unit housing surveillance footage, unless otherwise documented.<sup>200</sup>

At 6:41 a.m., a detainee approached PADRON's cell to wake him up for breakfast. The detainee looked through PADRON's cell window, and when PADRON did not respond, he told detainee (b)(6); (b)(7)(C) that PADRON was sleeping and would not wake up. (b)(6); (b)(7)(C) then entered PADRON's cell for a few seconds and called for (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) then entered PADRON's cell; he later recalled trying to wake up PADRON but felt his body was cold and appeared blue.<sup>202</sup>

At 6:42 a.m., when (b)(6); (b)(7)(C) felt no pulse, he called a code blue over the radio indicating an emergency response.<sup>203</sup> He then tried to disperse the detainees who started walking toward and congregating around PADRON's cell; five other deputies arrived shortly thereafter. Deputy (b)(6); (b)(7)(C) stated that when she arrived, PADRON was lying on his back; she checked for a pulse, which did not exist, and noted PADRON felt cold to the touch.<sup>204</sup>

At 6:43 a.m., deputies began locking down the Delta Unit, Sgt. (b)(6); (b)(7)(C) arrived and Sgt. (b)(6); (b)(7)(C) called the Key West dispatch to send EMS.<sup>205</sup> (b)(6); (b)(7)(C) and Sgt. (b)(6); (b)(7)(C) then placed PADRON on the floor and began CPR.<sup>206</sup> (b)(6); (b)(7)(C) assisted with

<sup>197</sup> "Deputy seen in footage" means it appears (b)(6); (b)(7)(C) was conducting rounds on the upper tier of the unit; however, it is evident that when he walked down the stairs in front of PADRON's cell, he never walked by or even close to PADRON's cell.

<sup>198</sup> MCDC Delta Unit Video Surveillance Footage, timed 4:55 a.m. to 07:03 a.m., dated November 1, 2018.

<sup>199</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 28, 2018.

<sup>200</sup> See MCDC Video Surveillance Footage from 5:58 a.m. to 7:10 a.m. on November 1, 2018.

<sup>201</sup> ERAU interview with detainee (b)(6); (b)(7)(C), dated November 16, 2018.

<sup>202</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 28, 2018.

<sup>203</sup> See MCSO Jail Log by Date/Time With Linked Inmates entry by (b)(6); (b)(7)(C), dated November 1, 2018.

<sup>204</sup> See MCDC Death After Action statements by (b)(6); (b)(7)(C) on November 1, 2018; ERAU interviews with (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C), dated November 28, 2018.

<sup>205</sup> See MCSO Jail Log Report by Date/Time With Linked Inmates, dated November 1, 2018.

<sup>206</sup> ERAU notes that, as MCDC did not record their response efforts with a handheld camera, ERAU is unable to address the administration of CPR outside of MCDC staff statements.



breaths using an oxygen mask while (b)(6); (b)(7)(C) performed chest compressions.<sup>207</sup> Shortly afterward, (b)(6); (b)(7)(C) arrived with the crash cart. (b)(6); (b)(7)(C) used trauma sheers to cut PADRON's clothing off and (b)(6); (b)(7)(C) attached the AED pads to PADRON's chest. (b)(6); (b)(7)(C) replaced (b)(6); (b)(7)(C) performing chest compressions.<sup>208</sup> (b)(6); (b)(7)(C) documented the AED noted no rhythm, after which CPR resumed.<sup>209</sup> (b)(6); (b)(7)(C) later recalled that two cycles of CPR occurred before MCDC medical staff arrived.<sup>210</sup>

At 6:54 a.m., four EMS responders arrived and took over CPR.<sup>211</sup>

At 6:55 a.m., two additional EMS responders arrived.

At 6:58 a.m., RN Adams exited the Delta Unit with the crash cart.

At 7:03 a.m., EMS responders, escorted by (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) and Probationary Officers (b)(6); (b)(7)(C), departed the Delta Unit with PADRON on a gurney.<sup>212</sup> (b)(6); (b)(7)(C) ran down the hall toward the EMS responders with a piece of paper, which detailed PADRON's history and physical, along with a copy of his medications.<sup>213</sup> Video from several other cameras showed the responders' passage from the Delta Unit to the sally port.<sup>214</sup> A mechanical chest compression device, attached to the gurney, performed chest compressions as an EMS responder squeezed an Ambu bag,<sup>215</sup> providing PADRON rescue breaths. A seventh EMS responder, not seen in the Delta Unit footage, is also seen carrying equipment.

At 7:07 a.m., EMS responders lifted PADRON, on the gurney, into the ambulance.

At 7:09 a.m., Deputy (b)(6); (b)(7)(C) entered the side door of the ambulance.<sup>216</sup> Although both (b)(6); (b)(7)(C) accompanied PADRON in the ambulance to the hospital, only Deputy (b)(6); (b)(7)(C) can be seen boarding the ambulance.<sup>217</sup>

<sup>207</sup> See MCSO Incident Report Statements by (b)(6); (b)(7)(C) dated November 1, 2018.

<sup>208</sup> See MCDC Death After Action statements by (b)(6); (b)(7)(C)

<sup>209</sup> See (b)(6); (b)(7)(C) encounter note, dated November 1, 2018. The last entry in PADRON's medical record was RN (b)(6); (b)(7)(C) note documenting the emergency response.

<sup>210</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 28, 2018.

<sup>211</sup> See Email from MCDC HSA (b)(6); (b)(7)(C) dated December 19, 2018. MCDC Main Control log's times are not consistent with video footage. During his interview with ERAU on November 28, 2018, Sgt. Paskiewicz stated he documented the times of events occurring during the emergency response on a piece of paper as staff on the scene reported it to him. He then later entered the times into the MCDC Jail Log Report system.

<sup>212</sup> See MCDC surveillance footage, timed 7:03:47 a.m. to 07:03:59 a.m., dated November 1, 2018.

<sup>213</sup> *Ibid*; see also (b)(6); (b)(7)(C) encounter note, dated November 1, 2018.

<sup>214</sup> See MCDC surveillance footage videos, timed 7:03:34 a.m. through 7:06:49 a.m., dated November 1, 2018.

<sup>215</sup> 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.

<sup>216</sup> MCDC sally port surveillance footage, timed 7:07:27 a.m. to 07:10:38 a.m., dated November 1, 2018.

<sup>217</sup> See MCSO Incident Report by (b)(6); (b)(7)(C) dated November 1, 2018. As neither Deputy (b)(6); (b)(7)(C) wrote incident reports, it is unclear if Deputy (b)(6); (b)(7)(C) was in the ambulance or in a chase vehicle. During (b)(6); (b)(7)(C) interview with ERAU, he noted only personnel directly involved in an emergency response are required to write incident statements.

At 7:10 a.m., the ambulance departed MCDC for LKMC.

At 7:15 a.m., PADRON arrived to the LKMC ED in asystole<sup>218</sup> with a mechanical chest compression device performing chest compressions and an airway in place.<sup>219</sup> EMS gave unspecified medications and glucose to PADRON, which yielded no response. EMS personnel told the hospital that PADRON was cool and cyanotic<sup>220</sup> from his chest to his head. The hospital did not administer any medications.

At 7:17 a.m., LKMC ceased CPR and Attending Physician (b)(6); (b)(7)(C) pronounced PADRON's death.<sup>221</sup> She documented the differential diagnosis<sup>222</sup> as cardiac and respiratory arrest.

At 7:20 a.m., (b)(6); (b)(7)(C) notified main control and main control notified (b)(6); (b)(7)(C) that LKMC declared PADRON's death.<sup>223</sup> Deputy M (b)(6); (b)(7)(C) stayed with PADRON's body<sup>224</sup> while (b)(6); (b)(7)(C) returned to the facility.<sup>225</sup> (b)(6); (b)(7)(C) then notified (b)(6); (b)(7)(C) of PADRON's death while (b)(6); (b)(7)(C). Although Deputy (b)(6); (b)(7)(C) and Major (b)(6); (b)(7)(C) are not available for interview during ERAU's site visit, Captain (b)(6); (b)(7)(C) directed all actions following PADRON's death.<sup>227</sup>

No MCDC medical staff wrote incident statements related to the emergency response, and Dr. (b)(6); (b)(7)(C) stated no one asked him to write a clinical summary.<sup>228</sup> Furthermore, (b)(6); (b)(7)(C) advised ERAU he did not review PADRON's medical records after his death.<sup>229</sup>

## Post-Death Events

On November 1, 2018, at an unspecified time, (b)(6); (b)(7)(C) took pictures of PADRON's cell and he and (b)(6); (b)(7)(C) secured it with yellow crime scene tape.<sup>230</sup> A Monroe County Major Crimes detective arrived at MCDC and inspected the scene. According to Resident Agent in Charge (RAC) (b)(6); (b)(7)(C) from the Florida Department of Law Enforcement (FDLE), pursuant to a 2014 Memorandum of Understanding between the FDLE and Sheriff's Office, FLDE investigates

<sup>218</sup> Asystole is a form of cardiac arrest in which the heart has stopped beating and there is no electrical activity in the heart.

<sup>219</sup> See LKMC ED Nurse's Notes, dated November 1, 2018.

<sup>220</sup> Cyanosis refers to bluish discoloration to the skin.

<sup>221</sup> See LKMC ED Nurse's Notes, dated November 1, 2018.

<sup>222</sup> Differential diagnoses refers to two or more conditions that share similar signs or symptoms.

<sup>223</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 27, 2018.

<sup>224</sup> As MCDC did not direct (b)(6); (b)(7)(C) to keep a log of events at the hospital, it is unclear when (b)(6); (b)(7)(C) left the hospital and when the Medical Examiner arrived at the hospital.

<sup>225</sup> Ibid; see also MCSO Incident Report by (b)(6); (b)(7)(C) dated November 1, 2018.

<sup>226</sup> See MCSO Jail Log Report by Date/Time with Linked Inmates entry by (b)(6); (b)(7)(C) dated November 1, 2018.

<sup>227</sup> ERAU interview with Captain (b)(6); (b)(7)(C) dated November 27, 2018.

<sup>228</sup> ERAU interview with HSA (b)(6); (b)(7)(C) dated November 27, 2018; ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018. As (b)(6); (b)(7)(C) is the MCDC Medical Director, it is unclear who he expected to direct him to write a clinical summary or review PADRON's files post-mortem.

<sup>229</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 29, 2018.

<sup>230</sup> ERAU interview with (b)(6); (b)(7)(C) dated November 27, 2018; ERAU interview with (b)(6); (b)(7)(C) dated November 28, 2018.



all in-custody deaths.<sup>231</sup> As evident in pictures taken of PADRON's cell, there were several different types of medications found in his cell. Major Crimes requested (b)(6); (b)(7)(C) identify these medications after they broke the tape on the cell and, per her recollection,<sup>232</sup> the medications were: antacids, ibuprofen, Mobic for arthritis pain, and a medication for urinary incontinence, none of which MCDC medical staff prescribed PADRON. His own prescription medications were not found among the pills.

At approximately 8:10 a.m., MCDC notified ERO Miami that an LKMC physician pronounced PADRON's death.<sup>233</sup> Three minutes later, ERO Miami notified ICE headquarters.

At approximately 8:28 a.m., ERO Miami telephonically notified the ICE OPR duty agent of PADRON's passing.<sup>234</sup>

At approximately 8:37 a.m., ERO Miami emailed the Joint Intake Center (JIC) regarding PADRON's death.<sup>235</sup>

At 5:01 p.m., ERO HQ emailed the Cuban embassy regarding PADRON's death.<sup>236</sup>

At an unknown time, the ERO Miami Acting FOD Jim Martin dated a letter to PADRON's wife, expressing his condolences.

**On November 5, 2018**, at 9:00 a.m., Captain (b)(6); (b)(7)(C) held an after-action meeting with staff directly involved in the emergency response and summarized the meeting in a memorandum to M (b)(6); on the same date. He included the names of additional security responders who did not write incident reports, including Deputies (b)(6); (b)(7)(C) as well as Probationary Officers (b)(6); (b)(7)(C).

**On November 27, 2018**, Wellpath legal counsel (b)(6); (b)(7)(C) indicated the corporate mortality review was still in progress. Pending completion of the mortality review, nurses were re-trained in the Hypertension Pathway.

**On February 6, 2019**, Major Age provided ERO an undated document from RA (b)(6); (b)(7)(C) stating that based on the Medical Examiner's conclusion and other information gathered, he was closing the PADRON case.<sup>237</sup>

<sup>231</sup> ERAU interview with FDLE RA (b)(6); (b)(7)(C), dated November 27, 2018.

<sup>232</sup> ERAU interview with (b)(6); (b)(7)(C), dated November 28, 2018.

<sup>233</sup> See PADRON ICE SIR, dated November 2, 2018.

<sup>234</sup> *Ibid.*

<sup>235</sup> *Ibid.*

<sup>236</sup> See email titled Formal Notification: Passing of Cuban Citizen Wilfredo Padron, dated November 1, 2018.

<sup>237</sup> See Miami Regional Operations Center In-Custody Death Summary by RAC (b)(6); (b)(7)(C) undated; see also email titled "FW: PADRON" from MCDC Major (b)(6); (b)(7)(C) to ICE SDDO (b)(6); (b)(7)(C) dated February 6, 2019.

On March 8, 2019, MCDC sent PADRON's property to his next-of-kin.<sup>238</sup> The Monroe County Medical Examiner documented PADRON's cause of death as thrombosis of the right coronary artery due to atherosclerotic cardiovascular disease.<sup>239</sup>

## **FINDINGS**

ERAU reviewed the medical care KNSPC and MCDC provided PADRON, as well as each facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found no deficiencies in KNSPC's compliance with the ICE PBNDS 2011 but found seven deficiencies in MCDC's compliance with the ICE PBNDS 2008. Additionally, ERAU has included other areas of concern that are not covered by the PBNDS 2008. 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 (V)(I)(1):** "The clinical medical authority shall be responsible for review of all health screening forms within 24 hours or next business day to assess the priority for treatment (for example, Urgent, Today, or Routine)."
  - On August 18, 2018, the facility's ARNP, Moore, in lieu of the Clinical Medical Director, reviewed and signed PADRON's intake screening. The MCDC Clinical Medical Director, (b)(6); (b)(7)(C), did not provide a delegation of authority document inclusive of this responsibility.
2. **Medical Care, Section (II)(37):** "Non-English-speaking detainees and/or detainees who are deaf and/or hard at hearing will be provided interpretation/translation services or other assistance as needed for medical care activities."
  - Throughout his detention, both medical and security staff determined interpretation was needed to communicate effectively with PADRON, including during his intake at MCDC. Although PADRON submitted six out of nine Healthcare Requests in English, it is unclear if PADRON requested assistance from Spanish-speaking staff or detainees for translation.<sup>240</sup> Nonetheless, the facility failed to meet its language access obligations. For example, in a Healthcare Request dated October 18, 2018, PADRON requested medical staff check his blood pressure. As PADRON wrote the request in Spanish, the triage nurse, who does not speak Spanish, used Google Translate and incorrectly identified the complaint as a mental health matter and referred PADRON to mental health rather than to a clinician.
3. **Medical Care, Section (V)(U)(1):** "The administrative health authority shall maintain a complete health record on each detainee that is: organized uniformly in accordance with recognized medical records standards; available to all practitioners and used by them for health

<sup>238</sup> See FedEx tracking number 823719021650, shipped on March 8, 2019.

<sup>239</sup> See Exhibit 3: Autopsy Report of Wilfredo Padron, 18-00182.

<sup>240</sup> As ERO notified OPR that detainee (b)(6); (b)(7)(C) would be repatriated to the Dominican Republic before the on-site review dates, ERAU conducted a telephonic interview with the detainee on November 16, 2018. Detainee (b)(6); (b)(7)(C) who was housed in cell two, beside PADRON's, stated he frequently interpreted in English for PADRON. He concluded PADRON did not speak English but most likely understood a little. Additionally, a nurse's note by the LKMC Emergency Department (ED) on October 26, 2018, documented PADRON spoke "a little English."



care documentation; properly maintained and safeguarded in a securely locked area within the medical unit.”

- Three Healthcare Requests triaged on August 19, 2018, September 25, 2018, and October 19, 2018, were not included in PADRON’s medical record. ERAU only learned of these Healthcare Requests upon inspection of PADRON’s property, where he kept copies of these documents.
- On October 10, 2018, LPN (b)(6); (b)(7)(C) encounter note indicated ARNP (b)(6); (b)(7)(C) and a dental professional assessed PADRON; however, neither provider documented their encounter with PADRON nor co-signed the note to authenticate the information.
- On October 31, 2018, the day before PADRON’s death, medical staff assessed PADRON for complaints of chest pain. Medical staff did not document the approximately 18-minute long encounter or record vital sign results in PADRON’s medical record. As discussed earlier in this report, (b)(6); (b)(7)(C) stated that ARNP (b)(6); (b)(7)(C) took over the encounter, which is not substantiated by video evidence. In fact, a review of video footage indicated ARNP (b)(6); (b)(7)(C) was briefly present in the area but then left without interacting with PADRON. Furthermore, (b)(6); (b)(7)(C) did interact with (b)(6); (b)(7)(C) but denied substantial involvement in the encounter; video footage showed her speaking with (b)(6); (b)(7)(C) and PADRON for at least three minutes. The only written documentation of this encounter MCDC provided, which ERAU discovered the existence of through interviews, was a handwritten note by RN (b)(6); (b)(7)(C) on the Sick Bay Shift Report indicating PADRON’s blood pressure was elevated at 153/89 and his pulse and pulse oxygen readings were normal.

4. **Medical Care, Expected Outcomes (II)(2):** “Health care needs will be met in a timely and efficient manner.”

- On August 29, 2018, PADRON informed medical staff that during his August 23, 2018, medical encounter with (b)(6); (b)(7)(C) he allegedly requested aspirin for use as a blood thinner due to his stroke history. Again, on September 10, 2018, PADRON requested aspirin from medical staff. On September 13, 2018, approximately 21 days after his alleged first request, PADRON received his first dose of aspirin.
- On August 29, 2018, PADRON reported taking fiber for constipation. Although (b)(6); (b)(7)(C) documented in her encounter note that medical staff would prescribe him fiber, and the provider signed off on the encounter note, (b)(6); (b)(7)(C) did not separately refer the request for provider review. The provider did, however, sign off on the encounter note. MCDC did not prescribe PADRON fiber until 58 days later, on October 26, 2018, once he returned from a hospital visit, as he was diagnosed with constipation.

5. **Medical Care, Expected Outcomes (II)(5):** “Detainees will receive timely follow-up to their health care requests.”

- On September 5, 2018, MCDC medical staff triaged a Healthcare Request PADRON dated September 4, 2018, in which he complained of a cold, runny nose, and wheezing. Medical staff assessed PADRON on September 10, 2018, for concerns unrelated to the aforementioned Healthcare Request. On September 25, 2018, 21 days after submitting his original Healthcare Request, PADRON presented himself to medical for a sick call walk-in

appointment complaining of feeling extremely sick. During this encounter, medical staff determined PADRON had a cold.

- On September 15, 2018, MCDC medical staff triaged a Healthcare Request PADRON dated September 13, 2018, in which he complained of facial swelling, gum issues, and not being able to use his dentures. Approximately one month later, during a sick call encounter on October 10, 2018, PADRON complained of a sore spot in his mouth. Medical staff noted that dental had assessed PADRON for an aphthous ulcer; however, there was no dental encounter scheduled or documented in PADRON's medical record to support this assessment occurred.
- On October 24, 2018, MCDC MHC (b)(6); (b)(7)(C) saw PADRON pursuant to his placement on the mental health list by LPN (b)(6); (b)(7)(C) who incorrectly identified PADRON's October 18, 2018, Healthcare Request as a mental health matter due to her mistranslation. Once PADRON denied submitting a mental health sick call request, MHC (b)(6); (b)(7)(C) noted the Healthcare Request was in error but did not notify LPN (b)(6); (b)(7)(C) to follow-up. Medical staff did not make a new referral for PADRON's actual October 18, 2018, Healthcare Request.

6. **Medical Care, Expected Outcomes (II)(29):** "Health care services will be provided by a sufficient number of appropriately trained and qualified personnel, whose duties are governed by thorough and detailed job descriptions and who are verifiable licensed, certified, credentialed, and/or registered in compliance with applicable state and federal requirements."

- On August 20, 2018, LPN (b)(6); (b)(7)(C) independently diagnosed and administered medication to PADRON using the Pathway for Cold/Allergy Symptoms.<sup>241</sup> Per the Florida Nurse Practice Act Statutes, RNs are authorized to provide "assessment, nursing diagnosis, planning, intervention, and evaluation of care" consistent with their "substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences." The Act states LPNs may perform selected acts, including administration of treatments and medications, under the direction of an RN or provider. Because (b)(6); (b)(7)(C) was not acting under the direction of an RN or provider, Creative Corrections advised ERAU that LPN (b)(6); (b)(7)(C) acted outside the scope of her practice.

7. **Medical Care, Expected Practices (V)(F):** "Accountability for administering or distributing medications in a timely manner and according to licensed provider orders."

- On August 20, 2018, (b)(6); (b)(7)(C) administered over-the-counter medication cetirizine without a provider order. The Pathway for Cold/Allergy Symptoms, which she used, did not authorize this medication. If authorized by another Pathway, MCDC did not provide it to ERAU.
- On September 10, 2018, (b)(6); (b)(7)(C) prescribed prescription fluconazole without a provider order. Additionally, MCDC did not provide a Pathway that would have authorized RN (b)(6); (b)(7)(C) to prescribe fluconazole for PADRON's symptoms absent a provider order.

<sup>241</sup> The physician-approved CCS Pathways direct and duly authorize nursing assessments, diagnoses, and issuance of specified medications based on assessment findings.



- On September 25, 2018, (b)(6); (b)(7)(C) administered over-the-counter medication cetirizine based upon her assessment that PADRON had a cold. The Pathway for Cold/Allergy Symptoms did not authorize this medication. If authorized by another Pathway, MCDC did not provide it to ERAU.

Although not deficiencies in the facility's compliance with the ICE PBNDS 2008, ERAU notes MCDC did not comply with the following directives:

1. MCDC Bureau Directive 8:020, *Observation of General Population and Special Inmates*: "The deputy will continuously move about the housing dorm/unit so that a personal visual observation of each inmate is made at least once every 30 minutes on an irregular schedule to ensure their state of well-being (i.e., they are alive, free from injury or assault, and that their needs are being tended to)."
  - On November 1, 2018, the day of PADRON's death, surveillance footage supported that between 3:00 a.m. and 6:00 a.m., Deputy Pierrilus conducted only two of his six logged rounds.<sup>242</sup>
2. MCDC Bureau Directive 8:021, *Population Count Principles and Procedures, General Principles of Counting*: "Unit A1, B, B1, C, D, KV/PK cells: For the face to photo [sic] count, the inmates will stand in their cells with their ID's in hand. The deputy will open door [sic] and the inmate will present the ID to the deputy for face to photo [sic] verification along with the site placement checking for accuracy. Once the inmates have been verified and counted, the cell is re-secured."
  - On October 31, 2018, video surveillance footage confirmed that during the 11:00 p.m. face-to-photo count, Deputy Pierrilus did not open PADRON's cell door.
3. MCDC Bureau Directive 8:021, *Population Count Principles and Procedures, General Principles of Counting*: "Deputies must be positive they see a living human body before counting an inmate as present...When making night counts, flashlights shall be used judiciously, but enough light should be thrown on the inmate to ensure that a dummy is not being counted. Rather than count an inmate present on the basis of the sight of hair, shoes, or parts of clothing the deputy must be certain he or she is seeing human flesh and/or movement."
  - On November 1, 2018 (b)(6); (b)(7)(C) logged a physical headcount at 4:18 a.m.; however, video surveillance footage supports he did not approach PADRON's cell during the count.

Although not violations of the ICE PBNDS 2008, ERAU noted the following areas of concern regarding PADRON's medical care, safety, and security at MCDC:

1. Neither the Clinical Medical Director, (b)(6); (b)(7)(C) nor HSA (b)(6); (b)(7)(C) directed medical staff involved in the November 1, 2018, emergency response to write incident statements. Incident

<sup>242</sup> ERAU notes that, although requested on multiple occasions, MCDC did not provide the Delta Unit video footage covering the entirety of November 1, 2018. As such, ERAU was only able to review and confirm rounds logged by Deputy Pierrilus during the time period of 3:00 a.m. to 6:00 a.m. on November 1, 2018.

statements are crucial to promptly documenting what transpired during an incident while fresh on staff's minds.

2. Although (b)(6); (b)(7)(C) made no mention in his August 23, 2018 initial chronic care evaluation encounter note of PADRON's acid reflux, he entered a chronic care follow-up appointment order on August 23, 2018 noting he started PADRON on Zantac for reflux. There was no prescription order submitted for Zantac on or around this date; therefore, medical staff were unable to administer the medication. PADRON would not receive his first dosage of Zantac from medical staff until 50 days later, after an October 10, 2018 sick call visit during which PADRON complained of constipation and strain during bowel movements, prompting ARNP Moore to prescribe PADRON Zantac for reflux.
3. PADRON told medical staff on August 29, 2018, and September 10, 2018, that he requested aspirin from (b)(6); (b)(7)(C) on August 23, 2018, due to his stroke history. As (b)(6); (b)(7)(C) did not document PADRON's stroke history or his request for aspirin during the August 23, 2018, encounter, ERAU is unable to determine if PADRON did, in fact, notify (b)(6); (b)(7)(C) about his stroke history or request aspirin. PADRON separately notified (b)(6); (b)(7)(C) on August 20, 2018, and (b)(6); (b)(7)(C) during his physical assessment on August 29, 2018, of his stroke history. (b)(6); (b)(7)(C) actually signed off on the physical assessment but did not add the stroke history to PADRON's Problem List or prescribe PADRON aspirin thereafter. In a chart review on September 14, 2018, ARNP (b)(6); (b)(7)(C) noted that (b)(6); (b)(7)(C) had started PADRON on aspirin, but again, neither provider added PADRON's stroke history to his Problem List. Creative Corrections advised that including this information on a Problem List, which generally includes all known medical conditions, can further ensure the information is readily available to other healthcare staff during subsequent encounters.
4. On September 6, 2018, (b)(6); (b)(7)(C) changed the administration time for PADRON's hypertension medication, amlodipine, based solely on a review of his chart. As ARNP (b)(6); (b)(7)(C) did not speak to PADRON in person, subjective and objective information related to the adjustment was not documented, nor did she educate PADRON on the updated administration time. A face-to-face encounter, including patient education, could have enabled medical personnel to address PADRON's concern that amlodipine was not the medication he arrived to MCDC with, even though KNSPC and MCDC had prescribed him both hypertension medications.
5. Apart from PADRON's intake screening and initial physical examination, nursing encounter documentation lacked adequate information, including general SOAPE documentation.<sup>243</sup> According to Creative Corrections, this is not only standard nursing practice but also helps organizations ensure data is consistent, complete, and easily understood. All Pathways MCDC provided include subjective and objective fields for staff to enter information. Additionally, nurses did not consistently obtain full sets of vital signs, nor did they assess PADRON's multiple complaints of pain using a standardized pain scale, both as directed by all the Pathways MCDC provided.

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<sup>243</sup> SOAPE refers to documentation that includes Subjective and Objective information, Assessment findings, Plan of care, and patient Education.



6. Security staff brought PADRON to medical on five of the six days preceding his death. Observations and concerns related to the encounters are summarized as follows:

- On October 26, 2018, (b)(6); (b)(7)(C) appropriately<sup>244</sup> notified (b)(6); (b)(7)(C) after taking PADRON's vital signs and finding his blood pressure was elevated at 196/98, which ultimately resulted in his transport to LKMC. However, (b)(6); (b)(7)(C) did not document assessment of PADRON upon his return from the ED four hours later, nor did she notify a provider before directing his return to the housing unit. Creative Corrections advises both actions would have been prudent nursing practice given the reason PADRON was sent to the hospital.
- On October 28, 2018, (b)(6); (b)(7)(C) did not use the Hypertension Pathway,<sup>245</sup> as appropriate, given PADRON's complaint of left arm pain and his history of hypertension.
- On October 29, 2018, after security brought PADRON down to medical for complaints of chest pain, (b)(6); (b)(7)(C) checked PADRON's blood pressure three times during the span of 20 minutes, with the last recorded blood pressure still reading elevated at 157/97.<sup>246</sup> (b)(6); (b)(7)(C) only documented in her encounter note that medical moved PADRON to the sick bay after consultation with (b)(6); (b)(7)(C) without additional context. Approximately 35 minutes after PADRON's last blood pressure reading, (b)(6); (b)(7)(C) documented that security staff sent PADRON to medical for his complaint of chest pain and that she assessed his vital signs. However, there are no additional vital signs documented in PADRON's medical record, and during interview (b)(6); (b)(7)(C) denied (b)(6); (b)(7)(C) made her aware of the earlier readings. (b)(6); (b)(7)(C) further documented that PADRON informed her he was not actually experiencing chest pain, but instead, wanted to have lab tests done to rule out pancreatitis; therefore, medical staff placed PADRON in sick bay for observation and would draw his labs while he fasted. PADRON remained in sick bay for approximately ten more hours, during which time medical staff documented no assessments or vital sign readings. Although completed within (b)(6); (b)(7)(C) given timeframe, the lab studies were not drawn for another 48 hours. Later that evening, an unknown medical staff member instructed security to return PADRON to his housing unit, without reassessing his blood pressure and without provider authority.
- On October 30, 2018, PADRON initially refused his evening hypertension medication and told (b)(6); (b)(7)(C) he had a headache, chest pain, and felt like he was having a stroke like he had had in the past. Once in the sick bay, (b)(6); (b)(7)(C) discussed PADRON's medication refusal and associated concerns with him and eventually successfully encouraged him to take his medications. Despite the serious concern PADRON voiced,

<sup>244</sup> During his interview with ERAU on November 29, 2018, (b)(6); (b)(7)(C) stated that MCDC follows the AHA blood pressure category guidelines and that nurses should have reported PADRON's higher blood pressure readings to a facility Health Care Provider (HCP).

<sup>245</sup> See Exhibit 2: CCS Nursing Documentation Pathway for Hypertension.

<sup>246</sup> The CCS Hypertension Pathway states an individual with a blood pressure that is normal to high with a history of hypertension, who is also on medication, should be scheduled for HCP follow-up within seven days. The Pathway does not clarify what normal or high blood pressure is but states that if an individual's diastolic blood pressure is over 100 with cardiac history or symptoms, medical staff should consider following emergent protocols, which require an immediate evaluation by an HCP. If an HCP is not available, EMS should be called and a provider should be notified. The Pathway has a disclaimer reading, "This pathway is not meant to be applicable to every patient nor to take the place of sound medical judgement; when in doubt, please contact a medical provider."

(b)(6); (b)(7)(C) did not notify a provider or consult an RN when she took PADRON's blood pressure, which was elevated at 160/98. The next morning, (b)(6); (b)(7)(C) entered an encounter note documenting that she changed (b)(6); (b)(7)(C) referral for a doctor sick call the previous evening to a provider visit. However, the only provider order scheduled on this date documented that a provider was to see PADRON on November 2, 2018, to review PADRON's labs with him and discuss his concern about pancreatitis.

7. Although security staff logged PADRON's escort to medical for reported chest pain on three other occasions, they did not log escorting him to medical for this issue on October 31, 2018, the day before his death.
8. MCDC security staff did not use a handheld camera during its emergency response; consequently, ERAU was unable to determine what transpired in PADRON's cell during the emergency response apart, from security staff incident statements. Although the PBNDS 2008 Emergency Plans standard states, "At least one video camera shall be maintained in the Control Center for use in emergency situations..." it is ERAU's interpretation that the intent of this standard is to address the type of emergency responses that require a contingency plan. Contingency-specific plans discussed in the Emergency Plans (V)(E) standard are all of a security and safety nature and not related to medical care emergencies. However, the use of handheld camera footage during medical emergency responses is pertinent material for investigations, administrative file reviews, and after-action reviews, to specifically determine a timeline of events, staff responsibilities and collaboration, and the efficacy of Cardiopulmonary Resuscitation (CPR), especially when those events are not captured on facility surveillance footage.
9. Deputies (b)(6); (b)(7)(C), who were all involved in the emergency response, did not write incident statements.



## **APPENDIX A**

| <b>TABLE 1: PADRON'S CRIMINAL OFFENSE CONVICTIONS WHILE PRESENT IN THE UNITED STATES</b>                                             |                        |                                                     |                                              |
|--------------------------------------------------------------------------------------------------------------------------------------|------------------------|-----------------------------------------------------|----------------------------------------------|
| <b>Charges<sup>247</sup></b>                                                                                                         | <b>Conviction Date</b> | <b>Court Jurisdiction</b>                           | <b>Sentence</b>                              |
| Grand theft of vehicle <sup>248</sup>                                                                                                | January 20, 1987       | 11 <sup>th</sup> Judicial Circuit Court of Florida  | 2 years' probation                           |
| Aggravated assault with a weapon, carrying a concealed weapon, cocaine possession, and attempting to destroy evidence <sup>249</sup> | April 20, 1992         | 11 <sup>th</sup> Judicial Circuit Court of Florida  | 11 months and 29 days' confinement           |
| Unlawful application for driver's license and false affidavit/perjury official proceedings <sup>250</sup>                            | January 7, 1999        | 11 <sup>th</sup> Judicial Circuit Court of Florida  | 2 years' probation                           |
| Unlawful driving as a habitual traffic offender and resisting an officer without violence <sup>251</sup>                             | January 7, 1999        | 11 <sup>th</sup> Judicial Circuit Court of Florida  | 2 years' probation                           |
| Possession of a controlled substance <sup>252</sup>                                                                                  | October 7, 2010        | 216 <sup>th</sup> District Court in Kerr County, TX | 2 years' confinement with 3 years' probation |

## **EXHIBITS**

1. Creative Corrections Healthcare and Security Compliance Analysis
2. CCS Nursing Documentation Pathway for Hypertension
3. Autopsy Report of Wilfredo Padron, 18-0182, undated

<sup>247</sup> This list only includes charges which resulted in a disposition of convicted.

<sup>248</sup> See Order Granting Probation, Eleventh Judicial Circuit of Florida – Dade County, dated January 20, 1987.

<sup>249</sup> See DHS Customs and Border Protection (CBP) NNSV Query Result, dated August 15, 2018.

<sup>250</sup> See Special Conditions of Probation, Eleventh Judicial Circuit of Florida – Dade County, dated January 7, 1999.

<sup>251</sup> *Ibid.*

<sup>252</sup> See PADRON's Criminal History Record, dated August 15, 2018.



U.S. Immigration  
and Customs  
Enforcement

JAN 31 2020

MEMORANDUM FOR: Timothy S. Robbins  
Acting 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 Division

SUBJECT: Detainee Death Review Findings – Wilfredo PADRON  
JICMS #201901028

The U.S. Immigration and Customs Enforcement (ICE) Office of Professional Responsibility (OPR) External Reviews and Analysis Unit (ERAU) completed its review of the death of Wilfredo PADRON, a 58-year-old citizen of Cuba, who died on November 1, 2018, while in ICE custody at the Lower Keys Medical Center (LKMC) in Key West, Florida (FL). The Monroe County Medical Examiner documented PADRON's cause of death as thrombosis of the right coronary artery due to atherosclerotic cardiovascular disease.<sup>1</sup>

### Abbreviated Chronology<sup>2</sup>

On August 15, 2018, PADRON reported to the ICE Office of Enforcement and Removal Operations (ERO) Miami Miramar sub-office as required. ERO Miami revoked PADRON's Order of Supervision (OSUP) and detained him at the Krome North Service Processing Center (KNSPC) in Miami, FL in anticipation of PADRON's removal. On August 18, 2018, ERO Miami transferred PADRON to the Monroe County Detention Center (MCDC) in Key West, FL.

On August 29, 2018, PADRON notified MCDC medical staff that he had a medical history of six strokes and required aspirin, as he alleged to have requested from the MCDC Medical Doctor (MD) six days prior during PADRON's initial chronic care evaluation. After asking medical staff on one additional occasion, on September 10, 2018, the MCDC MD prescribed PADRON aspirin, a blood thinning agent commonly used as a preventative measure for those at risk of having a

<sup>1</sup> Thrombosis refers to the formation of a blood clot within a blood vessel. Atherosclerosis refers to the buildup of fats, cholesterol and other plaque-causing substances on the walls of the arteries, which may cause a narrowing of the passage for blood flow. Plaque can break off, triggering a blood clot (thrombosis).

<sup>2</sup> See accompanying Detainee Death Review for complete chronology.



stroke or heart attack. MCDC medical staff administered PADRON his first dose of aspirin 21 days after his alleged first request.

On October 26, 2018, at approximately 1:35 a.m., Emergency Medical Services (EMS) transported PADRON to LKMC as he was in hypertensive crisis and complaining of sharp chest pain radiating to his left arm and back. LKMC released PADRON approximately three hours later, diagnosing him with constipation, unspecified.

On October 30, 2018, at 11:10 p.m., PADRON refused to take his evening hypertension medication during pill pass because he thought it was making his blood pressure worse. He also told nursing staff he had a headache, chest pain, and felt like he was having a stroke like he had in the past. After speaking with the nurse, PADRON stated he only wanted to be seen by the doctor. The nurse assessed PADRON, and because she believed PADRON was stable at that time and she had convinced him to take his evening medications, security staff escorted him back to his housing unit.

On October 31, 2018, at 10:42 p.m., PADRON spoke with a family member over the phone. At 11:05 p.m., although a deputy documented conducting a face-to-photo count at PADRON's cell, the deputy did not open the cell door, as required by facility policy. The deputy further documented that between 12:00 a.m. and the end of his shift at 6:00 a.m., he conducted an additional 13 security rounds and 5 head counts. Although ERAU requested video footage for the 6-hour time period, the facility only provided footage for 3:00 a.m. to 6:00 a.m. Video surveillance showed the deputy only conducted two of the six rounds he logged between 3:00 a.m. and 6:00 a.m.<sup>3</sup>

On November 1, 2018, at 6:42 a.m., during breakfast, a detainee found PADRON unresponsive in his cell. The deputy on duty immediately responded and called for an emergency response. At 6:43 a.m., security staff began CPR. Shortly afterward, MCDC medical staff arrived. At 6:54 a.m., Monroe County EMS arrived and took over CPR. At 7:10 a.m., EMS departed MCDC with PADRON and arrived at LKMC five minutes later. At 7:17 a.m., a physician declared PADRON dead.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care KNSPC and MCDC provided PADRON, as well as each facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found no deficiencies in KNSPC's compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011. However, ERAU found seven deficiencies in MCDC's compliance with the ICE PBNDS 2008. In the attached report, ERAU has included other Areas of Concern that are not covered by the PBNDS 2008. These deficiencies and Areas of Concern are noted for informational purposes only and should not be construed as contributory to the detainee's death.

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<sup>3</sup> ERAU notified the ICE Joint Intake Center (JIC) of this matter on December 20, 2018, when it became aware of the issue (JICMS case number: 201902698). On September 19, 2019, OPR, who referred the case to the ERO Administrative Inquiry Unit (AIU), closed the investigation with a final determination of substantiated.



1. **Medical Care, Section (V)(I)(1):** In lieu of the MCDC Clinical Medical Director (CMD), the facility's Advanced Registered Nurse Practitioner (ARNP) reviewed and signed PADRON's intake screening. The MCDC CMD did not provide a delegation of authority document inclusive of this responsibility.
2. **Medical Care, Section (II)(37):** MCDC medical and security staff inconsistently provided interpretation services, although they were needed to communicate effectively with PADRON. For instance, in one Healthcare Request, PADRON requested in Spanish that medical staff check his blood pressure. The triage nurse, who does not speak Spanish, used Google Translate to review the request and incorrectly identified the complaint as a mental health matter. The mistranslation resulted in PADRON's referral to mental health rather than to a clinician. Once PADRON denied submitting a mental health sick call request, medical staff did not make a new referral for his actual request.
3. **Medical Care, Section (V)(U)(1):**
  - Three Healthcare Requests that ERAU located in PADRON's property were not included in PADRON's MCDC medical record.
  - A Licensed Practical Nurse's (LPN) encounter note indicated an ARNP and a dental professional assessed PADRON; however, neither provider documented their encounter with PADRON or co-signed the LPN's note to authenticate the information.
  - Although medical staff assessed PADRON for complaints of chest pain the day before his death, they never entered the approximately 18-minute encounter with PADRON or his vital signs into PADRON's medical record. ERAU only learned of the encounter through interviews with security staff.
4. **Medical Care, Expected Outcomes (II)(2):**
  - Approximately 21 days after his alleged first request, PADRON received his first dose of aspirin for use as a blood thinner due to his stroke history.
  - Although a Registered Nurse (RN) noted PADRON would be prescribed fiber for constipation on August 29, 2018, MCDC did not prescribe him fiber until 58 days later, upon his return from a hospital visit, during which he was diagnosed with constipation.
5. **Medical Care, Expected Outcomes (II)(5):**
  - Twenty-one days after submitting his original Healthcare Request complaining of cold systems, PADRON presented himself to medical for a sick call walk-in appointment as he felt extremely sick. During this encounter, medical staff determined PADRON had a cold.
  - On September 13, 2018, PADRON submitted a Healthcare Request in which he complained of dental issues. Approximately one month later, during a sick call encounter, PADRON complained of a sore spot in his mouth. Medical staff noted that dental had assessed PADRON for an aphthous ulcer; however, there was no dental encounter scheduled nor was there any additional documentation to support this dental assessment occurred within PADRON's medical record.
  - An MCDC Mental Health Counselor (MHC) saw PADRON pursuant to his placement on the mental health list by an LPN who incorrectly identified PADRON's Healthcare Request as a mental health matter due to her mistranslation. Although PADRON



denied submitting a mental health sick call request, which the MHC noted within the encounter, the MHC did not notify the referring LPN to follow up. Medical staff did not make a new referral for PADRON's actual Healthcare Request, in which PADRON expressed concern about his blood pressure.

6. **Medical Care, Expected Outcomes (II)(29):** Although an LPN independently diagnosed PADRON and administered him medication using a physician-approved nursing protocol, per the Florida Nurse Practice Act Statutes, LPNs may perform only selected acts, including administration of treatments and medications, under the direction of an RN or provider. As such, the LPN acted outside the scope of her practice considering the diagnosis and administration of medication was not under the direction of an RN or provider.

7. **Medical Care, Expected Practices (V)(F):**

- An LPN administered over-the-counter medication without a provider order. Furthermore, the protocol she used did not authorize this medication.
- An RN prescribed prescription medication without a provider order.
- An RN administered over-the-counter medication based upon her assessment that PADRON had a cold. The protocol for Cold/Allergy Symptoms, which she did not use, did not authorize this medication.

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

Enclosure  
PADRON Detainee Death Review Report



AUTOPSY REPORT

Case No. ML19-2167

July 1, 2019

ON THE BODY OF

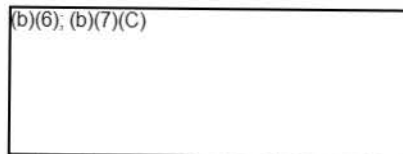
Yimi Balderramos-Torres

CAUSE OF DEATH: Sudden cardiac death associated with biventricular  
cardiac dilatation

MANNER OF DEATH: Natural

DATE OF DEATH: June 30, 2019

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



Assistant Medical Examiner

09/27/19

MMDDYY



POSTMORTEM EXAMINATION ON THE BODY OF

Yimi Balderramos-Torres

**HISTORY:** The decedent is a 30-year-old Honduran man who was discovered unresponsive in bed at an Immigration and Customs Enforcement (ICE) detention facility on June 30, 2019, at approximately 5:39 a.m. Resuscitation was attempted, which included placement of an automated external defibrillator (AED) and Emergency Medical Services were summoned. Resuscitation was continued, and he was transported to Memorial Hermann Northeast Hospital, arriving at approximately 6:44 a.m. on June 30, 2019. He was declared dead at 6:45 a.m. on June 30, 2019.

**AUTOPSY:** The autopsy is performed at the Harris County Institute of Forensic Sciences by Assistant Medical Examiner (b)(6); (b)(7)(C) M.D., pursuant to Article 49.25, Texas Code of Criminal Procedure, beginning at approximately 9:42 a.m. on July 1, 2019.

Special Agent (b)(6); (b)(7)(C) of the Department of Homeland Security and Special Agent (b)(6); (b)(7)(C) the Federal Bureau of Investigation are in attendance during the autopsy.

**EXTERNAL APPEARANCE:** Green plastic bracelets around the wrist and ankle have the inscription "ML19-2167, Yimi Balderramos-Torres." A detention facility identification band around the left wrist has the inscription "Yimi Balderramos-Torres" and the decedent's picture and date of birth. The body is that of an approximately 66 inch, 134 pound, normally developed, well-nourished adult Hispanic man who appears compatible with the reported age. Rigor mortis is fully developed, is symmetric, and is not easily broken. The posterior livor mortis is pink-red and blanches with pressure. The skin turgor is normal.

The scalp is not injured, and is covered by up to 4.0 centimeter black hair. Facial hair consists of black stubble in the distribution of a mustache and goatee. The irides appear hazel, and the pupils are approximately 5 millimeters in diameter each. The sclerae are anicteric. The conjunctivae have no hemorrhages or petechiae. The external ears are normally formed, and are free of discharge. The nasal septum is intact, and the nares are free of foreign material. The oral mucosa has no lesions, injuries, or petechiae. The oral mucosal frenula are intact. The native dentition is in

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

good condition. The facial skeleton is palpably intact. The neck is symmetric and has no injuries or discernible surgical scars.

The torso is symmetric and has no discernible surgical scars. A 0.3 centimeter round hyperpigmented scar is on the lateral aspect of the right upper chest. A 3.0 centimeter oval scar is on the superior aspect of the left shoulder. A 0.4 centimeter round brown scab is on the posterior left axillary region. The abdomen is soft and mildly distended. A few, 0.2 to 0.3 centimeter round hyperpigmented scars are on the abdomen. The back has no abnormalities. The external adult male genitalia and anus have no lesions or injuries. The testes are intrascrotal.

The upper and lower extremities have symmetric musculature and no palpable fractures. A few, 1.0 to 2.5 centimeter thin linear scars are on the upper extremities. A 2.4 centimeter linear oblique scar is on the anterolateral aspect of the distal left forearm and wrist. The hands are not injured. The fingernails are long and intact. A 2.5 centimeter oval scar is on the lateral aspect of the proximal right thigh. A 13.0 by 8.0 centimeter area of multiple, 0.9 to 1.5 centimeter linear and irregular scars, is on the anterior aspect of the right knee. A 9.0 by 8.5 centimeter area of multiple, 1.0 to 2.0 centimeter linear and irregular scars, is on the anterior aspect of the left knee and extends to the anteromedial aspect of the proximal left leg. The lower extremities have no palpable edema.

**CLOTHING AND PERSONAL EFFECTS:** The decedent is clad in a hospital gown that is discarded. Received in the body transport bag with the decedent are a pair of blue pants, a pair of white underwear, and two white socks. The clothing is returned with the decedent.

**EVIDENCE OF MEDICAL INTERVENTION:** An endotracheal tube extends from the mouth and is positioned in the trachea. Electrocardiogram pads are on the chest and abdomen. Combination pacing/defibrillator/electrocardiogram pads are on the right side of the upper chest and on the left side of the lower chest.

An intravascular catheter is inserted in the anterolateral aspect of the proximal left forearm. A white plastic hospital bracelet around the left wrist has the inscription "Balderramos-Torres, Yimi" and the decedent's date of birth.

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



EVIDENCE OF INJURY:

External: Two, 1.7 by 0.7 centimeter and 0.7 by 0.5 centimeter brown-red slightly dried abrasions are on the lateral aspect of the proximal left thigh. There are no cutaneous injuries of the face, scalp, torso or remaining extremities.

Internal: A 1.0 by 0.6 centimeter area of subscalpular soft tissue hemorrhage is on the anterior aspect the left frontal region. There are no cranial or intracranial injuries. Full body radiographs are performed, and there are no fractures.

INTERNAL EXAMINATION:

**BODY CAVITIES:** The subcutaneous fat of the chest and abdominal wall is free of hemorrhage, and is approximately 1.0 centimeter thick at the umbilicus. The organs are in their normal anatomic positions. The pleural cavities each contain approximately 20 milliliters of red-orange serosanguineous fluid, and have no adhesions. The peritoneal cavity does not contain fluid and has no adhesions. The diaphragm is normal in configuration and is intact. The mediastinum and retroperitoneum have no tumors or hemorrhage.

**HEAD (CENTRAL NERVOUS SYSTEM):** The scalp is intact. The left frontal region has focal subscalpular soft tissue hemorrhage as previously described. The skull is intact and has no fractures. There is no epidural or subdural hemorrhage. The dura mater is smooth and has no masses or membranes. The brain is 1400 grams. The leptomeninges are thin and transparent without subarachnoid hemorrhage or exudates. The vessels and cranial nerves at the base of the brain are normally formed and have no abnormalities. The cerebral hemispheres are symmetric. The gyri and sulci are normally formed. The cortical gray-white matter junction is distinct. The cerebrum has no tumors, infarcts, or hemorrhages. The ventricles are symmetric and are not dilated or obstructed. The deep gray nuclei have no abnormalities. The mammillary bodies and hippocampi are symmetric without abnormalities. The brainstem and cerebellum are normally formed and have no tumors or hemorrhage.

**NECK:** A layered anterior neck dissection demonstrates that the muscles are free of hemorrhage and injuries. The hyoid bone and laryngeal cartilages are intact without fractures. The epiglottis and larynx are lined by smooth, pink-tan mucosa without

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

masses, edema, or petechiae. The tongue has no bite marks, injuries, or intramuscular hemorrhage. The palate has no defects. The atlanto-occipital articulation is stable. The cervical vertebrae have no hemorrhage of the prevertebral muscles and soft tissues, or palpable fractures.

**CARDIOVASCULAR SYSTEM:** The pericardial sac does not contain excess fluid, and the pericardium has no adhesions. The heart is 340 grams and has a smooth epicardial surface with a normal amount of epicardial fat and focal petechiae of the anterior and posterior epicardium. The great vessels and pulmonary veins are in the normal anatomic position. The right dominant coronary artery system courses in the expected fashion without atherosclerosis or other anomalies. The coronary ostia are patent, and normally positioned.

The cardiac chambers do not contain masses or thrombi. The atria do not appear dilated. The right ventricle is dilated with a diameter of 3.8 centimeters, and extends to the apex of the heart. The left ventricle is dilated with a diameter of 4.0 centimeters. The atrial and ventricular septa are intact. The endocardium is smooth without areas of scarring or hemorrhage. The myocardium is brown-red and firm without hemorrhage or scarring. The left ventricle, interventricular septum, and right ventricle are 1.3 centimeters, 1.3 centimeters, and 0.4 centimeter in maximal thickness, respectively. The cardiac valves are thin and delicate with circumferences as follows: Tricuspid valve 11.5 centimeters, pulmonic valve 8.0 centimeters, mitral valve 10.6 centimeters, and aortic valve 6.2 centimeters. The aorta is intact without defects, aneurysms or injuries and is lined by tan-yellow intima with a few fatty streaks.

**RESPIRATORY SYSTEM:** The trachea and mainstem bronchi are patent, and free of masses and obstructive foreign material. They are lined by smooth red-pink mucosa without exudates. The mainstem bronchi contain red-tinged frothy fluid. The trachea and mainstem bronchi have no masses. The right lung is 1210 grams and the left lung is 1110 grams. The visceral pleura are smooth. The parenchyma is red-purple and expresses an abundant amount of blood-tinged, frothy fluid upon compression. The lungs have no masses or areas of consolidation. The pulmonary arteries are free of thromboemboli. The pulmonary vessels have no abnormalities. The right lung is inflated with formalin prior to obtaining histologic sections.

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



**HEPATOBIILIARY SYSTEM:** The 1610 gram liver has a smooth and intact capsule. The parenchyma is brown-red without masses or palpable fibrosis. The gallbladder contains approximately 2 milliliters of yellow-brown viscous bile and has a yellow-tan velvety mucosa.

**ALIMENTARY SYSTEM:** The esophagus is intact and is lined by gray-tan smooth mucosa without masses or varices. The stomach contains 100 milliliters of dark brown fluid and dark brown unrecognizable partially digested food fragments. There are no pills, pill fragments, or granular material within the gastric contents. The stomach has no ulcers or masses. The intestines have a smooth serosal surface. The intestines are opened demonstrating liquid brown stool within the small intestines and firm, and soft formed brown stool within the large intestines. No foreign objects or pills are identified within the intestinal contents. The intestinal mucosa is tan-brown with normal folds and no ulcers or masses. The vermiform appendix is intact and unremarkable. The rectum has a normal mucosa. The pancreas has tan-yellow, rubbery, lobulated parenchyma.

**GENITOURINARY SYSTEM:** The right and left kidneys are 120 grams and 130 grams, respectively. The cortical surfaces are smooth. The parenchyma is brown-red with distinct corticomedullary junctions and no masses. The renal calyces and ureters are not dilated or obstructed. The bladder is distended by 260 milliliters of translucent yellow urine. The bladder mucosa is tan-white and smooth. The testes and prostate gland have no abnormalities.

**RETICULOENDOTHELIAL SYSTEM:** The 100 gram spleen has a gray-purple, smooth and intact capsule. The parenchyma is red-purple and firm without masses or prominent white pulp. The regional lymph nodes do not appear enlarged.

**ENDOCRINE SYSTEM:** The pituitary gland, thyroid gland, and adrenal glands have no abnormalities.

**MUSCULOSKELETAL SYSTEM:** The musculoskeletal system is normally developed. The muscles are red-brown and firm. The sternum, clavicles, ribs, vertebrae, pelvic bones, and bones of the extremities have no palpable fractures. The soft tissues of the posterior neck, torso and extremities are examined; there are no regions of soft tissue hemorrhage.

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

**RADIOGRAPHS:** Full body radiographs are performed, and there are no fractures.

**TOXICOLOGY:** Samples submitted are vitreous fluid, urine, bile, gastric contents, liver, brain, and blood from the femoral vessels and aorta. A postmortem rapid urine drug screen is negative for stimulant drugs, benzodiazepines, opiates, barbiturates and tetrahydrocannabinol (THC).

**OTHER TESTING:** A sample of aorta blood and a sample of spleen are submitted for bacterial cultures. A swab from the nasopharynx and oropharynx is submitted for viral cultures.

**HISTOLOGY:** Representative sections of heart, lungs, liver, kidneys, pancreas, adrenal glands, thyroid gland, proximal trachea, mainstem bronchus, diaphragm and brain are retained for microscopic examination.

#### PATHOLOGICAL FINDINGS

- I. Sudden cardiac death
  - a. Biventricular dilatation of heart
  - b. Concentric left ventricular hypertrophy
  - c. Heart weight (340 grams) within normal range for height (315 grams +/- 40 grams)
  - d. Pulmonary congestion and edema (combined lung weight: 2320 grams)
  - e. Myocyte hypertrophy and focal fibrosis (microscopic examination of heart)
  - f. Arteriolosclerosis and glomerulosclerosis (microscopic examination)
  - g. Acute hypoxia-ischemia (microscopic examination of brain)
  - h. Circumstances
    - i. Witnessed to have seizure-like activity and "odd snoring sound" while sleeping, and then subsequently found unresponsive (Investigative report)
    - ii. Predominantly asystole with one rhythm reading of fine ventricular fibrillation (EMS records)
  - i. See COMMENT
- II. Toxicology, including vitreous electrolytes, non-contributory (see TOXICOLOGY REPORT)

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



III. Other testing

- a. No bacteria identified in cultures of spleen (postmortem sample, Ben Taub General Hospital Microbiology Department)
- b. Gram positive rods identified on gram stain of blood culture, but no growth in culture, most consistent with postmortem bacterial contamination (postmortem sample, Ben Taub General Hospital Microbiology Department)
- c. No viruses identified (postmortem swabs of nasopharynx and oropharynx, LabCorp)

IV. Additional medical history

- a. Previous self-reported episode of chest pain (Investigative report)
- b. No history of seizures (medical records, Investigative report)
- c. Mosquito bites of torso and extremities without sequelae, and treated with topical cream (medical records)

V. Urinary retention (260 milliliters)

VI. Minor blunt force injuries

- a. Two cutaneous abrasions of proximal left thigh
- b. Focal subscalpular soft tissue hemorrhage without cranial or intracranial injuries
- c. No radiographic findings of trauma

COMMENT: Medical records, surveillance video from the detention center, and scene photos from the detention center were reviewed. In addition, more detailed information regarding Mr. Balderramos-Torres' past medical history and family history were obtained from the decedent's legal next of kin (father) and brother. Upon review of the surveillance videos, it is noted that the decedent is observed in bed without any physical altercations prior to going to sleep or during sleep. He is also observed demonstrating suspected seizure-like activity and faintly observable decreasing respirations. At autopsy, there was no evidence of significant trauma that would result in, or contribute to Mr. Balderramos-Torres' death. Autopsy and microscopic examinations were significant for cardiovascular findings as previously described, and no other etiology of sudden death.

In some cases of sudden cardiac death, an underlying genetic condition is identified that may be linked to an inherited sudden arrhythmic death syndrome. Consultation with

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

(b)(6); (b)(7)(C) was offered to the decedent's father to discuss whether or not Mr. Balderramos-Torres would be a candidate for genetic testing; however, currently, consent has not been given by the legal next of kin to be contacted by (b)(6); (b)(7)(C). Should consent be received in the future, and specimens are still available for testing, the decedent's case may be re-evaluated at that time. Due to the possibility of a hereditary disorder, it was recommended to the family that they obtain a copy of this autopsy report for review with their personal physician(s). This case was reviewed in consultation with Pediatric Cardiologist and Electrophysiologist, (b)(6); (b)(7)(C) and Cardiovascular Pathologist, (b)(6); (b)(7)(C) consultants to the Harris County Institute of Forensic Sciences. In addition, this case was also reviewed at the QA and Peer Review Conference on September 11, 2019.

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



HARRIS COUNTY INSTITUTE OF FORENSIC SCIENCES  
1861 OLD SPANISH TRAIL  
HOUSTON, TEXAS 77054

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

ML19-2167

Assistant Medical Examiner

MICROSCOPIC EXAMINATION

Twenty-seven H&E stained slides are examined:

Heart (E-H, R-AA): Cardiac myocyte hypertrophy; focal interstitial and perivascular fibrosis; focal intramyocardial vessels with arteriosclerosis; no interstitial acute or chronic inflammation; sections of the conduction system, including the sinoatrial node and atrioventricular node, demonstrate myocyte hypertrophy, and no acute or chronic inflammation

Lungs (A-D): Vascular congestion with extravasation of red blood cells; edema

Trachea and mainstem bronchus (P): Mild vascular congestion; no mucosal or submucosal chronic or acute inflammation

Liver (A): Hepatocytes containing glycogen; rare hepatocytes with macrovesicular steatosis

Pancreas (B): Focal autolysis; no acute or chronic inflammation; no fibrosis

Kidneys (A, B): Rare glomeruli with global sclerosis; tubular and vascular congestion; tubular autolysis

Thyroid gland (I, Q): No significant histopathologic diagnosis; section of parathyroid gland with no significant histopathologic diagnosis

Adrenal gland (Q): No significant histopathologic diagnosis

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

Brain, frontal cortex, hippocampi, right basal ganglia, right thalamus, midbrain, pons, and medulla (J-O): Focal vessels with perivascular hemosiderin-laden macrophages, sparse chronic inflammation, and arteriolosclerosis, consistent with hypertensive changes; globus pallidus with focal vessels with mineralization, consistent with hypertensive changes; vascular congestion; focal vessels with congestion and red blood cell extravasation; scattered neurons with pyknotic nuclei and hypereosinophilia, consistent with acute hypoxia-ischemia

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

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

09/27/19  
MMDDYY

Assistant Medical Examiner



# HARRIS COUNTY INSTITUTE OF FORENSIC SCIENCES

1861 Old Spanish Trail

Houston, TX 77054-2001

Phone: 832-927-5005 FAX: 832-927-2876

## TOXICOLOGY REPORT

September 05, 2019

LABORATORY NUMBER: ML19-2167

SERVICE REQUEST: 0001



Deceased: YIMI BALDERRAMOS-TORRES

Submitted By:

Submission Date: July 01, 2019

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

Assistant Medical Examiner

Harris County Institute of Forensic Sciences

1861 Old Spanish Trail

Houston, TX 77054

### RESULTS:

#### 007 - Vitreous Humor

##### Analyte

Sodium  
Potassium  
Chloride  
Glucose  
Urea Nitrogen  
Creatinine

##### Result

145 ± 5 mEq/L  
10.4 ± 0.7 mEq/L  
122 ± 8 mEq/L  
36 ± 5 mg/dL  
11 ± 2 mg/dL  
0.4 ± 0.1 mg/dL

##### Analytical Method

Ion Selective Electrode  
Ion Selective Electrode  
Ion Selective Electrode  
Spectrophotometry  
Spectrophotometry  
Spectrophotometry

##### Analyst

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

#### 001 - Blood (femoral)

##### Analyte

Acetone  
Ethanol  
Isopropanol  
Methanol

##### Result

None Detected  
None Detected  
None Detected  
None Detected

##### Analytical Method

Headspace GC/FID  
Headspace GC/FID  
Headspace GC/FID  
Headspace GC/FID

##### Analyst

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

#### 002 - Blood (aorta)

##### Analyte

Amphetamine / MDA  
Benzodiazepines  
Benzoylcegonine  
Cannabinoids  
Carisoprodol  
Fentanyl  
Methadone  
Methamphetamine / MDMA  
Opiates

##### Result

None Detected  
None Detected  
None Detected  
None Detected  
None Detected  
None Detected  
None Detected  
None Detected  
None Detected

##### Analytical Method

Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA  
Immunoassay - ELISA

##### Analyst

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

Medical Examiner's Initials and Date

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

09/06/19

All testing is accredited by the Texas Forensic Science Commission and by the laboratory's ISO/IEC 17025 and American Board of Forensic Toxicology accreditation issued by the ANSI National Accreditation Board.

Refer to certificate and scope of accreditation FT-0076.

We welcome your feedback at <http://ifs.harriscountytexas.gov/Pages/CrimeLaboratoryService.aspx>

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

AMERICAN  
OVERSIGHT

DHS-20-0638-C-000402

NCJEST-All v01222019

2020-ICLI-00057 980

## SERVICE REQUEST: 0001

**002 - Blood (aorta)**

| <u>Analyte</u>                 | <u>Result</u> | <u>Analytical Method</u> | <u>Analyst</u>    |
|--------------------------------|---------------|--------------------------|-------------------|
| Oxycodone                      | None Detected | Immunoassay - ELISA      | (b)(6); (b)(7)(C) |
| Phencyclidine                  | None Detected | Immunoassay - ELISA      |                   |
| Standard Basic Drug Screen     | None Detected | GC/MS                    |                   |
| 7-aminoflunitrazepam           | None Detected | LC/TOF MS                |                   |
| Brompheniramine                | None Detected | LC/TOF MS                |                   |
| Buprenorphine                  | None Detected | LC/TOF MS                |                   |
| Butylone                       | None Detected | LC/TOF MS                |                   |
| Carbamazepine                  | None Detected | LC/TOF MS                |                   |
| Chlordiazepoxide               | None Detected | LC/TOF MS                |                   |
| Chlorpheniramine               | None Detected | LC/TOF MS                |                   |
| Diphenhydramine                | None Detected | LC/TOF MS                |                   |
| Ethylone                       | None Detected | LC/TOF MS                |                   |
| Ketamine                       | None Detected | LC/TOF MS                |                   |
| Lorazepam                      | None Detected | LC/TOF MS                |                   |
| Mephedrone                     | None Detected | LC/TOF MS                |                   |
| Methedrone                     | None Detected | LC/TOF MS                |                   |
| Methorphan                     | None Detected | LC/TOF MS                |                   |
| Methylenedioxypyrovalerone     | None Detected | LC/TOF MS                |                   |
| Methylone                      | None Detected | LC/TOF MS                |                   |
| Methylphenidate                | None Detected | LC/TOF MS                |                   |
| Methylpyrrolidinopropiophenone | None Detected | LC/TOF MS                |                   |
| Midazolam                      | None Detected | LC/TOF MS                |                   |
| Naphyrone                      | None Detected | LC/TOF MS                |                   |
| Oxcarbazepine                  | None Detected | LC/TOF MS                |                   |
| Oxycodone                      | None Detected | LC/TOF MS                |                   |
| Oxymorphone                    | None Detected | LC/TOF MS                |                   |
| Promethazine                   | None Detected | LC/TOF MS                |                   |
| Quetiapine                     | None Detected | LC/TOF MS                |                   |
| Ritalinic acid                 | None Detected | LC/TOF MS                |                   |
| Topiramate                     | None Detected | LC/TOF MS                |                   |
| Tramadol                       | None Detected | LC/TOF MS                |                   |
| Zaleplon                       | None Detected | LC/TOF MS                |                   |
| Zolpidem                       | None Detected | LC/TOF MS                |                   |
| Zopiclone                      | None Detected | LC/TOF MS                |                   |

**007 - Vitreous Humor**

| <u>Analyte</u> | <u>Result</u> | <u>Analytical Method</u> | <u>Analyst</u>    |
|----------------|---------------|--------------------------|-------------------|
| Ketones        | None Detected | Color Test               | (b)(6); (b)(7)(C) |

Uncertainty of Measurement: The uncertainty value for ethanol represents an expanded uncertainty expressed at the 99.73% level of confidence. The uncertainty values for all other analytes represent an expanded uncertainty expressed at the 95.45% level of confidence.

Medical Examiner's Initials and Date

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

09/06/19

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DHS-20-0638-C-000403 All v01222019



LABORATORY NUMBER: ML19-2167

DATE: September 5, 2019

SERVICE REQUEST: 0001

Only those items listed in the results section were tested.

Evidence Disposition: All items will be retained by the laboratory for at least one year following the issuance of an original Toxicology Report.

INSTITUTE OF FORENSIC SCIENCES

SEP 05 2019

RECEIVED  
RECORDS CUSTODIAN

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

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

Case Reviewer  
Toxicologist II  
September 04, 2019

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

Expert Reviewer  
Deputy Chief Toxicologist  
September 05, 2019

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

Medical Examiner's Initials and Date

09/06/19

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

AMERICAN  
OVERSIGHT

DHS-20-0638-C-000404 All v01222019

2020-ICLI-00057 982

**DETAINEE DEATH REVIEW**  
**Yimi BALDERRAMOS-Torres, A206179679**  
**Healthcare and Security Compliance Analysis**  
**Houston Contract Detention Facility**  
**Houston, Texas**

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 Yimi Alexis BALDERRAMOS-Torres while he was detained at the Houston Contract Detention Facility. A site visit was conducted July 23-24, 2019 by ERAU personnel (b)(6); (b)(7)(C) Management and Program Analyst and team leader; (b)(6); (b)(7)(C) Management and Program Analyst; and (b)(6); (b)(7)(C) Inspections and Compliance Specialist; 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. ERAU requested Creative Corrections' participation 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 summary of events, and conclusions. The information and findings herein are based on analysis of BALDERRAMOS's medical record and detention file, tour of the medical area and housing unit, interviews of staff and detainees, analysis of video footage, review of policies, and incident related documentation.

## **SYNOPSIS**

Yimi Alexia BALDERRAMOS-Torres (BALDERRAMOS), 30 years old, was detained at the Montgomery Processing Center (MPC) in Houston, Texas from June 6, 2019 until June 18, 2019 when he was transferred to the Houston Contract Detention Facility (HCDF). Healthcare staff at MPC treated him for a rash caused by insect bites, a condition that HCDF healthcare staff determined resolved upon his arrival. Medical staff at both facilities identified no other medical or mental health conditions, and none were reported by BALDERRAMOS.

On June 30, 2019 at approximately 4:40 a.m., a detainee in the bed next to BALDERRAMOS noticed the upper portion of his body slumped on the floor and reached to wake him. When BALDERRAMOS did not wake up, the other detainee lifted him back into his bed and returned to his own. Approximately 50 minutes later, detainees alerted the housing unit officer that they could not wake BALDERRAMOS for breakfast. The officer confirmed BALDERRAMOS was unresponsive, and immediately called a medical emergency. Security and medical personnel responded in under two minutes and performed cardio pulmonary resuscitation pending the





arrival of emergency medical services personnel approximately 13 minutes later. BALDERRAMOS was taken to the hospital by ambulance where the emergency department physician pronounced his death at 6:45 a.m.

The autopsy report states the cause of death was sudden cardiac death associated with biventricular cardiac dilatation, and the manner of death was natural.

## FACILITY DESCRIPTION

HCDF is owned and operated by CoreCivic. The staff complement consists of 62 civilian positions and 266 security officers. The security rank structure includes a chief of security, captains, lieutenants, and detention officers. ICE Enforcement and Removal Operations (ERO) personnel provide onsite oversight.

Facility capacity is 1000. The average daily population is 922 and the average length of stay is 49 days. On the day of BALDERRAMOS's death, the facility held 913 detainees.

## HEALTHCARE SERVICES

HCDF earned reaccreditation by the National Commission on Correctional Health Care in February 2019. Healthcare is provided 24 hours a day, seven days a week by ICE Health Services Corp (IHSC), contractor STG International (STGi), and STGi subcontractor Ning Solutions. The staffing plan authorizes 55 positions, nine of which are designated for commissioned officers of the U.S. Public Health Service (PHS). PHS officers include the Health Services Administrator (HSA) who is a registered nurse (RN), an Assistant HSA, facility health program manager, a behavioral health professional, pharmacist, nurse manager, and three RNs. A General Schedule for Federal Pay position, vacant since November 2018, is allocated for the Clinical Director. IHSC (b)(6); (b)(7)(C) serves as the acting Clinical Director in the interim. STGi positions include a contract coordinator, one physician, three advanced practice providers (APP)<sup>1</sup>, ten RNs, four licensed vocational nurses (LVN), one psychiatrist, two pharmacists, two pharmacy technicians, a dental assistant, two radiology technicians, four medical records technicians, and an administrative assistant. The staff plan also authorizes 11 positions not designated as IHSC or contract. The 11 positions include five APPs, a dentist and five RNs.

According to Commander (b)(6); (b)(7)(C) HSA, five medical staff are fluent in Spanish, and professional interpretation services are provided through Interpretalk. IHSC's electronic medical record system, eClinical Works (eCW), is used at HCDF.

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<sup>1</sup> Advanced practice providers include physician assistants and nurse practitioners.

ERAU verified the credentials of all nurses are current, and training records document all healthcare and security staff involved in the emergency response are certified in cardio pulmonary resuscitation.

## DETENTION SUMMARY

BALDERRAMOS was classified low custody and remained in the same general population housing unit during following completion of the intake process. He received no disciplinary incident reports and filed no grievances. In his only request, he asked for a Bible.<sup>2</sup> Initials document receipt of the request, without disposition. Following his death, staff found a Bible among the property items in BALDERRAMOS's cell<sup>3</sup>, suggesting his request was honored.

BALDERRAMOS made 40 telephone calls between June 19 and 29, 2019, all in Spanish. In a call at 5:29 p.m. on June 29, 2019, approximately 12 hours before the medical emergency, he stated he had stomach issues he attributed to the food but was starting to feel better.<sup>4</sup> In a call approximately two and half hours later, BALDERRAMOS did not reference feeling poorly.<sup>5</sup>

BALDERRAMOS arrived at HCDF with \$1.00. On June 24, 2019, his funds account was credited \$100.00 by way of a Western Union Interface initiated by (b)(6); (b)(7)(C). The next day, BALDERRAMOS made a commissary purchase in the amount of \$39.55, leaving a balance of \$61.45.<sup>6</sup> His remaining funds and personal property were mailed to a family member following his death.

## NARRATIVE

### Montgomery Processing Center, Houston, TX

On June 6, 2019, (b)(6); (b)(7)(C) RN, initiated a pre-screening documenting BALDERRAMOS arrived at 11:30 p.m.<sup>7</sup> (b)(6); (b)(7)(C) used an interpreter to conduct the pre-screening in Spanish. Findings were normal, and a chest x-ray showed no active tuberculosis disease<sup>8</sup>.

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<sup>2</sup> See email, Request to Staff, dated June 24, 2019.

<sup>3</sup> See CoreCivic In-Cell Property List, dated June 30, 2019.

<sup>4</sup> See email from (b)(6); (b)(7)(C) BALDERRAMOS-Phone Record/Conversations, dated August 2, 2019.

<sup>5</sup> *Id.*

<sup>6</sup> See Transaction Receipt, dated June 19, 2019.

<sup>7</sup> See Pre-screen, dated June 7, 2019. (b)(6); (b)(7)(C) did not record the time she conducted the pre-screen.

<sup>8</sup> See electronic radiology report, Montgomery Processing Center, dated June 7, 2019.



On June 7, 2019 at 3:13 a.m., (b)(6); (b)(7)(C) conducted BALDERRAMOS's intake screening.<sup>9</sup> She noted the following<sup>10</sup>:

- BALDERRAMOS's vital signs were within normal limits, as follows: temperature 98.6, pulse 61, blood pressure 104/64, and respirations 17. He was 65.5 inches in height and weighed 119 pounds.
- BALDERRAMOS complained of insect bites over his trunk and extremities obtained while crossing the desert.
- BALDERRAMOS denied other medical or mental health conditions.

(b)(6); (b)(7)(C) assessment found BALDERRAMOS at risk for impaired skin integrity.

At 5:46 a.m., (b)(6); (b)(7)(C) nurse practitioner (NP), completed BALDERRAMOS's physical examination complex (PE-C).<sup>11</sup> The NP noted the following:

- BALDERRAMOS's vital signs were all within normal limits as follows: temperature 98.2, pulse 53<sup>12</sup>, blood pressure 127/75, and respirations 16. He weighed 120.8 pounds.
- BALDERRAMOS had scattered erythematous<sup>13</sup> rashes on his trunk and extremities, with healing nail scratch marks, but there were no signs of infection.

The assessment finding was bites or stings by nonvenomous insects and other nonvenomous arthropods<sup>14</sup>. Other findings were normal. (b)(6); (b)(7)(C) prescribed hydrocortisone cream<sup>15</sup> and ammonium lactate cream<sup>16</sup> to be applied to the rash twice daily for 14 days, and she instructed BALDERRAMOS to notify staff if he developed any symptoms. (b)(6); (b)(7)(C) concluded the physical examination by scheduling a follow-up appointment in one year and clearing him for custody.

On June 18, 2019 at 11:01 a.m., (b)(6); (b)(7)(C) RN, completed a transfer summary documenting BALDERRAMOS had no medical history, his chest x-ray was normal, and that he had no pending appointments or diagnostic testing<sup>17</sup>.

<sup>9</sup> Encounter times are based on the time medical staff recorded vital signs unless otherwise indicated in the progress note. ERAU approximated timing of medical encounters as best possible.

<sup>10</sup> See medical record encounter note, dated June 6, 2019.

<sup>11</sup> A PE-C is the initial health assessment of patients with chronic conditions, conducted by a provider. Because ERAU did not visit MPC, reviewers were unable to verify that (b)(6); (b)(7)(C) scheduled BALDERRAMOS for a PE-C due to the rash.

<sup>12</sup> A pulse rate lower than 60 is not uncommon in athletes and young adults.

<sup>13</sup> Erythematous refers to abnormal redness of the skin due to skin injury, infection, or inflammation.

<sup>14</sup> Arthropods are an invertebrate animal such as an insect, spider, or crustacean.

<sup>15</sup> Hydrocortisone cream is used to treat inflammation and dry, itchy skin.

<sup>16</sup> Ammonium lactate cream is used to treat dry, scaly, itchy skin.

<sup>17</sup> See transfer summary, Montgomery Processing Center, dated June 18, 2019.

## Houston Contract Detention Facility

(b)(6); (b)(7)(C) VN, completed BALDERRAMOS's pre-screening, documenting he arrived at 5:30 p.m. and that she conducted the encounter in Spanish.<sup>18</sup> She confirmed receipt and review of transfer summary from MPC. Pre-screening findings were normal.

At 8:16 p.m., (b)(6); (b)(7)(C) conducted the intake screening in Spanish, noting the following<sup>19</sup>:

- BALDERRAMOS's vital signs were within normal limits, as follows: temperature 98.9, pulse 72, blood pressure 130/77, respirations 16, and oxygen saturation 99<sup>20</sup>. He weighed 125.8 pounds.
- BALDERRAMOS denied any current or past medical, mental health, or dental problems or regular use of any type of medication.
- BALDERRAMOS denied seizures or conditions that might affect his activities of daily living.
- BALDERRAMOS denied use of tobacco, alcohol, or drugs.

(b)(6); (b)(7)(C) entered no in response to questions related to observation of bumps, rash, lesions, bruises, jaundice<sup>21</sup>, and scars. Until brought to her attention by ERAU, (b)(6); (b)(7)(C) was unaware MPC identified a rash caused by insect bites treated with prescription creams. She asserted she checked BALDERRAMOS's arms and neck and found no signs of rash.<sup>22</sup> She concluded the intake screening was normal, medically cleared BALDERRAMOS for custody, and provided him verbal and written patient education information in Spanish.<sup>23</sup>

BALDERRAMOS signed but did not date a medical consent form.<sup>24</sup> The witness signature is dated June 18, 2019. (b)(6); (b)(7)(C) stated to ERAU that all detainees sign consent forms intake screening, so she was certain he signed the form on June 18, 2019.<sup>25</sup>

On a form in Spanish, the title of which translates to Commitment Summary (b)(6); (b)(7)(C) (b)(6); (b)(7)(C) documented he booked BALDERRAMOS at 10:46 p.m. The form documents his primary language was Spanish and his classification was low, and includes identifying

<sup>18</sup> See Pre-screen, dated June 7, 2019; also, ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019.

<sup>19</sup> See Intake, dated June 18, 2019.

<sup>20</sup> Oxygen saturation is a measure of the specific balance of oxygen in the blood, with normal levels to be 95 to 100.

<sup>21</sup> Jaundice refers to yellowing of the skin.

<sup>22</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>23</sup> See Intake, dated June 18, 2019.

<sup>24</sup> See Medical Consent Form, dated June 18, 2019.

<sup>25</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>26</sup> See Resumen de Compromiso del Recluso/Detenido, printed June 20, 2019.



information, religious affiliation, and an emergency contact. The only other booking form bearing a date of June 18, 2019 is the ICE Custody Classification Worksheet. (b)(6); (b)(7)(C) completed the form and classified BALDERRAMOS low, and she and a supervisor signed the form this date. Inexplicably, a date of June 19, 2019 appears at the top of the form.<sup>27</sup>

**On June 20, 2019**, two days after BALDERRAMOS's arrival, Core Civic personnel completed multiple booking forms printed in Spanish.<sup>28</sup> The forms appear to include a property and funds inventory, record of issuance of facility clothing and other items, notification phone calls will be monitored and mail will be searched, and acknowledgement of receipt of the handbook, orientation, and other detention information. BALDERRAMOS signed and dated all the forms.<sup>29</sup> In addition, BALDERRAMOS signed a form in English and Spanish acknowledging he received a copy of the CoreCivic/HPC Sexual Abuse and Assault Prevention and Intervention brochure and the ICE National Detainee Handbook.<sup>30</sup>

At 11:42 a.m. (b)(6); (b)(7)(C) completed an Assessment Questionnaire concluding BALDERRAMOS was not at risk for sexual abuse or assault victimization and did not pose a predatory risk.<sup>31</sup> She did not note whether she completed the assessment in Spanish or used interpretation assistance.

At an unknown time, security personnel assigned BALDERRAMOS to dorm B10 bed 11, a lower bunk.<sup>32</sup> His housing did not change prior to the medical emergency on June 30, 2019. B10 is a single tier, direct supervision housing unit comprised of a dormitory section with 20 sets of bunk beds and a dayroom. The dorm and dayroom form an L shape and are joined by an open hallway. The dorm is an open configuration with three rows of bunk beds. The officer's podium is in dayroom near the door to the unit. There are three wall-mounted security cameras, two covering the dorm and one covering the dayroom.<sup>33</sup>

**On June 29, 2019** at 3:45 p.m., (b)(6); (b)(7)(C) RN, conducted BALDERRAMOS's initial physical examination using an interpreter<sup>34</sup>. She noted the following:

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<sup>27</sup> See ICE Custody Classification Worksheet, dated June 19, 2019. ERAU does not know the full name and title of D. Shields, or the name and title of the supervisor.

<sup>28</sup> See Disposicion de Propiedad No Permitida; Lista de Recibir y Descarga; Recibo de Propiedad Entregado de la Facilidad; Denegacion de Propiedad; Monitoreo de Llamadas Telefonicas del Recluso/Residente; and Correo del Recluso/Detenido, dated June 20, 2019.

<sup>29</sup> Staff signatures on the forms are illegible, although similar to that of (b)(6); (b)(7)(C) on the ICE Custody Classification Worksheet.

<sup>30</sup> See Sexual Abuse and Assault Prevention and Intervention Acknowledgement Form, dated June 20, 2019.

<sup>31</sup> See Assessment Questionnaire Information, dated June 20, 2019.

<sup>32</sup> HCDF did not provide documentation showing where BALDERRAMOS was housed between his arrival on June 18, 2019 and assignment to B10 on June 20, 2019. Calvin Blue, Chief of Security, informed ERAU BALDERRAMOS was assigned to bed 11 during tour of the housing unit on July 23, 2019.

<sup>33</sup> ERAU tour, dated July 23, 2019.

<sup>34</sup> See PE-Initial, dated June 29, 2019.

- BALDERRAMO's vital signs were within normal limits, as follows: temperature 98.1, pulse 84, blood pressure 136/83, respirations 18, and oxygen saturation 100. He weighed 126.6 pounds.
- BALDERRAMOS denied medical, mental health, or dental problems, and appeared to be in no acute distress, well developed, and well nourished.
- BALDERRAMOS was fully oriented, with normal thoughts and behaviors.
- BALDERRAMOS's physical examination resulted in normal findings relating to skin, heart, lungs, and abdomen. He ambulated without apparent difficulty, was able to sit and stand without difficulty, and had no deformity to his limbs.

(b)(6); (b)(7)(C) concluded there were no abnormal assessment findings and scheduled a follow up in one year. During interview with ERAU, she described BALDERRAMOS as very pleasant, stating he answered all questions spontaneously and demonstrated no sign of depression.<sup>35</sup> She said there was no evidence of the rash treated at MPC. (b)(6); (b)(7)(C) Acting Clinical Director, electronically signed the physical examination on July 1, 2019, at 8:00 a.m.<sup>36</sup>

**On June 30, 2019** at approximately 5:38 a.m., the officer assigned to B10, (b)(6); (b)(7)(C) discovered BALDERRAMOS unresponsive and called medical emergency. The video surveillance footage shows that during the five and a half hours preceding the medical emergency, (b)(6); (b)(7)(C) conducted security checks approximately every 30 minutes on an irregular basis<sup>37</sup>. His logbook entries largely align with the video evidence.<sup>38</sup> At 4:41 a.m., less than 30 seconds after (b)(6); (b)(7)(C) conducted a security check through the area around BALDERRAMOS's bunk, video from the bed area shows BALDERRAMOS moving in his bed; then he rolled to his right. His upper torso then slid off the bed with his head landing on the floor.<sup>39</sup> His lower body remained on the bed. Six seconds later, detainee (b)(6); (b)(7)(C) reached over from his bed next to BALDERRAMOS and tried to wake him. After approximately a minute and a half, (b)(6); (b)(7)(C) lifted BALDERRAMOS back onto his bed and returned to his own.<sup>40</sup> In the meantime, the video shows Officer (b)(6); (b)(7)(C) moving about in the B10 day room area, but he does not appear to notice BALDERRAMOS's partial fall from his bed and MORAN's actions.

<sup>35</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>36</sup> See PE-Initial, dated June 29, 2019.

<sup>37</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019. Officer Robles conducted rounds in accordance with Core Civic Post Orders, COR-PO-16, Section F, which states, "Security checks will be conducted on each shift in a manner to prevent inmate/residents from knowing the extent and time of the check. At HCDF the frequency of security checks at irregular times not to exceed thirty (30) minute intervals."

<sup>38</sup> See B10 Logbook, dated June 30, 2019.

<sup>39</sup> Based on ERAU's analysis of the video, BALDERRAMOS's head hit the floor with impact; however, ERAU cannot determine whether the impact may have caused injury.

<sup>40</sup> MORAN and other detainees assigned to bunks near BALDERRAMOS were released from HCDF prior to ERAU's site visit and therefore, were not interviewed.



For approximately ten minutes after (b)(6); (b)(7)(C) lifted BALDERRAMOS back onto his bed, video evidence suggests BALDERRAMOS was breathing.<sup>41</sup> ERAU last observed breathing at 4:54:49 a.m. At 5:02 a.m., (b)(6); (b)(7)(C) looked toward BALDERRAMOS's bunk from the entry area. He started a security check at approximately 5:15 a.m., walking directly past the bunk at approximately 5:19 a.m. At 5:29 a.m., he moved the breakfast meal food cart into the dayroom and began supervising the tray service process.

At 5:30 a.m., detainees attempted to wake BALDERRAMOS.<sup>42</sup> Approximately eight minutes later, a detainee identified as (b)(6); (b)(7)(C) notified (b)(6); (b)(7)(C). BALDERRAMOS did not wake. (b)(6); (b)(7)(C) immediately went to the bunk and attempted to wake him, then raised his radio to call for medical assistance. He told ERAU that he shook BALDERRAMOS three times before calling the emergency.<sup>43</sup> (b)(6); (b)(7)(C) RN, and (b)(6); (b)(7)(C) N, arrived at the scene in just over one minute, followed quickly by Captain (b)(6); (b)(7)(C) and Lieutenant (b)(6); (b)(7)(C). Officer (b)(6); (b)(7)(C) documented he arrived at the same time.<sup>45</sup>

In her medical record entry describing the response, (b)(6); (b)(7)(C) documented she and (b)(6); (b)(7)(C) were in the dorm conducting sick call when Officer (b)(6); (b)(7)(C) called the medical emergency.<sup>46</sup> She noted the following examination findings:

- BALDERRAMOS was lying in bed, unresponsive to stimuli. He was pulseless and without spontaneous respirations.
- BALDERRAMOS's general appearance was dusky, cyanotic<sup>47</sup> and non-responsive. He had no signs of neurologic reflexes<sup>48</sup>.
- BALDERRAMOS's head was normal in appearance with no bruising or bleeding noted.
- BALDERRAMOS's skin was dry, and free of visible lacerations, bruises, or bleeding.

(b)(6); (b)(7)(C) note further states she and (b)(6); (b)(7)(C) immediately moved BALDERRAMOS to the floor for initiation of cardio pulmonary resuscitation (CPR) and CoreCivic activated 911.<sup>49</sup> Lieutenant (b)(6); (b)(7)(C) clarified that (b)(6); (b)(7)(C) directed the 911 call and that he passed the

<sup>41</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019. ERAU concluded BALDERRAMOS was breathing based on observation that his blanket slightly rose and fell over the period.

<sup>42</sup> *Id.*

<sup>43</sup> ERAU interview with Officer (b)(6); (b)(7)(C), dated July 24, 2019.

<sup>44</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019.

<sup>45</sup> See Office (b)(6); (b)(7)(C) Incident Statement, dated June 30, 2019.

<sup>46</sup> See medical record encounter note, dated June 30, 2019. (b)(6); (b)(7)(C) was not available for interview.

<sup>47</sup> Cyanotic refers to a blue color of the skin.

<sup>48</sup> Neurologic reflexes are involuntary and nearly instantaneous movement in response to a stimulus.

<sup>49</sup> See medical record encounter note, dated June 30, 2019.

direction to B Control.<sup>50</sup> The B-Control logbook<sup>51</sup> and Houston Fire and Rescue Emergency Medical Services (EMS) report<sup>52</sup> document the 911 dispatch call was made at 5:40 a.m.

At approximately 5:41 a.m., (b)(6); (b)(7)(C) RN, arrived at BALDERRAMOS's bed with medical equipment.<sup>53</sup> Officer (b)(6); (b)(7)(C) responded with (b)(6); (b)(7)(C) reporting to ERAU that it was her understanding that (b)(6); (b)(7)(C) received instruction to bring the automated external defibrillator (AED), oxygen and stretcher to the scene.<sup>54</sup> (b)(6); (b)(7)(C) opened the oxygen and passed an ambu bag to (b)(6); (b)(7)(C) who was positioned at the detainee's head.<sup>55</sup> (b)(6); (b)(7)(C) applied the AED, ambu bag, and oxygen<sup>56</sup> and (b)(6); (b)(7)(C) and Lieutenant (b)(6); (b)(7)(C) rotated performance of chest compressions.<sup>57</sup> (b)(6); (b)(7)(C) stated to ERAU that BALDERRAMOS's skin was not cold and she observed no mottling.<sup>58</sup> Asked about possible injury resulting from BALDERRAMOS's head having hit the floor when he partially fell from the bunk, (b)(6); (b)(7)(C) stated she was unaware of the fall<sup>59</sup>.

(b)(6); (b)(7)(C) documented that after approximately 15 rounds of CPR, blood drained from the side of BALDERRAMOS's mouth and nose.<sup>60</sup> During compressions she turned his head to the right to clear the airway for oxygenation, noting no blood pooling in the back of the mouth.

The B-Control officer logged that an ambulance arrived on site at 5:48 a.m.<sup>61</sup> The video shows the first EMS responders arrived on scene at approximately 5:52 a.m. and within a minute, took over CPR.<sup>62</sup> During the next two minutes, six additional EMS responders arrived. Paramedic (b)(6); (b)(7)(C) documented BALDERRAMOS was in cardiac arrest.<sup>63</sup> Facility staff reported to EMS responders that BALDERRAMOS fell out of bed at approximately 5:00 a.m. and was assisted back into it, then was found unresponsive approximately a half hour later.<sup>64</sup> Paramedic

<sup>50</sup> ERAU interview with Lieutenant (b)(6); (b)(7)(C) dated July 23, 2019.

<sup>51</sup> See B-Control logbook, dated June 30, 2019.

<sup>52</sup> See Houston Fire and Rescue Hospital/Patient PCR report, dated July 1, 2019.

<sup>53</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019.

<sup>54</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated July 25, 2019 and Officer (b)(6); (b)(7)(C) Incident Statement, dated June 30, 2019.

<sup>55</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019.

<sup>56</sup> *Id.*

<sup>57</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019. There is no documentation of defibrillation.

<sup>58</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019. Mottling refers to the red or purple marbling of the skin when the blood flow slows.

<sup>59</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019.

<sup>60</sup> See medical record encounter note, dated June 30, 2019.

<sup>61</sup> See B-Control logbook, dated June 30, 2019.

<sup>62</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019.

<sup>63</sup> See Houston Fire and Rescue Hospital/Patient PCR report, dated June 30, 2019.

<sup>64</sup> *Id.* ERAU was unable to determine which staff member reported the fall to the paramedics, or how the staff member learned of the fall.



(b)(6); (b)(7)(C) also documented there were copious amounts of blood coming from the patient's mouth, in contrast with the observations of facility responders who reported they noted some, but not a lot, of blood.<sup>65</sup> EMS rescue efforts<sup>66</sup> included using their own AED with no shock advised; completing an electrocardiogram (EKG)<sup>67</sup>; providing oxygen; administering epinephrine<sup>68</sup> and intubating<sup>69</sup> the patient. Paramedic (b)(6); (b)(7)(C) noted BALDERRAMOS remained asystole<sup>70</sup> during much of the response. They were unable to reestablish cardiac rhythm.

EMS responders loaded BALDERRAMOS onto the gurney and exited B10 at 6:13 a.m.<sup>71</sup>, escorted by Officer (b)(6); (b)(7)(C). The ambulance left HCDF for Memorial Hermann Health System, Northeast Hospital in Houston at 6:26 a.m.<sup>72</sup> Lieutenant (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) participated in the hospital detail, Officer (b)(6); (b)(7)(C) accompanying BALDERRAMOS in the ambulance<sup>73</sup> and Lieutenant (b)(6); (b)(7)(C) following in the chase vehicle.<sup>74</sup> (b)(6); (b)(7)(C) were in B10 during the emergency response; Officer (b)(6); (b)(7)(C) had just reported to duty for day shift when instructed by Lieutenant (b)(6); (b)(7)(C) to prepare for the transport.

During the transport, EMS responders continued CPR and turned over care upon arrival at the emergency department.<sup>75</sup> The time of arrival was 6:37 a.m., one hour and one minute after Officer (b)(6); (b)(7)(C) called the medical emergency (b)(6); (b)(7)(C) evaluated BALDERRAMOS at 6:40 a.m., at which time the patient remained asystole.<sup>76</sup> (b)(6); (b)(7)(C) wrote that per EMS, a bystander reported that BALDERRAMOS fell from his bunk at 5:00 a.m. and went back to bed.<sup>77</sup> At 5:30 a.m., he was unresponsive when bystanders tried to wake him for breakfast. (b)(6); (b)(7)(C) documented there was no bystander CPR and an approximate 30-

<sup>65</sup> ERAU interviews with RN (b)(6); (b)(7)(C) dated July 23 and 24, 2019.

<sup>66</sup> See Houston Fire and Rescue Hospital/Patient PCR report, dated June 30, 2019.

<sup>67</sup> An EKG is a test that records the electrical activity of the heart.

<sup>68</sup> Epinephrine, also known as adrenaline, is a medication used in medical emergencies to improve breathing, stimulate the heart, and increase a dropping blood pressure.

<sup>69</sup> Intubation is the insertion of a tube into the patient's mouth to serve as an artificial ventilation passage into the trachea.

<sup>70</sup> Asystole, also referred to as flatline on the heart monitor, is total cessation of the heart's electrical activity.

<sup>71</sup> Video surveillance footage, B10 Bed Area and B10 Day Area, dated June 30, 2019.

<sup>72</sup> See Officer (b)(6); (b)(7)(C) Incident Statement, dated June 30, 2019.

<sup>73</sup> See B-Control logbook entry dated June 30, 2019, and Houston Fire and Rescue Hospital/Patient PCR report, dated June 30, 2019.

<sup>74</sup> See Lieutenant (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) Incident Statements, dated June 30, 2019.

<sup>75</sup> See Officer (b)(6); (b)(7)(C) Incident Statement, dated June 30, 2019.

<sup>76</sup> See Houston Fire and Rescue Hospital/Patient PCR report, dated June 30, 2019, and Officer (b)(6); (b)(7)(C) Incident Statement, dated June 30, 2019.

<sup>77</sup> See Memorial Hermann Emergency Department Report, dated June 30, 2019.

<sup>78</sup> Officer (b)(6); (b)(7)(C) stated to ERAU that he provided the information concerning BALDERRAMOS's fall, but did not recall who shared the information with him. ERAU interview with Officer (b)(6); (b)(7)(C) dated July 23, 2019.

minute down time prior to EMS arrival. He also documented EMS reported the detainee had blood on his face and was asystole upon arrival; therefore, CPR was initiated.<sup>79</sup> In the Medical Decision-Making section, (b)(6); (b)(7)(C) noted the following:

- BALDERRAMOS presented in cardiopulmonary arrest. He was pulseless and CPR was in progress.
- BALDERRAMOS had blood in the oropharynx<sup>80</sup>, possibly resulting from a fall or potential seizure in which the tongue was injured.
- BALDERRAMOS remained in asystole, and bedside ultrasound demonstrated no cardiac activity.

After concluding continued resuscitation efforts were futile and in consideration of what he called BALDERRAMOS's prolonged down time (b)(6); (b)(7)(C) pronounced BALDERRAMOS's death at 6:45 a.m. In the Impression and Plan/Diagnosis section of his note (b)(6); (b)(7)(C) entered cardiac failure.

BALDERRAMOS's body was moved from to another room in the emergency department pending transfer to the morgue.<sup>81</sup> While in the room, Lieutenant (b)(6); (b)(7)(C) instructed (b)(6); (b)(7)(C) to take four photographs of BALDERRAMOS's body with a camera brought to the hospital by Officer (b)(6); (b)(7)(C). At approximately 10:25 a.m., BALDERRAMOS was moved to the morgue, then was picked up by the medical examiner at 1:10 p.m. Lieutenant (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) left the hospital to return to the facility at 1:30 p.m.

Following the medical emergency, all staff involved in responding to B10 and assigned to the hospital detail wrote Incident Statements. They included officers who reported to B10 upon hearing the medical emergency call but did not directly participate in the response, as well as the officer who relieved Officer (b)(6); (b)(7)(C). With slight deviation, the statements provide descriptive information consistent with the video and other staff reports. In addition, (b)(6); (b)(7)(C) Unit Manager and Duty Officer for the day, requested statements from three detainees, including (b)(6); (b)(7)(C). All three detainees refused to cooperate<sup>84</sup>.

<sup>79</sup> ERAU's scope does not include interview of external caregivers; therefore, reviewers cannot explain (b)(6); (b)(7)(C) note. Staff started CPR within two minutes after Officer (b)(6); (b)(7)(C) responded to BALDERRAMOS's bed and found him unresponsive, and continued CPR until EMS arrived and took over resuscitation efforts.

<sup>80</sup> Oropharynx is a part of the throat at the back of the mouth, behind the oral cavity.

<sup>81</sup> See Incident Statements, Officer (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>82</sup> See Officer (b)(6); (b)(7)(C) Incident Statement, dated June 30, 2019. ERAU was not provided with copies of the photographs.

<sup>83</sup> Officers who submitted Incident Statements not named in the narrative because they played no direct role include (b)(6); (b)(7)(C)

<sup>84</sup> See Incident Statements, (b)(6); (b)(7)(C) dated June 30, 2019.



The same day, (b)(6); (b)(7)(C) Investigation Manager, produced a memorandum directed to (b)(6); (b)(7)(C) Assistant Warden, detailing her after action investigation.<sup>85</sup> Her investigation included analysis of video evidence and a general summary of BALDERRAMOS's known health status. In addition, she documented the following:

- Notification of death to facility leadership and the ICE Contracting Officer Representative.
- Notification of Houston Police Department and arrival of officers at the hospital at 9:27 a.m. on the day of death.
- Notification of the Honduran Consulate and BALDERRAMOS's next of kin, (b)(6); (b)(7)(C) his brother, by ICE.
- Arrival of two agents of the Federal Bureau of Investigation at 4:43 p.m. on the day of death. The agents took pictures of the dorm area and took possession of BALDERRAMOS's bedsheet and blanket after signing a chain of custody form.

At an unknown time, Officer (b)(6); (b)(7)(C) inventoried and packed BALDERRAMOS's personal property.<sup>86</sup> A United States Postal Service Certified Mail Receipt documents the property and remaining funds balance of \$61.45 were sent to (b)(6); (b)(7)(C) Norwalk, CT on July 11, 2019.<sup>87</sup>

An autopsy report from the Harris County Institute of Forensic Sciences states the cause of death was sudden cardiac death associated with biventricular cardiac dilatation<sup>88</sup>, and the manner of death was natural.<sup>89</sup> Findings of the accompanying Toxicology Report, dated September 4, 2019, were determined to be non-contributory to the death.

## CONCLUSIONS

Officer (b)(6); (b)(7)(C) responded to BALDERRAMOS's bunk without delay when informed he would not wake, and immediately called medical emergency. Before the event, Officer (b)(6); (b)(7)(C) made required security rounds, the timing of which coincidentally did not allow observation of BALDERRAMOS's partial fall from his bunk. Medical and security personnel responded in under two minutes and took necessary and appropriate action. Following the emergency and BALDERRAMOS's death, facility leadership gathered Incident Statements from all involved staff and directed completion of an after-action investigation.

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<sup>85</sup> See CoreCivic Houston Processing Center Memorandum, dated June 30, 2019.

<sup>86</sup> See Authorized In-Cell Property List, dated June 30, 2019, in file Detention, 14 Personal Property Forms.

<sup>87</sup> See Certified Mail Receipt, dated July 11, 2019. ERAU cannot determine who originated the receipt.

<sup>88</sup> Biventricular Cardiac dilatation refers to enlargement of both lower pumping chambers of the heart, preventing the heart from relaxing and filling with blood as it should.

<sup>89</sup> See Harris County Institute of Forensic Sciences, signed September 27, 2019 by (b)(6); (b)(7)(C), MD, Assistant Medical Examiner.

ERAU identified no deficiencies in the ICE 2011 PBNDS, Medical Care, revised 2016. ERAU identified the following deficiency in the ICE 2011 PBNDS, Admission and Release, revised 2016:

Section (II)(7), which states, “Each newly admitted detainee shall be kept separated from the general population until health, housing and custody classification is completed but not longer than 12 hours.”

- HCDF staff did not fully complete BALDERRAMOS’s admission processing, including housing determination, upon his arrival. He was not fully processed until June 20, 2019, two days after his admission.





## Detainee Death Review Report

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**Yimi BALDERRAMOS-Torres**

Date of Death: June 30, 2019

Alien File Number: 206 179 679

Joint Integrity Case Management System (JICMS) # (b)(6); (b)(7)(C); (b)(7)(E)

April 1, 2020

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

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## **DETAILS OF REVIEW**

From July 23 to 24, 2019, U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) staff visited the Houston Contract Detention Facility (HCDF) in Houston, Texas (TX), to review the circumstances surrounding Yimi BALDERRAMOS-Torres' (BALDERRAMOS') 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.<sup>1</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to BALDERRAMOS, in addition to conducting in-person interviews of individuals employed at HCDF, ICE Health Service Corps (IHSC) staff assigned to HCDF, and the local ICE Office of Enforcement and Removal Operations (ERO) field office. BALDERRAMOS was detained at HCDF from June 6, 2019 through June 18, 2019, where he remained until his transfer to the hospital. The Assistant Medical Examiner from the Harris County Institute of Forensic Sciences documented the cause of death was sudden cardiac death associated with biventricular cardiac dilation,<sup>2</sup> and the manner of death was natural.<sup>3</sup>

## **FACILITY PROFILE**

HCDF is owned and operated by CoreCivic, and the ERO Houston Field Office provides oversight. HCDF is a contract detention facility and required to comply with ICE Performance-Based National Detention Standards (PBNDS) 2011. HCDF is authorized by ICE to house male and female detainees for periods longer than 72 hours and has an ICE detainee bed capacity of 1,000. Medical care at HCDF is provided by IHSC and supported by contract companies STG International (STG) and Ning Solutions. On the day of BALDERRAMOS' death, HCDF housed approximately 913 male and female ICE detainees.

## **IMMIGRATION HISTORY<sup>4</sup>**

On August 5, 2013, a U.S. Customs and Border Protection (CBP) agent encountered BALDERRAMOS in Rio Grande Valley, TX and determined BALDERRAMOS had unlawfully entered the United States from Mexico.<sup>5</sup> The CBP agent arrested BALDERRAMOS and transported him to the Kingsville Border Patrol Station.

On August 6, 2013, during processing, BALDERRAMOS told the CBP agent he entered the U.S. near Hidalgo, TX on July 25, 2013.<sup>6</sup> The CBP agent served BALDERRAMOS with a Notice and Order of Expedited Removal (Form I-860), charging him with inadmissibility pursuant to Section

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<sup>1</sup> See Exhibit 1: BALDERRAMOS Detainee Death Review Healthcare and Security Compliance Analysis, dated September 9, 2019.

<sup>2</sup> Biventricular cardiac dilation refers to enlargement of both lower pumping chambers of the heart which prevent the heart from relaxing and filing with blood as it should.

<sup>3</sup> See Exhibit 2: Harris County Institute of Forensic Sciences, by (b)(6); (b)(7)(C) signed September 27, 2019.

<sup>4</sup> There is no criminal history to report for BALDERRAMOS.

<sup>5</sup> See ENFORCE Alien and Removal Module (EARM), Encounters, created August 7, 2013.

<sup>6</sup> See Record of Sworn Statement in Proceedings (Form I-867A), dated August 6, 2013.

212 (a)(7)(A)(i)(I) of the Immigration and Nationality Act (INA) as an immigrant who is not in possession of a valid unexpired visa.<sup>7</sup>

On August 9, 2013, CBP transferred BALDERRAMOS into ERO San Antonio's custody, and he was transported to the Brooks County Jail in Falfurrias, TX.<sup>8</sup>

On August 14, 2013, ERO San Antonio deported BALDERRAMOS to Honduras.<sup>9</sup>

On May 19, 2019, a CBP agent encountered BALDERRAMOS and his son in El Paso, TX and determined they had unlawfully entered the United States.<sup>10</sup> The CBP agent arrested BALDERRAMOS and transported him to the El Paso Border Patrol Station for processing. The CBP agent served BALDERRAMOS with a Notice to Appear (Form I-862), charging him with removability pursuant to Section 212 (a)(7)(A)(i)(I) of the INA. On the same day, CBP returned BALDERRAMOS and his son to Mexico under the Migration Protection Protocol<sup>11</sup> to await a hearing before an immigration judge scheduled for September 30, 2019.<sup>12</sup>

On May 27, 2019, BALDERRAMOS entered the United States near Hidalgo, TX without having been admitted or paroled by an immigration officer.<sup>13</sup>

On June 6, 2019, deputies from the Montgomery County Sheriff's Office (MCSO) in Conroe, TX, conducted a traffic stop and found BALDERRAMOS and 10 other individuals in the vehicle, all of whom admitted to being in the United States illegally.<sup>14</sup> The MCSO deputies suspected they were smuggled into the United States and contacted the ICE Office of Homeland Security Investigations (HSI) in Houston, who responded and took BALDERRAMOS and the other occupants of the vehicle into custody. HSI Houston issued BALDERRAMOS a Notice of Intent/Decision to Reinstate a Prior Order (Form I-871) of removal pursuant to section 241(a)(5) of the INA, as an alien who illegally reentered the United States after having been previously removed or departed voluntarily while under an order of exclusion, deportation or removal.<sup>15</sup>

On that same day, HSI Houston transferred BALDERRAMOS into ERO's custody at the Montgomery ICE Processing Center (MIPC) in Conroe, TX.<sup>16</sup>

On June 18, 2019, ERO Houston transferred BALDERRAMOS to HCDF, where he remained until his death.<sup>17</sup>

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<sup>7</sup> See Form I-860, dated August 6, 2013.

<sup>8</sup> See ENFORCE Alien Detention Module (EADM), Detention Details.

<sup>9</sup> See ENFORCE Alien Detention Module (EADM), Detention Details.

<sup>10</sup> See EARM, Encounters, created date May 19, 2019.

<sup>11</sup> See <https://www.dhs.gov/news/2019/01/24/migrant-protection-protocols>

<sup>12</sup> See ICE Significant Incident Report, dated July 1, 2019.

<sup>13</sup> See Warrant of Removal/Deportation (Form I-205), dated June 6, 2019. There is no additional information regarding this encounter in EARM or BALDERRAMOS's Alien File.

<sup>14</sup> See EARM, Encounters, created date June 6, 2019.

<sup>15</sup> See Form I-871, dated June 6, 2019.

<sup>16</sup> See I-203, Order to Detain or Release Alien, dated June 6, 2019.

<sup>17</sup> See EARM, Actions/Decisions, dated June 18, 2019.



## **CHRONOLOGY OF EVENTS**

### **Montgomery ICE Processing Center**

#### **June 6, 2019**

At approximately 11:30 p.m.,<sup>18</sup> Registered Nurse (RN) (b)(6); (b)(7)(C) completed BALDERRAMOS' medical pre-screening using a Spanish interpreter.<sup>19</sup> (b)(6); (b)(7)(C) documented that BALDERRAMOS denied having any current illnesses or health problems and denied taking any medications. (b)(6); (b)(7)(C) ordered a chest X-ray, which was negative for active tuberculosis (TB).<sup>20</sup>

Around the same time, an unknown officer admitted BALDERRAMOS into MIPC.<sup>21</sup> An unknown officer inventoried BALDERRAMOS' personal property and listed a pair of shoes, boxers, a shirt, and a belt.<sup>22</sup> BALDERRAMOS signed a form acknowledging he received the ICE National Detainee Handbook, the facility handbook, and viewed the Prison Rape Elimination Act video.<sup>23</sup>

#### **June 7, 2019**

At an unknown time, an unknown officer completed BALDERRAMOS' classification rating and appropriately classified him as low; an unknown supervisor approved the rating.<sup>24</sup>

At 3:13 a.m.,<sup>25</sup> (b)(6); (b)(7)(C) completed BALDERRAMOS' medical intake screening using a Spanish interpreter and documented his vital signs were within normal limits.<sup>26</sup> BALDERRAMOS denied having any medical or mental health conditions and denied taking any medications but complained of a rash on his arms and abdomen, which he stated he obtained while in the desert. (b)(6); (b)(7)(C) assessment was documented as at risk for impaired skin integrity with no prescribed medication remedy. (b)(6); (b)(7)(C) medically cleared BALDERRAMOS for custody.

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<sup>18</sup> 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 BALDERRAMOS. When citing medical entries within this report, ERAU utilized timestamps for vital signs, electronic signatures, or specific times documented by medical staff within the medical record.

<sup>19</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated June 6, 2019.

<sup>20</sup> See Radiology Report, dated June 6, 2019.

<sup>21</sup> See GEO Track, Subject Profile, printed date June 7, 2019. The officer names on the MIPC documents are illegible.

<sup>22</sup> See Personal Property Receipt, dated June 6, 2019.

<sup>23</sup> See GEO Detainee Orientation Acknowledgement, dated June 7, 2019. ERAU notes the form is dated June 7, 2019 at 11:30 p.m.; however, BALDERRAMOS arrived to MIPC on June 6, 2019 at 11:30 p.m.

<sup>24</sup> See Montgomery Processing Center Custody Classification Worksheet, dated June 7, 2019. The officer names on the MIPC documents are illegible.

<sup>25</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated June 7, 2019.

<sup>26</sup> 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 less than 120/80.

At 5:46 a.m., Nurse Practitioner (NP) (b)(6); (b)(7)(C) completed BALDERRAMOS's complex physical examination<sup>27</sup> using a Spanish interpreter and documented his vital signs were within normal limits with the exception of a low heart rate<sup>28</sup> of 53 beats per minute.<sup>29</sup> (b)(6); (b)(7)(C) noted that BALDERRAMOS had red rashes on his arms, legs, and abdomen, with healing scratch marks and no signs of infection. (b)(6); (b)(7)(C) assessment finding was bites or stings by nonvenomous insects, for which he prescribed hydrocortisone cream<sup>30</sup> and ammonium lactate cream<sup>31</sup> as keep-on-person (KOP) medication. (b)(6); (b)(7)(C) instructed BALDERRAMOS on how to access medical care via sick call should he have any further issues and scheduled his next physical exam in one year.

## June 18, 2019

At 11:01 a.m., RN (b)(6); (b)(7)(C) completed BALDERRAMOS's medical transfer summary documenting he had no medical history, and his chest X-ray was negative for active TB.<sup>32</sup> There was no information present on the medical transfer summary about BALDERRAMOS' rash. RN (b)(6); (b)(7)(C) medically cleared BALDERRAMOS for transfer.

## Houston Contract Detention Facility

At approximately 5:30 p.m., Licensed Vocational Nurse (LVN) (b)(6); (b)(7)(C) completed BALDERRAMOS' pre-screening in Spanish.<sup>33</sup> (b)(6); (b)(7)(C) documented she reviewed the medical transfer summary from MIPC and that BALDERRAMOS' appearance, behavior, and breathing were normal.

At 8:16 p.m., LVN (b)(6); (b)(7)(C) completed BALDERRAMOS' medical intake screening in Spanish and documented<sup>34</sup> the following:

- BALDERRAMOS' vital signs were within normal limits.
- BALDERRAMOS denied having any current or past medical, mental health, or dental issues or taking any medication.
- BALDERRAMOS did not have any bumps, rashes, lesions, bruises, cuts, or scars.

(b)(6); (b)(7)(C) stated she was unaware MIPC identified a rash caused by insect bites and that she checked BALDERRAMOS's arms and neck and found no signs of a rash.<sup>35</sup> LVN (b)(6); (b)(7)(C) provided BALDERRAMOS with guidance on how to obtain access to medical care and the

<sup>27</sup> A complex physical examination is a health assessment conducted by a provider of patients with chronic conditions.

<sup>28</sup> Although the normal pulse range is 60 to 100 beats per minute, a pulse rate lower than 60 is not uncommon in athletes and young adults.

<sup>29</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated June 7, 2019.

<sup>30</sup> Hydrocortisone cream is used to treat inflammation and dry, itchy skin.

<sup>31</sup> Ammonium lactate cream is used to treat dry, scaly, itchy skin.

<sup>32</sup> See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>33</sup> See eCW Progress Note, by (b)(6); (b)(7)(C) dated June 18, 2019. (b)(6); (b)(7)(C) is fluent in Spanish.

<sup>34</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated June 18, 2019.

<sup>35</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 24, 2019.



grievance process, and medically-cleared him for custody. BALDERRAMOS signed the IHSC Medical Consent Form.<sup>36</sup>

At 10:46 p.m., Detention Officer (DO) (b)(6); (b)(7)(C) admitted BALDERRAMOS to HCDF.<sup>37</sup> At an unknown time, Classification Officer (b)(6); (b)(7)(C) completed BALDERRAMOS' classification rating and appropriately classified him as low; an unknown supervisor approved the rating.<sup>38</sup>

### June 19, 2019

At 2:35 a.m., an officer escorted BALDERRAMOS to housing unit B10, bed 11, a lower bunk.<sup>39</sup>

### June 20, 2019

Two days after BALDERRAMOS' arrival at HCDF, CoreCivic personnel completed multiple intake forms. The intake forms included a funds and personal property inventory,<sup>40</sup> issuance of facility clothing and other items,<sup>41</sup> and acknowledgement of receiving the ICE National Detainee Handbook, the facility handbook, and the sexual abuse and assault brochure.<sup>42</sup>

At 11:42 a.m. (b)(6); (b)(7)(C) completed BALDERRAMOS' risk assessment and determined he was not at risk of victimization or abuse.<sup>43</sup>

### June 29, 2019

At 3:45 p.m., RN (b)(6); (b)(7)(C) conducted BALDERRAMOS' initial physical examination using a Spanish interpreter and documented<sup>44</sup> the following:

- BALDERRAMOS's vital signs were within normal limits.
- BALDERRAMOS denied having any medical, mental health, or dental problems.
- BALDERRAMOS was fully oriented, with normal thoughts and behaviors.
- BALDERRAMOS did not have a rash or evidence of a skin infection.

(b)(6); (b)(7)(C) concluded there were no abnormal assessment findings and scheduled a follow-up appointment in a year. (b)(6); (b)(7)(C) described BALDERRAMOS as very pleasant, he answered all questions spontaneously, and he did not demonstrate any signs of depression.<sup>45</sup> Additionally, RN

(b)(6); (b)(7)(C) said there was no evidence of the rash MIPC treated.

<sup>36</sup> See IHSC Medical Consent Form, dated June 18, 2019.

<sup>37</sup> See Resumen de Compromiso del Recluso/Detenido, printed June 20, 2019.

<sup>38</sup> See ICE Custody Classification Worksheet, dated June 18, 2019. The supervisor's name is illegible.

<sup>39</sup> See Housing Photo Report, printed date June 30, 2019.

<sup>40</sup> See Disposicion de Propiedad No Permitada, dated June 20, 2019.

<sup>41</sup> See Recibo de Propiedad Entregado de la Facilidad, dated June 20, 2019.

<sup>42</sup> See Sexual Abuse and Assault Prevention and Intervention Acknowledgement Form, dated June 20, 2019.

<sup>43</sup> See Assessment Questionnaire Information, dated June 20, 2019. ERAU notes (b)(6); (b)(7)(C) did not document whether she completed the assessment in Spanish or used interpretation assistance.

<sup>44</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated June 29, 2019.

<sup>45</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 24, 2019.

## Day of Death – June 30, 2019

From 12:00 a.m. to approximately 5:30 a.m., (b)(6); (b)(7)(C) conducted security checks in housing unit B10 approximately every 30 minutes on an irregular basis;<sup>46</sup> his logbook entries aligned with the video surveillance.<sup>47</sup>

At 4:41 a.m.,<sup>48</sup> less than 30 seconds after (b)(6); (b)(7)(C) conducted a security check in B10, BALDERRAMOS moved in his lower bunk and rolled to his right with his torso sliding off the bed and his head landing on the floor, while his lower body remained on the bunk.<sup>49</sup> Six seconds later, detainee (b)(6); (b)(7)(C) reached over from his bunk across to BALDERRAMOS and tried to wake him. At approximately 4:43 a.m., (b)(6); (b)(7)(C) lifted BALDERRAMOS back onto his bunk and returned to his own bunk.<sup>50</sup> During this time, (b)(6); (b)(7)(C) was pacing in the dayroom area, but he did not notice BALDERRAMOS partial fall or (b)(6); (b)(7)(C) actions. For approximately 10 minutes thereafter, BALDERRAMOS moved within his bunk.<sup>51</sup> BALDERRAMOS last movement occurred at 4:54 a.m. At 5:02 a.m., (b)(6); (b)(7)(C) glanced towards BALDERRAMOS bunk from the entry area of the housing unit.

At 5:15 a.m., (b)(6); (b)(7)(C) conducted a security check and walked past BALDERRAMOS bunk at approximately 5:19 a.m.<sup>52</sup> At 5:29 a.m., the breakfast meal food cart arrived to B10 and DO (b)(6); (b)(7)(C) supervised the food tray service as detainees formed a line for breakfast. At 5:30 a.m., several detainees attempted to wake BALDERRAMOS for breakfast.

At approximately 5:38 a.m., detainee (b)(6); (b)(7)(C) that BALDERRAMOS would not wake up. (b)(6); (b)(7)(C) immediately went to BALDERRAMOS bunk and attempted to wake him, then called a medical emergency via his radio. (b)(6); (b)(7)(C) stated he shook BALDERRAMOS three times before he called the medical emergency.<sup>53</sup>

(b)(6); (b)(7)(C) were near B10 conducting sick call rounds when they heard the medical emergency. Approximately a minute later,<sup>54</sup> RNs (b)(6); (b)(7)(C) arrived at B10, and immediately thereafter, Captain (b)(6); (b)(7)(C) and DO (b)(6); (b)(7)(C) arrived.<sup>55</sup>

<sup>46</sup> See B10 Housing Area and B10 Dayroom Area Video Surveillance, dated June 30, 2019.

<sup>47</sup> See B10 Logbook, dated June 30, 2019.

<sup>48</sup> See B10 Housing Area Video Surveillance, dated June 30, 2019.

<sup>49</sup> Based on ERAU's analysis of the video surveillance, BALDERRAMOS head hit the floor with impact; however, ERAU cannot determine whether the impact may have caused injury.

<sup>50</sup> MORAN and other detainees assigned to bunks near BALDERRAMOS were released from HCDF prior to ERAU's site visit and therefore, were not interviewed.

<sup>51</sup> See B10 Housing Area and B10 Dayroom Area Video Surveillance, dated June 30, 2019. ERAU concluded BALDERRAMOS was breathing because his blanket slightly rose and fell.

<sup>52</sup> See B10 Housing Area and B10 Dayroom Area Video Surveillance, dated June 30, 2019.

<sup>53</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 24, 2019.

<sup>54</sup> See B10 Dorm Area and B10 Dayroom Area Video Surveillance, dated June 30, 2019.

<sup>55</sup> See Incident Statement by (b)(6); (b)(7)(C) dated June 30, 2019.



(b)(6); (b)(7)(C) documented that he observed BALDERRAMOS lying in the bunk pulseless, unresponsive to stimuli, and that his skin appeared blue.<sup>56</sup> (b)(6); (b)(7)(C) moved BALDERRAMOS to the floor, initiated cardiopulmonary resuscitation (CPR), and instructed security staff to call 911. Lieutenant (b)(6); (b)(7)(C) directed the 911 call and, he notified B-Control to call 911.<sup>57</sup> At 5:40 a.m., the B-Control Officer called 911.<sup>58</sup>

(b)(6); (b)(7)(C) who was in medical when she heard the medical emergency via a radio, stated she immediately retrieved the automated external defibrillator (AED),<sup>59</sup> oxygen tank and the stretcher, and proceeded to B10.<sup>60</sup> At approximately 5:42 a.m., (b)(6); (b)(7)(C) arrived at BALDERRAMOS' bunk.<sup>61</sup> (b)(6); (b)(7)(C) gave the AED to (b)(6); (b)(7)(C) who applied the AED pads on BALDERRAMOS' torso and placed the ambu-bag over his nose and mouth.<sup>62</sup> (b)(6); (b)(7)(C) and Lieutenant Marberry rotated performing chest compressions.<sup>63</sup> (b)(6); (b)(7)(C) stated that BALDERRAMOS' skin was not cold, and she did not observe mottling.<sup>64</sup> After approximately 15 rounds of CPR, (b)(6); (b)(7)(C) observed blood draining from the side of BALDERRAMOS' mouth and nose and turned his head to the right to clear the airway for oxygenation during compressions but did not see blood pooling in the back of his mouth.<sup>65</sup>

At 5:48 a.m., the ambulance arrived at HCDF.<sup>66</sup> At approximately 5:52 a.m.,<sup>67</sup> Houston Fire and Rescue Emergency Medical Service (EMS) responders arrived at BALDERRAMOS' side.<sup>68</sup> Upon arrival, EMS observed that BALDERRAMOS was in cardiac arrest, and facility staff were performing CPR with the AED attached. EMS responders assumed CPR duties and attached their AED. EMS responders observed a copious amount of blood coming from the BALDERRAMOS' mouth.<sup>69</sup> The AED did not advise shock; therefore, EMS responders completed an electrocardiogram (EKG),<sup>70</sup> administered epinephrine,<sup>71</sup> and intubated<sup>72</sup> BALDERRAMOS, but were unable to reestablish a heart rhythm.

<sup>56</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>57</sup> ERAU interview with Lieutenant Marberry, dated July 23, 2019.

<sup>58</sup> See B-Control Logbook, dated June 29, 2019. There were two officers assigned to the Control Room on this date; the logbook did not detail who completed which actions.

<sup>59</sup> An AED is a portable device that delivers an electric shock through the chest to the heart.

<sup>60</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019.

<sup>61</sup> See Incident Statement by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>62</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019. An ambu-bag is a handheld device used to provide positive pressure ventilation to patients who are not breathing or not breathing adequately.

<sup>63</sup> See B10 Housing Area and Dayroom Area Video Surveillance, dated June 30, 2019.

<sup>64</sup> ERAU interview with (b)(6); (b)(7)(C) dated July 23, 2019. Mottling refers to the red or purple marbling of the skin when the blood flow slows.

<sup>65</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>66</sup> See B-Control Logbook, dated June 30, 2019.

<sup>67</sup> See B10 Housing Area and Dayroom Area Video Surveillance, dated June 30, 2019.

<sup>68</sup> See Houston Fire and Rescue EMS Hospital/Patient Report, dated June 30, 2019.

<sup>69</sup> ERAU notes this is in contrast with the observations of facility responders who, while they reported noting some blood, would not have described it as a copious amount. ERAU interviews with (b)(6); (b)(7)(C) dated July 23 and 24, 2019.

<sup>70</sup> An EKG is a test that records the electrical signals in the heart to detect heart problems.

<sup>71</sup> Epinephrine is a chemical that narrows blood vessels and opens airways in the lungs.

<sup>72</sup> Intubation is the insertion of a tube into the patient's mouth to maintain an open airway.

(b)(6); (b)(7)(C) reported to B10 when they heard the medical emergency. At 6:13 a.m., EMS responders moved BALDERRAMOS onto the gurney and exited B10 en route to the sally port.<sup>73</sup> (b)(6); (b)(7)(C) instructed Lieutenant (b)(6); (b)(7)(C) to accompany the ambulance to the hospital.<sup>74</sup> (b)(6); (b)(7)(C) had just reported for duty when Lieutenant (b)(6); (b)(7)(C) instructed him to get the chase vehicle for a detainee escort to the hospital.<sup>75</sup> At 6:26 a.m.,<sup>76</sup> the ambulance departed HCDF, with (b)(6); (b)(7)(C) accompanying BALDERRAMOS in the ambulance, en route to Memorial Hermann Northeast Hospital (MHNH).<sup>77</sup> (b)(6); (b)(7)(C) followed the ambulance in the chase vehicle.<sup>78</sup>

During transport, EMS responders continued CPR.<sup>79</sup> At 6:37 a.m., the ambulance arrived to MHNH, and hospital staff assumed care of BALDERRAMOS.<sup>80</sup> Hospital staff continued CPR, but BALDERRAMOS remained unresponsive.

At 6:45 a.m., (b)(6); (b)(7)(C) discontinued resuscitation efforts and pronounced BALDERRAMOS dead.<sup>81</sup>

Hospital staff moved BALDERRAMOS' body to another room in the emergency department pending transfer to the morgue.<sup>82</sup>

At approximately 1:10 p.m., the medical examiner picked up BALDERRAMOS' body.<sup>83</sup> At 1:30 p.m., (b)(6); (b)(7)(C) left the hospital to return to HCDF.<sup>84</sup>

### Post-Death Actions

Following the medical emergency, facility leadership instructed all involved staff members to write an incident statement, including officers who reported to the medical emergency but did not directly participate in the response. Facility leadership also requested statements from three detainees, including (b)(6); (b)(7)(C) however, they all refused to provide a statement.<sup>85</sup>

At 11:25 a.m., ERO Houston notified the Honduran Consulate of BALDERRAMOS' death, who notified his next of kin.<sup>86</sup>

<sup>73</sup> See B10 Housing Area and Dayroom Area Video Surveillance, dated June 30, 2019.

<sup>74</sup> See Incident Statement by Lieutenant (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>75</sup> See Incident Statement by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>76</sup> See Houston Fire and Rescue Hospital/Patient Report, dated June 30, 2019.

<sup>77</sup> See Incident Statement by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>78</sup> See Incident Statement by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>79</sup> See Houston Fire and Rescue Hospital/Patient Report, dated June 30, 2019.

<sup>80</sup> *Id.*

<sup>81</sup> See Memorial Hermann Emergency Department Report, dated June 30, 2019.

<sup>82</sup> See Incident Statements by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>83</sup> See Incident Statement by Lieutenant (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>84</sup> See Incident Statement by (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>85</sup> See Incident Statements by Detainees (b)(6); (b)(7)(C) dated June 30, 2019.

<sup>86</sup> See ICE Significant Incident Report, dated July 1, 2019.



At an unknown time, (b)(6); (b)(7)(C) inventoried and packed BALDERRAMOS' personal property.<sup>87</sup> On July 11, 2019, BALDERRAMOS's personal property and remaining funds of \$61.45 were sent to his brother (b)(6); (b)(7)(C).

On September 4, 2019, (b)(6); (b)(7)(C) Assistant Medical Examiner from the Harris County Institute of Forensic Sciences, stated the cause of death was sudden cardiac death associated with biventricular cardiac dilation, and the manner of death was natural.<sup>89</sup> Findings of the accompanying Toxicology Report, dated September 4, 2019, were determined to be non-contributory to the death.<sup>90</sup>

## **FINDINGS**

ERAU reviewed the medical care HCDF provided BALDERRAMOS, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found the following deficiency in HCDF's compliance with ICE PBNDS 2011.

1. *Admission and Release*, Section (II)(7), which states, "Each newly admitted detainee shall be kept separated from the general population until health, housing and custody classification is completed but not longer than 12 hours."
  - On June 18, 2019, BALDERRAMOS arrived at HCDF; however, HCDF staff did not complete his admission processing until June 20, 2019.

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<sup>87</sup> See Authorized In-Cell Property List, dated June 30, 2019.

<sup>88</sup> See U.S. Postal Service Certified Mail Receipt, dated July 11, 2019. ERAU cannot determine who originated the receipt.

<sup>89</sup> See Exhibit 2: Harris County Institute of Forensic Sciences, by (b)(6); (b)(7)(C), signed September 27, 2019.

<sup>90</sup> See Toxicology Report, dated September 5, 2019.

## **EXHIBITS**

1. BALDERRAMOS Detainee Death Review Healthcare and Security Compliance Analysis, dated September 9, 2019.
2. Harris County Institute of Forensic Sciences, Autopsy Report, dated, July 1, 2019 signed on September 27, 2019.





U.S. Immigration  
and Customs  
Enforcement

MEMORANDUM FOR: Enrique M. Lucero  
Executive Associate Director  
Office of Enforcement and Removal Operations  
(b)(6); (b)(7)(C) (b)(6); (b)(7)(C)

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 – Yimi BALDERRAMOS-Torres  
(b)(6); (b)(7)(C); (b)(7)(E)

The U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) completed its review of the death of Yimi BALDERRAMOS-Torres (BALDERRAMOS), a 30-year-old citizen of Honduras, who died on June 30, 2019, at the Memorial Hermann Northeast Hospital (MHNH) in Humble, Texas (TX), while in the custody of ICE. The Assistant Medical Examiner of the Harris County Institute of Forensic Sciences documented<sup>1</sup> BALDERRAMOS's cause of death as a sudden cardiac death associated with biventricular cardiac dilation.<sup>2</sup>

### Abbreviated Chronology<sup>3</sup>

On June 6, 2019, deputies from the Montgomery County Sheriff's Office (MCSO) in Montgomery County, TX, conducted a traffic stop and found BALDERRAMOS and 10 other individuals in the vehicle and suspected they were being smuggled into the United States. The MCSO deputies contacted the ICE Office of Homeland Security Investigations (HSI) in Houston, TX, who responded and took BALDERRAMOS and the other occupants of the vehicle into custody. HSI issued BALDERRAMOS a Notice of Intent/Decision to Reinstate a Prior Order of removal pursuant to section 241(a)(5) of the Immigration and Nationality Act (INA).

On the same day, HSI transferred BALDERRAMOS into the custody of ICE Office of Enforcement and Removal Operations (ERO) at the Montgomery ICE Processing Center in Conroe, TX.

<sup>1</sup> See Harris County Institute of Forensic Sciences, by (b)(6); (b)(7)(C) signed September 27, 2019.

<sup>2</sup> Biventricular Cardiac dilation refers to enlargement of both lower pumping chambers of the heart, which prevents the heart from relaxing and filling with blood as it should.

<sup>3</sup> See accompanying Detainee Death Review for complete chronology.

During the medical intake screening, the Registered Nurse (RN) documented BALDERRAMOS complained of a rash on his arms and abdomen and prescribed him hydrocortisone cream and ammonium lactate cream to keep-on-person.

On June 18, 2019, an RN completed BALDERRAMOS's medical transfer summary documenting he had no medical history and his chest X-ray was negative for active tuberculosis but included no information about BALDERRAMOS's rash. ERO Houston transferred BALDERRAMOS to the Houston Contract Detention Facility (HCDF) in Houston, TX.

During the medical intake screening, the Licensed Vocational Nurse documented BALDERRAMOS did not have any bumps, rashes, lesions, or scars, and was not taking any medication.

On June 30, 2019, at approximately 5:38 a.m., a Detention Officer (DO) found BALDERRAMOS lying on his bunk unresponsive and immediately called a medical emergency. Medical staff directly responded and began cardiopulmonary resuscitation and a lieutenant instructed a control officer to call 911.

At approximately 5:52 a.m., Houston Fire and Rescue Emergency Medical Service (EMS) responders arrived and assumed lifesaving efforts. At 6:13 a.m., EMS responders moved BALDERRAMOS onto a gurney and proceeded to the sally port. At 6:26 a.m., the ambulance departed HCDF en route to MHNH.

At 6:37 a.m., the ambulance arrived to MHNH, and hospital staff assumed care of BALDERRAMOS. At 6:45 a.m., the doctor pronounced BALDERRAMOS deceased.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care HCDF provided BALDERRAMOS, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found one deficiency in HCDF's compliance with the ICE Performance Based National Detention Standards 2011.

1. **Admission and Release, Section (II)(7):** On June 18, 2019, BALDERRAMOS arrived to HCDF; however, HCDF staff did not complete his intake processing until June 20, 2019, two days after his admission.

If you have any questions, please contact me or have a member of your staff contact ICE OPR Unit Chief (b)(6); (b)(7)(C) at (202) 731-(b)(6); (b)(7)(C).

*Enclosure*

Yimi BALDERRAMOS-Torres Detainee Death Review Report



**Note:** Reviewers were not provided with documentation indicating medical observation status was ordered before these three nursing rounds. If (b)(6); (b)(7)(C) directed placement in the MHU pending provider evaluation, the direction was not carried out and no provider affirmed the placement.

Licensed Clinical Social Worker (LCSW) (b)(6); (b)(7)(C) conducted the required weekly mental health segregation round using interpretation assistance. He documented AMAR refused to cooperate despite numerous attempts to engage him, responding only “refuse” when mental health questions were asked. LCSW (b)(6); (b)(7)(C) wrote that the GEO officer said there were no observed mental health concerns but reported AMAR was angry about not being allowed to continue his hunger strike in the MHU; also, that he requested to be placed back in the MHU that on several occasions. AMAR was determined not suicidal, and no current mental health diagnosis was identified.

LCSW (b)(6); (b)(7)(C) so documented a mental health hunger strike follow up, again noting AMAR’s refusal to cooperate.

### **October 25, 2018**

As occurred the day before, nurses conducted a segregation round and three shift rounds suggesting AMAR was on medical observation status. All three notes include free-form narrative indicating he refused to cooperate with assessment, including taking vital signs and weight.

Lieutenant (b)(6); (b)(7)(C) RHU supervisor, completed an Administrative Detention Review form documenting he interviewed AMAR regarding his assignment to protective custody. The lieutenant repeated verbatim what Lieutenant (b)(6); (b)(7)(C) wrote at the time of the first review, writing, “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) went on to write, “He has now returned to his hunger strike declaration. He is still being offered 3 meals a day, but is choosing to decline them.” The lieutenant recommended retention of administrative segregation status. The recommendation was approved by the Warden and ICE Officer in Charge (signature illegible) the same day with copy of the form delivered to the detainee.

### **October 26, 2018**

RNs entered three encounter notes this date. In the first, the RN documented the reason for appointment was night rounds. She used the segregation template and added treatment notes suggesting hunger strike status. The second was a segregation round and the segregation template was used. Included in the RN’s note was reference to AMAR having reportedly eaten a PM snack. The third is discussed below.

**Note:** Reviewers were not provided with documentation of issuance of snacks or sack meals at any point during AMAR's detention, although available records suggest they were provided.

An Information Report by Officer (b)(6); (b)(7)(C) documents that at 4:00 p.m., he searched detainee AMAR's cell and found a rope made from clothing under the mattress. He placed the rope in the Lieutenant's office and notified the shift supervisor, Sergeant (b)(6); (b)(7)(C) and officer assigned to medical. During interview, (b)(6); (b)(7)(C) recalled that when the detainee went to the recreation yard, he searched his cell and found the rope under the mattress. He stated it was six and a half to seven feet long.

**Note:** AMAR's cell was searched in accordance with RHU Post Orders which state, "Cell searches will be conducted anytime a detainee is moved from their cell. The search will be annotated in the RHU logbook." Post Orders also state, "Whenever a detainee vacates a cell (for showers, recreation, a visit, etc.) staff are to conduct a cell inspection to include all walls, vents, and property."

**Note:** On interview, Lieutenant (b)(6); (b)(7)(C) was asked why AMAR was not charged with a disciplinary infraction for destruction of property. He stated, "ripping sheets up isn't that uncommon" and remarked that detainees rip up sheets to make belts and shoelaces.

(b)(6); (b)(7)(C) told the review team that after medical was called, a nurse who speaks Russian spoke to the detainee and held up the rope while she talked with him. The nurse was identified as (b)(6); (b)(7)(C) who, during interview, confirmed she held up the rope and asked detainee AMAR if he was trying to commit suicide. She stated he looked at her like "are you stupid?" and denied any suicidal thoughts. She stated she believed him, but acknowledged she did not know what was in his mind.

(b)(6); (b)(7)(C) entered an MHU admission note documenting AMAR was placed on suicide watch. She used interpretation assistance for the encounter. She wrote that the detainee "smiled the entire MHU suicide watch admission process", confirmed this information during interview. She also shared her observation that "it was a pretty well-made rope." In the MHU admission note (b)(6); (b)(7)(C) documented the admitting provider was (b)(6); (b)(7)(C) PhD psychologist. (b)(6); (b)(7)(C) did not make her own encounter entry and did not co-sign RN (b)(6); (b)(7)(C) note, but confirmed on interview that she directed AMAR's placement on suicide watch. She stated that after being told a rope was found in detainee AMAR's cell, she directed that he be brought to medical for assessment. GEO staff informed her that he refused to come and that they would have force him to do so by way of cell extraction. (b)(6); (b)(7)(C) said she then approached RN (b)(6); (b)(7)(C) who agreed to go to the RHU and speak with the detainee. When (b)(6); (b)(7)(C) returned, she brought the detainee with her. (b)(6); (b)(7)(C) recalled introducing herself to the detainee and that he said something like, "I don't have anything to say to you." According to (b)(6); (b)(7)(C) reported AMAR said he was not suicidal and had made the rope for a belt. She commented that it



“was not reasonable” that the rope was to be used as a belt, remarking the rope was too wide and long for that use. She stated that even if the rope had been smaller, in a high risk setting, there was “no way” she was not going to place AMAR on suicide watch.

By email timed 6:31 p.m. (b)(6); (b)(7)(C) notified GEO and ICE officials that the rope had been found and that AMAR was placed on suicide watch.

On a Special Needs Form, (b)(6); (b)(7)(C) documented that the detainee was to be placed on one-on-one suicide watch with safety smock and blanket, mattress on floor, and food with no plastic wrap or utensils. Per the Housing History Grid, detainee AMAR was assigned to MHU, cell 1A at 7:31 p.m.

**Note:** As shown in Appendix 2, an officer completed an Information Report documenting AMAR ate his full dinner meal. Based on his pattern of meal refusals, reviewers conclude this may be an error.

### October 27, 2018

(b)(6); (b)(7)(C) completed a suicide watch round with interpretation assistance. She wrote the following: “[Patient] reacted to the questions of, ‘do you feel like hurting yourself’, with smiling face and small laugh, then looked away from nurse and phone. He was asked a second time before nurse left the room and he appeared to react exactly the same. All other attempts at discussing other issues were not successful with this [patient] to engage in any conversation.”

(b)(6); (b)(7)(C) psychiatrist, documented completion of a comprehensive suicide risk assessment in a note he signed at 10:46 a.m. (b)(6); (b)(7)(C) interpreted for the encounter. Dr. (b)(6); (b)(7)(C) wrote that this was his first encounter with AMAR and that (b)(6); (b)(7)(C) placed the detainee on suicide watch the day before after a six feet long handmade rope was found under his mattress. (b)(6); (b)(7)(C) noted no self-harm behavior, and no suicidal ideation was reported by staff. AMAR was described as cooperative and pleasant, offering fair eye contact. He reported good sleep and appetite. He denied active mental health issues, hallucinations, delusions, or suicidal or homicidal ideations. AMAR also denied a history of psychiatric hospitalization, outpatient psychiatric treatment or counseling, or drug or alcohol abuse, and reported there was no family history of mental illness, history of suicide attempts, depression, or psychosis. Asked why he made a rope, AMAR stated, “I had nothing to do.” (b)(6); (b)(7)(C) reminded him “it is unsafe to be making a rope and hiding it under the mattress as it can be stolen by someone and can be used for suicide attempt, as well as hurting someone.” (b)(6); (b)(7)(C) discontinued suicide watch and placed AMAR on mental health observation with ten-minute checks by custody staff on an irregular basis. Follow up was to occur as scheduled, presumably meaning per the mental health observation protocol.

**Note:** In assessing the detainee’s suicide risk, (b)(6); (b)(7)(C) did not reference either AMAR’s hunger strike as a protest aimed at ensuring he remained in the U.S., or that his intake of food continued to be minimal.

The review team discussed the rope and its perceived significance with mental health providers during interviews. As noted, (b)(6); (b)(7)(C) stated she did not find AMAR's claim that he made it to use as a belt credible because of its length and width. According to LCSW (b)(6); (b)(7)(C), GEO staff told him the rope was a craft project, information (b)(6); (b)(7)(C) said he tended to believe despite the fact it was found hidden under AMAR's mattress. (b)(6); (b)(7)(C) CSW, remarked detainees in segregation braid things all the time. (b)(6); (b)(7)(C) reiterated AMAR's claim that he made the rope because he was bored, and emphasized that he denied suicidal thoughts and there was no indication he had a suicide plan.

AMAR's removal from suicide watch and placement on mental health observation was documented on a Special Needs Form. The conditions were ten-minute staggered checks, an RN round each shift, and a provider round and vital signs once per day. The detainee was also permitted commissary and personal property in his cell, including TV, radio, X-box, phone and books. Recreation and hygiene were encouraged.

As detailed below, detainee AMAR remained on mental health observation status until November 5, 2018. On October 28, 2018 he was moved to H Segregation for MHU overflow and was not returned to the MHU while mental health observation continued. Also as detailed, mental health providers conducted required daily rounds during the period. RNs made required nursing rounds, including rounds reflecting AMAR's overlapping mental health observation and segregation status once he was moved to H Segregation. Because the rounds are largely redundant, detail is not provided in the below chronology. In summary, the notes document AMAR consistently denied suicidal and homicidal ideation but refused to have his vital signs taken or otherwise cooperate with attempts to assess him. Many of the notes state he refused meals but ate fruit and drank Boost and Pedialyte. To the extent most nurses were able to complete them, encounters were conducted in English. (b)(6); (b)(7)(C) conducted her encounters in Russian.

#### **October 28, 2018**

(b)(6); (b)(7)(C) entered a mental health follow up note at 4:31 p.m. He documented he attempted the encounter using interpretation assistance, but AMAR refused to answer any questions. He only responded no and covered his head. During interview, LCSW (b)(6); (b)(7)(C) provided more detail, stating he placed the phone through the food port and asked AMAR to come to the door. In response, he turned away.

In a note he signed at 8:30 p.m., (b)(6); (b)(7)(C) documented (b)(6); (b)(7)(C) moved detainee AMAR to MHU overflow in segregation. According to CAPT (b)(6); (b)(7)(C) HSA, when the MHU reaches capacity, detainees determined most in need of MHU housing are given priority for housing in the unit; others are moved to segregation and flagged as MHU overflow patients. As noted previously, D3 is typically used for MHU overflow but according to (b)(6); (b)(7)(C), AMAR was placed in H Segregation because D Unit was not available.



Per the Housing History Grid, detainee AMAR was returned to cell 106 in H Segregation at 4:15 p.m. He would remain in this cell through November 15, 2018, the day of his suicide attempt.

H Segregation is NWDC's main RHU and has a capacity of 40. The unit has two tiers, each with ten double occupancy cells. There are two showers on each tier and two large, separate fenced-in outdoor recreation areas off the rear of the unit. According to Lieutenant (b)(6); (b)(7)(C) detainees on administrative segregation are allowed two hours of recreation daily in two one-hour increments. Showers are offered on Monday, Wednesday and Friday, with linen exchange. Televisions are positioned at every third cell.

Detainee AMAR was assigned to cell 106 on the lower tier. The cell door is steel and opens into the dayroom from right to left. The door has three separate viewing windows on the top half, the electronic pipe system sensor is in the center of the door, and a food/cuff port is below the sensor. Inside the cell is a stainless steel toilet/sink combination on the right front side with a steel bunk bed on the back right wall. The bunk bed has two open storage units attached to the bottom frame. A stainless steel desk with two attached stools is on the left side with an encased light above. To the left of the door inside the cell is an intercom button which alerts to Central Control. Cell doors are opened remotely from the Control Center.

#### October 29, 2018

An Administrative Segregation Order was completed by Lieutenant (b)(6); (b)(7)(C) stating that the detainee requested Protective Custody and did not request a hearing. Lieutenant (b)(6); (b)(7)(C) documented, "Detainee released by medical from constant watch. He was given the option to be housed in general population but he declined. He wished to be on Protective custody with no reason given." The form noted the detainee was housed in this status beginning on October 28, 2018. A copy of the order was provided to the detainee at 8:00 a.m.

**Note:** (b)(6); (b)(7)(C) accurately noted constant suicide watch was discontinued. However, he did not note that concurrent with protective custody, AMAR was in H Segregation as MHU overflow, on mental health observation.

A 24-hour review was conducted at the same time by (b)(6); (b)(7)(C) recommending continued administrative segregation. The recommendation was approved by the Warden the same day.

#### October 30, 2018

At 4:32 p.m. (b)(6); (b)(7)(C) documented another attempt to complete a mental health observation follow-up. He used the telephonic interpretation service for the encounter, but AMAR continued to avoid communication by pulling the bed cover over his head when asked to approach the cuff port to speak with him. (b)(6); (b)(7)(C) wrote that the mental team determined that because the detainee was non-communicative, continuation on mental health observation with irregular 10-minute irregular custody checks was necessary to assure his safety. He wrote, "The

concern for this [patient's] safety, stems from his recent making of a 6 foot rope and hiding it in his cell."

At 5:40 p.m., detainee AMAR attended recreation until 6:46 p.m. There is no record his cell was searched or inspected while he was at recreation.

**Note:** As noted above, RHU Post Orders require search anytime a detainee is moved from his cell.

#### **October 31, 2018**

(b)(6); (b)(7)(C) documented another unsuccessful attempt to evaluate the detainee. He again used interpretation assistance and wrote that the mental health team decided AMAR would remain on mental health observation with the same conditions.

According to the Daily Log, detainee AMAR showered on this date. His cell was searched twice. The Search Reports document unspecified trash was found and disposed.

#### **November 1, 2018**

(b)(6); (b)(7)(C) DS, entered an encounter note documenting AMAR was evaluated in the clinic for request to have his broken tooth extracted. The telephonic interpretation service was used for the encounter. The detainee's vital signs were within normal limits, except for a low heart rate of 59. His weight was 145.8. Based on the examination findings, the tooth was extracted with patient consent. Per the note and Special Needs Form (b)(6); (b)(7)(C) ordered a pureed diet for three days.

**Note:** This was the last time AMAR allowed his weight to be taken. Net weight loss since intake was 26 pounds.

(b)(6); (b)(7)(C) documented a mental health follow-up using the interpretation service. She wrote that when AMAR saw her coming, he smiled and shook his head when asked if he had any mental health complaints or suicidal ideation at the time. He turned to face the wall when asked additional questions. (b)(6); (b)(7)(C) te further states that AMAR was given support and encouragement and he was instructed to notify mental health or medical staff if he has any issues. She made no changes to his status.

An Administrative Detention Review form completed by Lieutenant (b)(6); (b)(7)(C) documents detainee AMAR was interviewed regarding his placement in Protective Custody. He wrote, "Detainee stated he would not live in general population and signed for protective custody. Detainee was previously on a hunger strike for an extended period of time. He is currently refusing facility provided meals, but is eating a Fruit and drinking fluids provided by medical. Detainee continues to refuse to live in general population." Lieutenant (b)(6); (b)(7)(C) commendation for retention in administrative segregation was approved by the Warden and ICE Officer in Charge (signature illegible) on the same date, with a copy delivered to the detainee.



A Search Report documents detainee AMAR's cell was searched and unspecified trash was found.

### **November 2, 2018**

(b)(6); (b)(7)(C) attempted a mental health assessment using interpretation assistance. She documented AMAR smiled and shook his head when asked if he had any mental health complaints or suicidal ideation, then turned his head away and refused to answer additional questions. His status remained unchanged.

Per the Daily Log, detainee AMAR went to recreation from 10:00 a.m. to 11:00 a.m.

**Note:** There is no record his cell was searched or inspected on this date.

### **November 3, 2018**

(b)(6); (b)(7)(C) conducted a mental health round, in English. He wrote that AMAR reportedly refused dinner and breakfast, but ate an evening snack. When asked why he was not eating, the detainee simply stated, "Refused" without elaboration. AMAR denied hallucinations, delusions, and suicidal or homicidal ideations. In his assessment (b)(6); (b)(7)(C) documented there was no mental health diagnosis at the time. He directed continuation of mental health observation with irregular ten-minute checks.

Per the Daily Log, detainee AMAR went to recreation from 3:30 p.m. to 4:08 p.m.

**Note:** There is no record his cell was searched or inspected on this date.

### **November 4, 2018**

(b)(6); (b)(7)(C) attempted another mental health follow up with the same result. He again used interpretation assistance. He wrote that AMAR was sitting at his table and when he saw the LCSW approach, he jumped up and went under the covers on his bed. He would not respond to any questions. Officers reported the detainee had gone to recreation when offered but had not showered in four days; also, that he was continuing to refuse meals. (b)(6); (b)(7)(C) determined that because AMAR was not responding to any questions about his mental state, refused to respond to questions regarding suicidality, and was not presenting any consistent stable behavior, he would remain on mental health observation with ten-minute irregular custody checks. His case would be reviewed by the mental health team the following day to consider disposition.

An Evidence/Search Report written by Officer (b)(6); (b)(7)(C) documents search of AMAR's cell at 6:22 p.m. resulted in discovery of a sheet torn in thirds as well as empty milk containers and Pedialyte bottles. Consistent with policy, the search was conducted while the detainee AMAR was participating in recreation. Officer (b)(6); (b)(7)(C) disposed of the items as trash and did not write an incident report or disciplinary report charging AMAR with destruction of facility property. She did not document the search or findings in the logbook although she stated during interview that it is her normal practice is to do so. She stated she was not aware a rope had been found hidden in

AMAR's cell on October 26, 2018. She said that if she had known, she would have written an Informational Report (IR).

**Note:** When asked on interview if he receives copies of RHU search reports, Lieutenant (b)(6); (b)(7)(C) stated the forms are sent to the administrative lieutenant and he does not receive a copy unless a disciplinary report is written as he is the disciplinary hearing officer.

**Note:** The Special Management Unit standard defines destroying clothing or bedding as extreme behavior that must be reported to the Field Office Director.

**Note:** Ostensibly because tearing sheets for use in craft projects is not uncommon, healthcare staff were not notified. HSA Nussbaum stated on interview that she became aware a torn sheet had been found this date only when she began preparing documents for the ERAU death review. She questioned why AMAR had not been charged with a disciplinary violation for destruction of property.

### November 5, 2018

AMAR was seen by mental health professionals twice this date. The first encounter was conducted by CDR (b)(6); (b)(7)(C) LCSW, who wrote AMAR declined use of an interpreter. He denied mental health issues/concerns and suicidal ideation, then refused to engage with her further. When asked if he wanted a word search puzzle, AMAR did not answer. Instead, he went to his bunk, laid down, and turned away from her. She slipped the puzzle under his door in case he wanted it later. Her assessment finding was no current mental health diagnosis. She did not address continuation of mental health observation status.

LCSW (b)(6); (b)(7)(C) entered a mental health follow up encounter note, documenting that he again used interpretation assistance. As before, the detainee covered his head and refused to respond to questions despite repeated attempts to engage him. LCSW (b)(6); (b)(7)(C) noted that during the earlier encounter with LCSW (b)(6); (b)(7)(C) AMAR denied any suicidal or homicidal ideations, and that GEO staff reported he had not presented any mental health concerns. He also noted AMAR's refusal of meals but consumption of fruit and supplements. LCSW (b)(6); (b)(7)(C) concluded the narrative section of his note as follows: "This [patient's] case has been reviewed by the MH team. Since (b)(6); (b)(7)(C) chart notes indicates that this [patient] does not have any MH issues and since all staff that have been able to interact with this [patient] have reported that [patient] does not endorse any [suicidal ideation/homicidal ideation] or [audio and visual hallucinations], the MH team concluded that this [patient] can be released from MH observation and discharged from the MHU." A follow up appointment was scheduled for the next day.

**Note:** The follow appointment was not completed.

LCSW (b)(6); (b)(7)(C) entered a second encounter note documenting discontinuation of mental health observation. In answer to many questions on the eCW form, he referred back to his previous note



for detail. The discharge diagnosis was adjustment disorder, to which the LCSW added remarks that the detainee was displaying safe behaviors, reporting future focus, sense of resiliency and belief system that discourages suicide; also that he agreed to commitment of treatment plan and safety plan.

**Note:** AMAR consistently refused to speak with mental health providers; therefore, the basis for (b)(6); (b)(7)(C) documentation that the detainee was reporting future focus, sense of resiliency and belief system that discourages suicide, or that he agreed to commit to treatment and safety plans is unclear. It is possible the remarks are pre-populated in the eCW note and were not amended.

In the summary of AMAR's MHU/MHU overflow stay, the LCSW noted he was admitted to MHU for suicide watch and downgraded to MHU observation with ten-minute irregular checks. Ongoing safe behaviors were observed and reported. AMAR was assessed for risk versus protective factors and deemed at low acute suicide risk. The least restrictive environment was identified as general population housing. (b)(6); (b)(7)(C) signed the note three days later.

**Note:** Detainee AMAR was not returned to general population as authorized by the mental health team, presumably because he was on protective custody concurrent with mental health observation. When mental health observation ended, protective custody status continued. There is no documentation of communications between healthcare and security personnel addressing termination of mental health observation.

During interviews, mental health professionals were asked for any comments about discontinuation of mental health observation, including whether the decision would have been different had the team known a torn sheet was found hidden in AMAR's cell the day before. Dr. (b)(6); (b)(7)(C) said mental health observation was discontinued because while it was recognized the detainee was not cooperative, "everybody decided he wasn't suicidal" and there was no indication he had any mental health problems. She commented that staff at NWDC are very cautious and received no pressure to discontinue either suicide watch or mental health observation. Regarding the discovery of a torn sheet the day before, she said AMAR showed no signs of suicidality; therefore, the decision to discontinue mental health observation would not have changed had the team known. By contrast, LCSW (b)(6); (b)(7)(C) said that had he been told about the sheet, he would have asked AMAR about it and would at least have continued mental health observation. He said he may have even placed him on constant watch because then, he "would have had a reason to do it." (b)(6); (b)(7)(C) said he was comfortable with the mental health team's decision to discontinue mental health observation based on available information. He stated they are professionals who used their judgment. He also commented that while in segregation, AMAR would be checked every 30 minutes.

**Note:** The mental health team approved AMAR for return to general population. As discussed below, he remained in H Segregation on protective custody and therefore, was

subject to 30 minute checks as (b)(6); (b)(7)(C) noted. However, continuation on that status was the province of security personnel and could have changed at any time.

The Daily Log for November 5, 2018 documents detainee AMAR went to recreation from 4:40 p.m. to 5:45 p.m. There is no record his cell was searched or inspected on this date.

### **November 6 - 14, 2018**

Detainee AMAR continued on administrative segregation for protective custody in H Segregation, cell 106 over the course of these nine days. Pertinent and noteworthy events are summarized as follows:

- RNs completed all required segregation rounds over the period. They used the segregation template, often adding notes addressing AMAR's consumption of fruit and supplements.
- On November 8, 2018 Lieutenant (b)(6); (b)(7)(C) completed an Administrative Detention Review form documenting he interviewed AMAR concerning his placement on protective custody. The Lieutenant documented the same information as he had during past reviews; specifically, "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." He added that AMAR "declared hunger Strike but is accepting other forms of nutrition including fresh fruit when it's on the menu." Lieutenant (b)(6); (b)(7)(C) recommendation for continuation of the status was approved by the Warden and ICE Officer in Charge (signature illegible) on the same date with a copy delivered to the detainee.
- Per entries to the H Segregation Daily Log, AMAR began accepting meals starting November 12, 2018.
- Entries to the Daily Logs document detainee AMAR went to recreation each day. The only day his cell was searched was November 7, 2018. This was the last documented search of detainee AMAR's cell prior to the medical emergency on November 15, 2018.
- On November 13, 2018, LCSW (b)(6); (b)(7)(C) documented the first weekly segregation round since mental health observation was discontinued. AMAR declined the option of using a Russian interpreter. The LCSW wrote that while lying on his bed, the detainee looked up briefly, denied any mental health issues or concerns, and then refused to further engage in conversation. The assessment finding was that there was no current mental health diagnosis.
- On November 14, 2018, AMAR refused a linen exchange.



## November 15, 2018 – Day of Medical Emergency

(b)(6); (b)(7)(C) documented a 30-day review of AMAR's medical record, confirming nurses and mental health providers made regular rounds. Her note states she sent a memorandum reporting her findings to the Warden and AFOD.

At 9:00 a.m., Lieutenant (b)(6); (b)(7)(C) completed an Administrative Detention Review form documenting he interviewed AMAR regarding his placement in protective custody. He again 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" (b)(6); (b)(7)(C) added, "He has been eating the facility provided meal regularly since 11/12/18. He would like to return to general population." Detainee AMAR signed a statement, in English, stating that he requested removal from protective custody. The Warden signed the form approving Lieutenant (b)(6); (b)(7)(C) recommendation that the detainee be returned to general population. The signature of an ICE official does not appear on the form, a copy of which was delivered to the detainee.

During interview, Lieutenant (b)(6); (b)(7)(C) stated that he had the unit officers ask detainee AMAR if he wanted to go to general population. Per the H Segregation Logbook, the officers assigned to the post for the shift were (b)(6); (b)(7)(C) Officer (b)(6); (b)(7)(C) informed Lieutenant (b)(6); (b)(7)(C) that she thought the detainee agreed to go to general population when she spoke with him. The Lieutenant then had Officer (b)(6); (b)(7)(C) confirm with detainee AMAR that he wished to return to general population. Officer (b)(6); (b)(7)(C) told him the detainee gave a thumbs up when asked. On interview, Officer (b)(6); (b)(7)(C) stated detainee AMAR understood very little English but she was able to communicate with him using hand signals. On this date, she remembered asking him if he wanted to go to general population and he replied yes. She then confirmed by asking if he wanted to "go out there with everyone else". She stated that detainee AMAR replied "I want out GP" and then repeated "G3, G3", referring to the dorm where he was assigned before his hunger strike. Officer (b)(6); (b)(7)(C) informed the review team that G3 was not an option because the unit was closed at the time. As noted below, Lieutenant (b)(6); (b)(7)(C) researched where other Russian detainees were housed so detainee AMAR would have others to speak with and visit when he moved.

Lieutenant (b)(6); (b)(7)(C) informed the review team that he reported AMAR's request to move to general population at the weekly administrative meeting where detainees in the RHU are discussed. Attendees at the meeting include the Warden, Associate Warden, Major, RHU Lieutenant, ERO personnel, and IHSC medical and mental health staff. Asked which mental health professionals attended the meeting, LCSW (b)(6); (b)(7)(C) said he did not recall. Although usually held at 1:00 p.m., the meeting was held at 11:00 a.m. During interview of AFOD (b)(6); (b)(7)(C) he recalled the group was informed AMAR was eating and in great spirits. He speculated that the detainee was unaware that he lost his appeal and was to be deported. AFOD (b)(6); (b)(7)(C) requested the opportunity to have a Deportation Officer (DO) meet with AMAR to deliver the news before he was transferred to general population. He explained to reviewers that he wanted to have the information conveyed in a controlled environment in case AMAR reacted badly (b)(6); (b)(7)(C) called that the



Warden expressed concern about delaying release from the RHU of a detainee who no longer wanted protective custody. As detailed below, (b)(6); (b)(7)(C) met with AMAR at 1:40 p.m.

**Note:** There is no documented or reported information that mental health staff in attendance arranged to meet with AMAR after he was told he lost his appeal.

In an email timed 1:19 p.m., Lieutenant (b)(6); (b)(7)(C) notified AFOD (b)(6); (b)(7)(C) and Supervisory Deportation and Detention Officer (SDDO) (b)(6); (b)(7)(C) that (b)(6); (b)(7)(C) once approved for transfer, AMAR would be moved to the A3 unit. The Lieutenant indicated there were three detainees in the unit with whom AMAR may be able to socialize. The detainees were from Romania, Russia and Nepal. At 1:31 p.m., SDDO (b)(6); (b)(7)(C) informed Lieutenant (b)(6); (b)(7)(C) by email that DO (b)(6); (b)(7)(C) would meet with detainee AMAR. SDDO (b)(6); (b)(7)(C) stated during interview that the meeting was set in motion pursuant to AFOD (b)(6); (b)(7)(C) direction to have the detainee informed he was to be removed from the U.S. before he was released from the RHU.

During interview of DO (b)(6); (b)(7)(C) he confirmed that SDDO (b)(6); (b)(7)(C) asked him to meet with detainee AMAR and inform him that his appeal had been denied and he was going to be deported. He detailed the instruction and his meeting with the detainee in a memorandum to AFOD (b)(6); (b)(7)(C) dated November 21, 2018, six days after AMAR's suicide attempt. Asked about the delay, DO (b)(6); (b)(7)(C) stated he wished he had written it the day the detainee attempted suicide but, he "wasn't in a frame of mind" to do so. In the memorandum, (b)(6); (b)(7)(C) documented he first heard from SDDO (b)(6); (b)(7)(C) by email timed 11:17 a.m. (b)(6); (b)(7)(C) replied that he had not yet disclosed AMAR's removal date to him. During interview, (b)(6); (b)(7)(C) said the detainee was scheduled for removal on November 26, 2018 and he delayed notification because he was aware of AMAR's hunger strike and brief placement on suicide watch. Per his memorandum, (b)(6); (b)(7)(C) received another email from SDDO (b)(6); (b)(7)(C) at 12:16 p.m. instructing him to meet with AMAR as soon as possible. Very soon thereafter, the SDDO reminded him in person that he was to see the detainee.

Video surveillance footage from H Segregation shows (b)(6); (b)(7)(C) arrived at 1:40 p.m. and proceeded to AMAR's cell. After he was placed in handcuffs, AMAR exited the cell and was escorted to the Lieutenant's office to speak with (b)(6); (b)(7)(C). During interview, he stated he used the telephonic interpretation service during the meeting. (b)(6); (b)(7)(C) wrote in his memorandum that he asked AMAR if he was up-to-date with the most recent decision. The detainee replied he had not received any updates. (b)(6); (b)(7)(C) then informed AMAR that the Board of Immigration Appeals had dismissed his appeal and that pursuant to a final order for removal, arrangements would be made to proceed with his removal from the U.S. to Russia. Detainee AMAR replied that he cannot return to Russia because he was afraid. During interview, (b)(6); (b)(7)(C) quoted AMAR as having said, "I can't go back." Per the memorandum, (b)(6); (b)(7)(C) explained to AMAR that his appeal having been dismissed, and an immigration judge having issued a removal order, he had to proceed with removal arrangements. (b)(6); (b)(7)(C) documented that detainee AMAR acknowledged he understood. When asked if he wanted to request that property be sent to him by family or friends, he replied that he had no family or friends in the U.S.



The video surveillance footage shows AMAR exiting the Lieutenant's office at 1:54 p.m., 12 minutes after he entered. After he was placed back in his cell, the officers returned to their desk and (b)(6); (b)(7)(C) left the unit. The officers did not make an entry in the unit logbook documenting this event.

Officer (b)(6); (b)(7)(C) stated on interview that (b)(6); (b)(7)(C) did not tell them what the meeting with AMAR was about. Asked during interview if he considered letting the officers know he had delivered bad news to AMAR, (b)(6); (b)(7)(C) stated that GEO officers are not sworn law enforcement officers and only staff with a need to know are kept apprised of deportation information. (b)(6); (b)(7)(C) told the review team that detainee AMAR "appeared to be good" when she returned him to his cell, and when she asked, "Are you good?" the detainee replied yes. In her report written following the emergency, (b)(6); (b)(7)(C) documented AMAR "had a normal baseline, nothing out of the ordinary" when she escorted him back to his cell. Asked what that meant, she told the review team that his normal baseline was sleeping, reading a book or writing and not talking very much. She noted no obvious signs of distress such as crying or agitation.

By email timed 1:57 p.m., (b)(6); (b)(7)(C) notified SDDO (b)(6); (b)(7)(C) finished meeting with AMAR and asked to be apprised when his transfer to A3 could proceed. At 2:11 p.m., SDDO (b)(6); (b)(7)(C) replied that she awaited confirmation from the AFOD who was in a meeting with the Warden. In an email to Lieutenant (b)(6); (b)(7)(C) timed 2:17 p.m., SDDO (b)(6); (b)(7)(C) wrote, "Good to go on Amar." The lieutenant stated on interview that since it was close to shift change he decided to have detainee AMAR moved following shift change. He stated that he intended for the move to be made prior to the formal count at 4:30 p.m. and the evening meal which is served at 5:30 p.m. Officer (b)(6); (b)(7)(C) confirmed on interview that releases from protective custody are typically completed on swing shift.

Detainee AMAR's suicide attempt occurred before the transfer was made. Based on the reviewer's analysis of housing unit video, Officer (b)(6); (b)(7)(C) began the final health and wellness check of her shift at 2:39 p.m.

**Note:** As previously discussed, post orders require health and wellness checks every 30 minutes. Review of logbook entries and electronic pipe system records confirmed that officers completed checks no more than 30 minutes apart throughout the shift.

The video shows Officer (b)(6); (b)(7)(C) began her round at the first cell on the lower tier across from the entry door. As she moved along the tier, she looked into each window and inserted the pipe into the sensors in the cell doors. The pipe system report documents the sensor was activated at AMAR's cell, 106, at 2:40 p.m. The video shows Officer (b)(6); (b)(7)(C) moved quickly past the cell, but she explained on interview that AMAR was standing up and looking at her. She said that if she does not pause at a cell, it is because the occupant is clearly visible and alright. The video shows Officer (b)(6); (b)(7)(C) took more time at other cells, carefully looking through the windows. Given the

totality of the evidence, the reviewer concludes that Officer (b)(6); (b)(7)(C) did a thorough round and ensured she saw “living breathing flesh” at each cell, including AMAR’s.

Per the video, Officer (b)(6); (b)(7)(C) arrived in H Segregation at 3:00 p.m. and Officer (b)(6); (b)(7)(C) immediately exited. Officer (b)(6); (b)(7)(C) explained during interview that because Officer (b)(6); (b)(7)(C) was starting her days off, they had agreed that Officer (b)(6); (b)(7)(C) would leave as soon as the first relief officer arrived. Officer (b)(6); (b)(7)(C) briefed Officer (b)(6); (b)(7)(C) and at 3:04 p.m., Officer (b)(6); (b)(7)(C) arrived on the unit. Officer (b)(6); (b)(7)(C) departed the unit soon thereafter. At 3:06 p.m., Lieutenant (b)(6); (b)(7)(C) exited his office and proceeded to the exit door to leave for the day. Officer (b)(6); (b)(7)(C) began his health and wellness check at the same time.

The pipe system report documents the sensor was activated at cell 106 at 3:06 p.m., 26 minutes after Officer (b)(6); (b)(7)(C) last health and wellness check. When he arrived at the cell, Officer (b)(6); (b)(7)(C) stopped and called to the lieutenant, who had not yet exited the unit, to bring the Life Knife<sup>14</sup>. He also called on his radio for Control to activate the IMS for a detainee engaged in self-harm. The Control Logbook documents that the IMS was activated at 3:07 p.m.

**Note:** As described above, IMS (Incident Management System) is a three tiered response system designed to ensure that the right personnel and equipment are present for an emergency response. Per facility policy, a detainee engaged in self-harm qualifies as a Phase I incident requiring response by internal personnel, only.

In his written Information Report, Officer (b)(6); (b)(7)(C) documented that when making his round, he arrived at cell 106 and observed “what appeared to be him sitting on the floor of the cell with his feet laying towards the cell door. I observed a clothing item over his face with a twine rope made from what appeared to be a sheet wrapped around the top of the bunk down to his neck.” On interview, Officer (b)(6); (b)(7)(C) stated that the noose was made of ripped up bed sheets.

Video shows Officer (b)(6); (b)(7)(C) went to cell 106 and then to the Lieutenant’s office to retrieve the shield<sup>15</sup>. At 3:07:03 p.m., Officers (b)(6); (b)(7)(C) were present at cell 106 but did not ask Central Control to open the cell door. The video shows that in the meantime, Lieutenant (b)(6); (b)(7)(C) immediately returned to his office and put down the items he was carrying. He returned to the exit door, which opens into the unit’s sally port. Within the sally port is a tool cage where the Life Knife is maintained.

As the lieutenant entered the sally port, (b)(6); (b)(7)(C) returned to the unit. She stated on interview that she heard the IMS call for a detainee engaging in self-harm and wondered, “which detainee?” Upon entering, she saw Officer (b)(6); (b)(7)(C) at cell 106 with another officer, with shield.

<sup>14</sup> The Life Knife is commonly known as a 911 knife, or cut down tool. The J shaped knife allows for safe and quick cutting of most fabrics and is used to cut a detainee down without causing further injury.

<sup>15</sup> A Plexiglas shield is used for cell entries in RHUs for the purpose of fending off a combative detainee or a weapon, if present, and provides safety to the other officers responding.



The video shows Officer (b)(6); (b)(7)(C) arrived at cell 106 at 3:07:14 p.m. after putting on gloves. Although there were three officers present, the door to the cell remained closed. At 3:07:20, three additional officers entered the unit. Lieutenant (b)(6); (b)(7)(C) handed the Life Knife to one of the officers as they passed, and that officer handed it to another ahead of him. At 3:07:38, with six staff present, the door was remotely opened by Control. In his written report, Officer (b)(6); (b)(7)(C) wrote, "Officer (b)(6); (b)(7)(C) and I stacked up outside the door waiting for responders. Officers (b)(6); (b)(7)(C) responded and at this time I told control via radio to access cell 106."

Lieutenant (b)(6); (b)(7)(C) was asked during interview how many staff must be present before a cell door is opened in an RHU. He responded, "We put it at three", referencing facility policy 3.4.1 which states, "If a detainee in RHU attempts suicide staff must wait for at least one additional staff member to arrive before entering the cell to assist the detainee." Lieutenant (b)(6); (b)(7)(C) stated that since two officers are assigned to the RHU, the policy requires a third officer to be present before a cell door is opened. The reviewer's analysis of RHU Post Orders identified conflicts with this interpretation. First, the Post Orders state, "(b)(7)(E) must be present when an H Segregation cell door is accessed." Second, the Post Orders include a specific section on suicide prevention which lists ICE Office of Detention and Removal High Risk Times and Places. Included among them are shift changes, change in legal status, special housing status, and single-cell segregation. This section states an officer's responsibility when they see a detainee in the process of attempting to commit suicide is to, "Preserve the life of the detainee by taking immediate, appropriate action." Procedures for fulfillment of that responsibility specify, "If the incident occurs in a Restricted Housing (*sic*) Unit, or Medical Isolation unit, you must wait for at least one additional staff member to arrive before entering the cell."

**Note:** Regardless of policy interpretation, there was minimal delay in entering detainee AMAR's cell. Had the door been opened when two officers were present, the cell would have been accessed 35 seconds sooner. Had the cell door been opened when three officers were present, the cell would have been accessed 24 seconds sooner.

Officers' descriptions of events following entry to the cell, as provided during interview and in written reports, is summarized as follows:

Officer (b)(6); (b)(7)(C) entered the cell first, with shield. Upon entry, he cleared the cell and put the shield to the side as the other officers entered. Officers observed the rope was tied around the back left top corner of the bunk bed. Officers (b)(6); (b)(7)(C) lifted AMAR to relieve the pressure on his neck while Officer (b)(6); (b)(7)(C) cut the noose from the bunk bed first, then from around the detainee's neck. Officer (b)(6); (b)(7)(C) described the rope as very tight, stating he could barely get his fingers between the rope and the detainee's neck. Officer (b)(6); (b)(7)(C) stated that the detainee's face was blue and lips were white when he was cut down. The officers then pulled the detainee outside the cell and into the dayroom. Purple indentations were observed where the rope had been. Officer (b)(6); (b)(7)(C) used the Life Knife to remove AMAR's sweatshirt and T-shirt.

Officer (b)(6); (b)(7)(C) shined a light in the AMAR's eyes but saw no pupil dilation. He stated he was about to begin CPR when PA (b)(6); (b)(7)(C) arrived.

Based on video surveillance footage, the officers moved AMAR from his cell to the dayroom at 3:07:57 p.m. (b)(6); (b)(7)(C) entered the unit less than a minute thereafter, with wheelchair. (b)(6); (b)(7)(C)'s encounter note documents AMAR was lying unresponsive on the floor and not breathing when he arrived with the initial medical response team and equipment. The airway was checked for obstruction, a sternal rub elicited no response, and a carotid pulse was unpalpable. CPR chest compressions were initiated, and accompanying nurses and GEO officers were ordered to call 911.

(b)(6); (b)(7)(C) recalled on interview that AMAR's chest was bare and officers were trying to rouse him when she and (b)(6); (b)(7)(C) arrived. She described the detainee as "still warm" but "very pale and completely lifeless." She stated he looked like he had a purple tattoo around his neck from the deep mark made by the rope. (b)(6); (b)(7)(C) said she wiped AMAR's chest and applied the automated external defibrillator (AED) pads. She then started the AED and placed the ambubag. She said that an officer helped hold the bag in place but it was difficult to get air in. She stated that she was getting a rise in the abdomen but not the chest. The video shows two additional medical staff arrived after (b)(6); (b)(7)(C) and that a gurney and backboard were brought to the scene.

Among the GEO personnel who responded to the emergency call were (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) stated during interview that he instructed Officer (b)(6); (b)(7)(C) to call 911. Asked why he had Officer (b)(6); (b)(7)(C) place the call instead of Central Control, he explained Officer (b)(6); (b)(7)(C) had immediate access to AMAR's ID card and was better able to answer questions 911 dispatchers often ask. Officer (b)(6); (b)(7)(C) said he grabbed detainee AMAR's ID and went to the Lieutenant's office to place the call. When he could not access an outside line, Officer (b)(6); (b)(7)(C) notified Sergeant (b)(6); (b)(7)(C) whereupon the sergeant tossed him his cell phone. Sergeant (b)(6); (b)(7)(C) estimated that Officer (b)(6); (b)(7)(C) ability to place the call using an internal line "probably cost us 30 seconds" in reaching 911. According to the Tacoma Fire Department report, the call was received at 3:11 p.m., four minutes after IMS was activated, and a vehicle was dispatched at 3:12 p.m.

Sergeant (b)(6); (b)(7)(C) also responded to the IMS call. He stated he began to arrange for two officers to escort the detainee to the hospital. He also posted two officers at perimeter gate 6 and instructed staff to leave the gate open for ease of access for Emergency Medical Services (EMS).

Video from the perimeter gate 6 area shows the officers were in place at 3:12:32 p.m. The perimeter gate was open. At 3:15:43 p.m. a fire truck entered the perimeter and at 3:16:24 p.m. an ambulance entered.

Video footage from the housing unit camera shows a total of nine EMS and fire department personnel entered the unit within approximately six minutes after IMS was activated. PA



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

encounter note documents the facility responders completed four to five cycles of CPR, using the AED, before the EMS team arrived and assumed care. Per the Tacoma Fire Department report, AMAR was unconscious, unresponsive, pulseless, and not breathing. His skin was warm, dry, and pale, and he had obvious ligature marks around his neck.

Video shows that at 3:25 p.m., EMS personnel left the unit and returned with a gurney. AMAR was placed on the gurney and wheeled off the unit in less than three minutes. In total, EMS responders were in H Segregation for approximately 12 minutes.

Most of the emergency response was also captured on a handheld video camera. The video, which started as officers moved AMAR from his cell to the dayroom, was taken by Lieutenant (b)(6); (b)(7)(C) initially, then by Officer (b)(6); (b)(7)(C)

Officer (b)(6); (b)(7)(C) stated that she was handed a second camera when she responded to the emergency but the battery immediately went dead when she started to record. Another battery was brought to the scene but it, too immediately went dead. A third battery was operable and Officer (b)(6); (b)(7)(C) believed she successfully recorded events through departure of the ambulance. However, when she looked for the footage she discovered she had not recorded anything. She stated she must have neglected to press the record button.

Because handheld video cameras afford a closer view and also record audio, additional detail is provided by the footage taken by Lieutenant (b)(6); (b)(7)(C). When EMS responders took over they immediately placed an IV through which they administered epinephrine<sup>16</sup> two times. Five minutes later, they asked how staff concluded the detainee had been hanging for 20 minutes. Someone replied that he was seen at 2:40 p.m. and found hanging at 3:06 p.m. An EMS responder stated, "OK, so that would have been 25 minutes." AMAR was intubated<sup>17</sup> and after approximately four minutes, the airway tube was removed and an ambubag was placed back on him. After ten minutes of emergency care, an EMS responder stated, "OK, I've got a pulse", mentioning the femoral artery. AMAR was lifted onto the gurney and taken off the unit quickly thereafter.

Video from perimeter gate shows the ambulance departed the facility at 3:34:50 p.m., followed by the fire engine. Officers (b)(6); (b)(7)(C) were assigned to the hospital detail, Officer (b)(6); (b)(7)(C) in the ambulance and Officer (b)(6); (b)(7)(C) driving the chase vehicle. Officer (b)(6); (b)(7)(C) stated on interview that he responded to the IMS call and was instructed by a supervisor to report to the armory and prepare a vehicle to follow the ambulance. From the armory, he secured a weapon, a ballistics vest and oleo capsicum spray as well as the trip kit which contains post orders, restraints and a log book. When he saw EMS coming out of H Segregation, he ran to his vehicle and started following once it moved through the exit gate. Officer (b)(6); (b)(7)(C) reported that

<sup>16</sup> Epinephrine is a hormone which supports heart function in the event of an emergency.

<sup>17</sup> Intubation refers to the process of inserting a tube through the mouth and into the airway.

the ambulance activated lights and siren and that a Tacoma Police Department patrol car followed the chase car.

(b)(6); (b)(7)(C) informed the review team that he was the fourth or fifth responder to arrive in response to the IMS call. He was part of the team that entered the cell and saw staff cut the rope from detainee AMAR's neck. Because the cell was very crowded, he stepped out to give others room and he never had hands on the detainee. He left H Segregation briefly when asked to retrieve a gurney from medical and upon return, was instructed by Sergeant (b)(6); (b)(7)(C) to prepare to accompany AMAR in the ambulance. Officer (b)(6); (b)(7)(C) stated that although he typically rides in the back of the ambulance when assigned to hospital details, EMS responders ask him to sit in front so they would have sufficient room to work on AMAR.

An entry to the Hospital Logbook documents the time of arrival at Saint Joseph's Hospital (CHI Franciscan Health) was 3:42 p.m. According to the hospital discharge summary, AMAR regained a heart rhythm following two rounds of CPR and one dose of epinephrine<sup>18</sup> while in the emergency department. In response to respiratory failure he was intubated, followed by transfer to the intensive care unit (ICU) for further care and treatment. An entry to the Hospital Logbook timed 5:15 p.m. documents AMAR's placement in the ICU followed a doctor's statement that he was not breathing on his own and announcement of brain death.

As noted above, a Tacoma Police Department patrol car followed the NWDC chase vehicle to the hospital. The patrol officer, (b)(6); (b)(7)(C) filed a report documenting that the charge nurse informed him AMAR had a heart rate but was not able to breathe on his own and was believed to be brain dead. Officer (b)(6); (b)(7)(C) report states that thereafter, the detainee was moved to the ICU pending evaluation by a neurologist. He further wrote that upon personal inspection, no signs of trauma were found on detainee AMAR, confirmed by two hospital staff. The detainee was wearing a C-collar which could not be removed due to concerns for a broken neck. The officer and hospital staff inspected AMAR's neck through the gaps in the collar and found nothing remarkable.

The following summarizes events and actions taken at NWDC following departure of EMS:

- Officer (b)(6); (b)(7)(C) is NWDC's designated crime scene officer. He stated during interview that he has had training in evidence and crime scene handling and in addition to serving as crime scene officer, he is in charge of the armory. Within minutes following departure of EMS, Officer (b)(6); (b)(7)(C) seen on video entering H Segregation with an evidence kit. He then placed crime scene tape around the area of the medical emergency and over the cell door. He reported that he notified Master Control that the door to cell 106 was not to be opened without the Warden's permission. The Warden and AFOD Bostock arrived in the unit shortly after Officer (b)(6); (b)(7)(C)

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<sup>18</sup> Epinephrine is a hormone, often used in medical emergencies to stimulate the heart and increase blood flow.



- Tacoma Police Department Officer (b)(6); (b)(7)(C) filed a written report documenting she arrived at NWDC while EMS responders were still on the scene. The report states that she interviewed Officer (b)(6); (b)(7)(C) and examined the cell with a forensics officer who took photographs. Officer (b)(6); (b)(7)(C) documented that the ligature was collected and was in two pieces. She wrote the following:

“The ligature appeared to be made of the same material as the bed sheet. It appeared to be similar in color and texture. The ligature appeared to be made of strips of the sheet fabric that was braided. The sheet from the bed was examined and photographed. There were documents inside the cell on the top bunk that appeared to be copies of internal documents of the facility. It was titled Evidence/Search Report. The report dated 11/8/18 indicated that the bed sheet removed from the cell on that day had been ripped into thirds. It appeared that (O) [sic] Amar may have been collecting the fabric material since 11/8/18.”

**Note:** Reference to 11/8/18 as the date of Evidence/Search Report appears to be an error. The accompanying photograph taken by police shows the date was November 4, 2018, consistent with the information described in the above chronology.

In his written report, Sergeant (b)(6); (b)(7)(C) documented the forensic officer removed four pieces of evidence from the cell and departed the unit at 5:19 p.m. The items removed were one pair of blue uniform pants, one sheet that had been ripped and two pieces of braided sheet made into a rope.

- Also in his report, Sergeant (b)(6); (b)(7)(C) documented that at 5:33 p.m., he and Officer (b)(6); (b)(7)(C) searched cell 106. They videotaped the search; however, at 5:51 p.m., the search was suspended because the camera battery died. A new battery was brought to the scene and the search resumed at 5:54 p.m. It concluded at 6:16 p.m.

**Note:** This was the third battery to fail this date. Sergeant (b)(6); (b)(7)(C) stated there are five handheld cameras available at NWDC, two in Central Control, one assigned to the roving/escort officer, and two maintained in the supervisor’s office. He stated the cameras are placed on a charger which shows a green light when a battery is fully charged; however, batteries drain immediately once the camera is turned on. Sergeant (b)(6); (b)(7)(C) stated this is the result of batteries not being properly rotated.

- Video from the H Segregation camera shows that within 20 minutes of the EMS responders’ departure, (b)(6); (b)(7)(C) arrived and started meeting with detainees one-on-one in the Lieutenant’s office to offer supportive counseling.
- Video taken on a handheld camera records staff’s verbal accounts of the emergency response. The video, which is 5:53 minutes in duration, opens with Lieutenant (b)(6); (b)(7)(C)

stating the time was 4:00 p.m. on November 15, 2018. He stated the detainee was discovered in cell 106 at shift change and that medical responded promptly and started CPR. Each officer involved then spoke directly to the camera, stating their name and describing the actions they took during the emergency.

- Chief of Security (b)(6); (b)(7)(C) stated he met with all but two staff responders prior to their departure from the facility and offered them services through the Employee Assistance Program (EAP). The other two staff had departed but were contacted by telephone the same day. Staff interviewed by the review team confirmed they were offered EAP.

(b)(6); (b)(7)(C) reported his supervisors apprised him of available employee assistance services, as well. In his November 21, 2018 memorandum, he wrote that he was very disturbed when informed by SDD (b)(6); (b)(7)(C) that detainee AMAR made a suicide attempt that appeared serious. During interview, (b)(6); (b)(7)(C) remarked that deportation officers are human and are impacted by detainees who beg and plead not to be deported, but the decision lies with the Court.

- With three exceptions, GEO staff who responded to the medical emergency submitted Incident Reports. (b)(6); (b)(7)(C) did not submit reports. Officer (b)(6); stated during interview that she was not told to write a report, and did not ask if she should. She did acknowledge that everyone who responds to an emergency should write a report. Sergeant (b)(6); was not aware Officer (b)(6); did not submit a report until asked about it on interview. He stated she should have written a report, adding that ensuring IRs are prepared is a shared responsibility between the officer and supervisor.

### **November 16, 2018 – November 24, 2018**

Detainee AMAR remained hospitalized over this period. GEO officers made appropriate entries to the Transport Logbook throughout his hospitalization, highlights of which may be found in Appendix 3.

There were no hospital updates documented in the medical record. Based on the reviewer's analysis of the CHI Franciscan Health Discharge Summary, AMAR remained non-responsive during his hospitalization, despite the fact he was not sedated. Following tests for brain activity, certification of brain death was signed at 4:45 p.m. on November 18, 2018. On November 21, 2018 four family conferences were conducted via telephone with the patient's mother and father in Eastern Russia, Khabarovsk to discuss their son's prognosis and plan for withdrawal of care. The calls occurred on November 21 and November 23, and two on November 24, 2018.

Hospital logbook entries on November 24, 2018 document that at 8:10 a.m., the doctor advised vigil officers that he would be calling the family at 4:00 p.m. Throughout the day, hospital staff changed the IV and cleaned and repositioned the detainee.



Officer (b)(6); (b)(7)(C) (first name unknown) were assigned to hospital vigil duty starting at 3:00 p.m. Entries to the Transport Log document that at 3:30 p.m., a nurse cleared AMAR's airway and that his blood pressure was low. At 4:18 p.m., the doctor requested an update from the nurse before his discussion with detainee AMAR's mother. At 5:52 p.m., the nurse announced AMAR would be removed from the ventilator and allowed to expire; also, that his organs would not be harvested. Officer (b)(6); (b)(7)(C) stated during interview that the nurse removed the detainee from the breathing machine and then checked for a pulse. The detainee stopped breathing. At 6:05 p.m., Officer (b)(6); (b)(7)(C) stated, "[Detainee] Amar has officially expired." The hospital discharge summary corroborates 6:05 p.m. was the time of death, nine minutes after the respiratory tube was removed. At 6:11 p.m. Sergeant (b)(6); (b)(7)(C) directed the officers to end the hospital watch and return to the facility. Officer (b)(6); (b)(7)(C) said that before he and Officer (b)(6); (b)(7)(C) left, hospital staff arrived with a body bag and tags and informed them hospital security staff would move the body to the morgue.

Neither a death certificate nor autopsy report were available as of the date of this report.

### Post-Death

A formal After Action Review (AAR) had not been conducted as of the review team's visit. The HSA stated that staff were "gun shy" about doing an after action review until the OPR Detainee Death Review was completed. She said they did not want to interfere in any way with OPR's review or "mess with staff memories" of events.

Detainee AMAR's property and funds in the amount of \$1003.86 remained in GEO's custody at the time of the site visit. In addition to stored property inventoried at intake, Officer (b)(6); (b)(7)(C) searched, organized and documented the following items were removed from AMAR's cell on November 20, 2018. The items were inspected by the review team.

- Pants – two pairs
- Shirts - two
- Shoes – one pair
- Socks – one pair
- Toothpaste and toothbrush
- Radio - one
- Cups – three
- Bowl - one
- Blankets – two
- Towel and washcloth
- Mattress
- Miscellaneous paperwork and NWDC forms

(b)(6); (b)(7)(C) stated during interview that he contacted the Russian Consulate for an address to send the detainee's property but had received no response as of the review team's site visit.

## Interviews

In addition to information reported during interviews as described above, the additional observations were shared:

- (b)(6); (b)(7)(C) stated that detainee AMAR mostly kept to himself and did not speak much to either medical or security staff. She said the detainee's normal activities consisted of writing, reading a book, walking and sleeping. She thought he may have been lonely because, as a low custody detainee, there was only one other detainee he was allowed to come in contact with when out of his cell in segregation. (b)(6); (b)(7)(C) said that when AMAR was offered recreation, showers or meals, he gave a clear verbal response of no or yes but would not say anything else.
- (b)(6); (b)(7)(C) echoed (b)(6); (b)(7)(C) observations. He stated that most detainees in RHU stand at the door and want contact with officers, but AMAR did not. He isolated himself and mostly sat on his bunk.
- (b)(6); (b)(7)(C) stated he considered AMAR a model detainee. He described him as very polite and noted he went to recreation and requested books to read.
- The other low custody detainee referred to by (b)(6); (b)(7)(C) was Canadian detainee Michael ANDREWS. He informed the review team that he and AMAR attended recreation together about five times. Although they were placed in separate recreation areas, they could see and talk with each other. He described AMAR as fairly intelligent and stated that he always carried an English/Russian dictionary with him. He said AMAR told him he was from a village in Russia and that he had been in Mexico prior to entering the U.S. AMAR liked hearing about Canada so they talked a lot about ANDREWS's home country. ANDREWS said AMAR was a "nice, decent person" and did not seem depressed during their interactions. He did, however, recall AMAR spoke of Russia being "monetarily repressive" and that it was not a good place for him.

## CONCLUSIONS

### Healthcare

In his first eight months of detention, AMAR requested healthcare services only four times, for cold symptoms, a broken tooth, ear pain, and feeling depressed because he wanted to be moved to G3, a housing unit with other Russian speaking detainees. AMAR was seen promptly and the complaints were appropriately addressed.

A week after the last encounter, and two days after AMAR was moved to G3 (b)(6); (b)(7)(C) directed his placement in segregation for monitoring of food and fluids consumption, presumably upon notification by security staff that he was refusing meals. The date was August 22, 2018. In his



encounter note, (b)(6); (b)(7)(C) documented AMAR said he would not eat in protest to the delay in deciding his asylum case. On the third day, when hunger strike as defined in the ICE detention standard was confirmed (b)(6); (b)(7)(C) initiated the hunger strike protocol. Nurses documented all required rounds, medical providers saw AMAR almost daily, and mental health providers saw him every other week. AMAR ate nothing and refused to cooperate with all monitoring requirements, including taking his vital signs and weight and measurement of intake and output of fluids. He would not drink from the pitcher of water provided, although he was observed surreptitiously drinking when at the sink in his cell. On the tenth day after ordering the hunger strike protocol, (b)(6); (b)(7)(C) documented her intention to seek a court order to compel AMAR's cooperation. The court order was obtained two days later and served on AMAR the next day, September 7, 2018. In a video-recorded meeting, (b)(6); (b)(7)(C) AFOD Bostock, and another ICE official used interpretation assistance to explain the order. AMAR agreed to drink an electrolyte solution rather than have an IV line placed, and allowed his weight, vital signs, urine and blood samples to be taken. There were marked orthostatic changes in his blood pressure and he had lost 21 pounds during the hunger strike; 30 since admission to NWDC. Laboratory studies were within normal limits. To combat dehydration (b)(6); (b)(7)(C) ordered Pedialyte. Six days later she ordered Boost as a nutritional supplement.

AMAR remained on hunger strike status for another five weeks after the court order was served. During the period, he continued to refuse meals but ate fruit from meal trays, drank Pedialyte and Boost, and cooperated with assessments. One week before she discontinued hunger strike status, (b)(6); (b)(7)(C) documented AMAR was getting about 1800 calories per day and not losing weight. She offered to return him to general population but the detainee stated he did not want to end his hunger strike. On October 16, 2018, after AMAR again informed her he wanted to continue his hunger strike while consuming adequate calories, (b)(6); (b)(7)(C) informed him there was no reason for him to remain in the MHU. She explained to the review team that she did not discontinue hunger strike monitoring earlier because of AMAR's determination to continue his protest. As was borne out, (b)(6); (b)(7)(C) believed he would continue his intake of calories if considered on hunger strike. For the next four weeks, AMAR's caloric consumption remained more or less status quo. The record suggests he may have also periodically eaten snack meals. Three days before his suicide attempt, for unknown reasons, he started eating full meals.

When hunger strike monitoring ended, AMAR requested protective custody rather than being returned to general population. He did not offer a reason to (b)(6); (b)(7)(C) nor do security records document he ever provided a clear reason. The segregation clearance and RN rounds entries for the next ten days document no suicidal ideation was identified. On October 26, 2018, an officer searching AMAR's cell found a six-foot rope fabricated from torn fabric hidden under his mattress. He was placed on suicide watch but was removed by the psychiatrist, (b)(6); (b)(7)(C). Asked why he made the rope, AMAR told (b)(6); (b)(7)(C) had nothing to do." (b)(6); (b)(7)(C) stated during interview that he tended to believe the detainee made the rope as a craft project.



(b)(6); (b)(7)(C) ordered AMAR's placement on mental health observation as a step-down from suicide watch. As a condition, security officers were to make irregular ten-minute checks. AMAR remained on mental health observation for nine days, eight spent in a segregation unit as MHU overflow. RNs made at least three rounds per day, documenting in their notes that AMAR denied suicidal ideation and expressed no complaints or concerns, but refused nursing assessment. Mental health providers' daily attempts to evaluate AMAR were also unsuccessful. He refused to speak at all or would simply respond no when asked if he had any mental health issues. On November 5, 2018, the mental health team discontinued mental health observation. The note summarizing the team's decision references the fact that (b)(6); (b)(7)(C) identified no mental health issues during his encounter with AMAR two days earlier; also, that all staff who had been able to interact with him reported he denied suicidal ideation. The team was not aware that the day before, an officer had discovered a sheet torn in thirds hidden in AMAR's cell. As discussed in Security conclusions, the officer did not write an incident report or charge the detainee with a disciplinary violation. Mental health providers offered differing opinions when asked if the mental health team would have made a different decision had it known of the torn sheet.

AMAR remained on protective custody when mental health observation was discontinued. RNs made required segregation rounds and a mental health provider attempted a weekly assessment. AMAR again refused to cooperate. On November 15, 2018, the multi-disciplinary segregation committee was informed he wanted to be moved to general population. At the request of the AFOD, it was agreed AMAR's transfer from the RHU would be delayed until informed his appeal had been denied and he would be deported. Arrangements were not made to ensure that after receiving the news, AMAR would be seen by a mental health professional, and the DO did not alert GEO officers he had delivered bad news.

AMAR's suicide attempt was discovered approximately 65 minutes after he met with the DO. Using another fabricated rope, he hanged himself within a 26-minute period between rounds, suggesting he had a suicide plan. With the exception of a very minor, insignificant delay in officers' entry to the cell, the response to the medical emergency by security and healthcare personnel was well executed. The medical record includes no updates following AMAR's transfer to the hospital; however, reviewers acknowledge they may be documented elsewhere.

## Compliance Findings

Creative Corrections cites the following deficiency in the ICE 2011 PBNDS, revised 201, governing healthcare:

**Significant Self-harm and Suicide Prevention and Intervention, section (V)(I)**, which states, "In the event a detainee dies as a result of a suicide, the Notification and Reporting of Detainee Deaths Directive shall be followed. In both cases, medical staff shall complete an Incident Report Form within 24 hours, and all staff who came into contact with the detainee before the suicide



attempt or death shall submit a statement describing their knowledge of the detainee and the incident.”

- (b)(6); (b)(7)(C) all of whom responded to the emergency, did not submit Information Reports. Submission of reports from all staff involved in responding to an emergency supports accountability and analysis of actions taken.

## Areas of Concern

As discussed in Security Conclusions, below, the healthcare reviewer endorses the area of concern and recommendations related to discovery of a torn sheet on November 4, 2018 and RHU cell searches. In addition, the healthcare reviewer notes the following:

- On the morning of his attempted suicide, mental health staff were among staff made aware that AMAR’s appeal had been denied. Arrangements were not made for a mental health professional to see him after he was notified he would be deported. Given his lengthy hunger strike as a protest related to his immigration case, and continuation of the protest in the form of refusal of meals until three days before his suicide attempt, evaluation of his mental state upon receiving the news was called for.
- Regarding use of interpretation assistance during the detention period, providers typically used the telephonic service or asked (b)(6); (b)(7)(C) to interpret. Use of interpretation assistance by nurses was more variable. Many documented AMAR understood enough English to allow them to conduct rounds, especially later during the detention period.

## Security

With few exceptions, officers completed incident reports documenting AMAR’s refusal of meals and consumption of fruit during his hunger strike. When medical staff discontinued hunger strike monitoring on October 16, 2018, detainee AMAR refused to go to general population and requested placement on protective custody. An order assigning him to administrative segregation was not completed until the day after the status was effective. Lieutenants completed required reviews of administrative segregation status thereafter, including while he was on overlapping mental health observation. Use of interpretation assistance was not documented during the reviews or during completion of any security processes.

Prior to placement on mental health observation, detainee AMAR spent one day on suicide watch after a rope made from fabric was found concealed under his mattress. The rope was discovered by an officer during routine search of the detainee’s cell on October 26, 2018. The officer appropriately wrote an Information Report and notified the shift supervisor and medical officer, who passed the information to healthcare staff. Nine days after the rope was discovered, another

officer searching AMAR's cell discovered a sheet torn in thirds. The officer documented the discovery on an Evidence/Search report rather than an Information Report, and did not relay news of the discovery to a shift supervisor or medical. The review team was told tearing sheets to make shoelaces, belts, or other craft projects is not uncommon among detainees.

The officers who discovered the rope and torn sheet had searched AMAR's cell in accordance with the RHU Post Orders. However, the requirement to search cells when detainees are elsewhere was not consistently followed. Every day after the torn sheet was found, up to and including the day before his suicide attempt on November 15, 2018, AMAR left his cell for recreation or showers. His cell was searched only once, on November 7, 2018.

On November 12, 2018, detainee AMAR started accepting meals again. On November 15, 2018, he told security staff that he wished to be released from protective custody. Lieutenant (b)(6); (b)(7)(C) shared the information with the multi-disciplinary segregation committee the same morning and identified a general population housing unit where there were other detainees with whom AMAR may be able to converse. The lieutenant delayed the transfer at the request of AFOD (b)(6); (b)(7)(C) pending notification of AMAR that his appeal was denied. The SDDO moved swiftly to arrange for (b)(6); (b)(7)(C) to meet AMAR and shortly before 2:00 p.m., the meeting concluded. The DO did not inform the housing unit officers that he notified the detainee he would be deported, stating deportation information is not shared with GEO officers because they are not law enforcement. He said AMAR stated, "I can't go back", but neither (b)(6); (b)(7)(C) nor the housing unit officer who returned the detainee to his cell observed any behaviors that raised any concern.

Because clearance to proceed with AMAR's transfer to general population was received within an hour of 3:00 p.m. shift change, Lieutenant (b)(6); (b)(7)(C) decided to delay the move until after the next shift came on duty. At 2:40 p.m., an officer making the last round of her shift saw detainee AMAR standing in his cell. During the next round at 3:06 p.m., detainee AMAR was discovered hanging by what the investigating police officer described as a ligature made of strips of braided sheet fabric. The GEO officer clearly and calmly called for an emergency response and the cut down tool. Response to the medical emergency by security and medical personnel was swift, although there was a brief delay in calling for the cell door to be opened. The delay was well under one minute. Once officers entered the cell, they worked as a team to lift AMAR upward to remove pressure from his neck and cut the ligature off. They then carried the detainee into the dayroom. 911 was called and responding medical staff performed CPR until EMS arrived and took over care, nine minutes after the initial emergency call. AMAR was taken by ambulance to the local hospital and was admitted to the ICU. He remained in the ICU, on life support, until November 24, 2018. Life support was discontinued and death was pronounced at 6:11 p.m. GEO officers maintained vigil during AMAR's hospitalization and made appropriate log entries.

Most staff involved in the emergency response wrote detailed information reports. Staff were debriefed and employee counseling services were offered. Mental health providers arrived in the housing unit within 30 minutes of EMS responders' departure to meet with detainees.



All relevant video was retained and reviewed by the Warden, (b)(6); (b)(7)(C) AFOD, and healthcare staff. However, a formal after action review had not been completed as of the date of the review team's site visit. The team was informed the decision was made to delay the formal after action review pending completion of ERAU's analysis.

Finally, the reviewer cites as a best practice the NWDC policy mandating daily review of RHU video by supervisors to confirm officer compliance with health and wellness check requirements. Logs and electronic systems document timeliness of rounds, but do not assure officers look in cells to confirm detainee welfare. Review of video by supervisors supports officers' completion of rounds in a manner fully consistent with policy.

### **Compliance Findings**

The reviewer identified the following deficiencies in the ICE 2011 PBNDS, revised 2016, governing safety and security.

**Terminal Illness, Advanced Directives and Death, section (V)(F)**, Disposition of Property, which 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.

- Detainee AMAR's property remained in GEO's possession at the time of the review team's visit.

**Emergency Plan, 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.'"

- Although NWDC has five handheld cameras available for use in emergency situations, three camera batteries failed during response to this emergency.

**Special Management Units, section (V)(A)(2)**, which states, "A written order shall be completed and approved by the facility administrator or designee before a detainee is placed in administrative segregation, except when exigent circumstances make such documentation impracticable. In such cases, an order shall be prepared as soon as possible. A. Prior to a detainee's actual placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing a detainee in administrative segregation. b. In an emergency, the detainee's placement in administrative

segregation may precede the paperwork, which the facility administrator or designee shall prepare as soon as possible after the detainee's placement."

- Detainee AMAR was assigned to administrative segregation on October 28, 2018; however, an order was not prepared until the following day. There were no known any exigent circumstances.

**Special Management Units, section (V)(R)(2)(c)**, which states, "Extreme detainee behavior, such as destroying clothing or bedding or harmful behavior to self or others, must be documented, made part of the detainee's file with the facility, and reported to the Field Office Director to implement necessary efforts to protect and care for the detainee.

- There is no documentation that the Field Office Director was notified when Detainee AMAR destroyed his sheet on November 4, 2018.

**Funds and Personal Property, section (V)(G)(1)**, which states, "For recordkeeping and accounting purposes, use of the G-589 Property Receipt form or its equivalent is mandatory to inventory any funds removed from a detainee's possession, and a separate G-589 form or its equivalent is required for each kind of currency and negotiable instrument. Removal and inventory of detainee funds shall be conducted by at (b)(7)(E) and in the presence of the detainee. Separate documentation should be made for each kind of currency and negotiable instrument, and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried. Officers should then deposit the funds with a copy of the documentation in the drop safe or similarly secured depository."

- The property inventory lists 21 foreign coins. The officer did not describe the type and amount of the currency.

## Areas of Concern

The following expands upon above cited deficiencies and offers additional concerns.

- A six-foot rope made from torn fabric was found hidden in detainee AMAR's cell on October 26, 2018. Nine days later, on November 4, 2018, a bed sheet torn in thirds was found. On November 15, 2018, AMAR hanged himself using a rope made from bed sheets. The reviewer cites the following related concerns, endorsed by the healthcare reviewer.

Based on staff reports, destruction of clothing and bed sheets for craft projects is a common occurrence among detainees. When officers find torn items during search, including in an RHU cell, the discovery is to be documented in the housing unit log and in a search report. The search reports are not reviewed by the RHU lieutenant, and a disciplinary charge does not ensue. As cited in Compliance Findings, above, the Special Management Units



standard defines tearing clothing or sheets as extreme behavior for segregated detainees, serious enough to require notification of the Field Office Director. In addition, the ICE detention standard, Contraband, specifically classifies a rope as hard contraband because it could aid in an escape. A rope may also be used for assault and as proven by AMAR, as an implement of self-harm.

To his credit, the officer who found the rope on October 26, 2018 made appropriate notifications, resulting in the detainee's placement on suicide watch. The officer who found the sheet torn into thirds nine days later documented the discovery on the search report, but the information went no further. Reviewers recommend that GEO take steps to ensure discovery of torn sheets and clothing in the RHU is documented as necessary to assure review by supervisory and healthcare staff, and to support compliance with the standard. In addition, because the disciplinary system may support behavior modification goals and staff awareness of detainee actions, reviewers also recommend enforcement of the facility rule prohibiting destruction of property.

- Closely aligned with the above concern is the fact that officers did not search AMAR's cell in the week preceding his suicide attempt. Among the purposes served by cell searches in an RHU is identification of contraband that may be used to facilitate a suicide attempt. The last search having been conducted on November 7, 2018, AMAR had ample time to make the rope he used to hang himself on November 15, 2018. The healthcare reviewer endorses this concern.
- AMAR attempted suicide approximately 65 minutes after informed by (b)(6); (b)(7)(C) that he would be deported. (b)(6); (b)(7)(C) did not inform housing unit officers that he delivered bad news, stating that because they are not law enforcement, detention officers cannot be made privy to deportation information. Reviewers do not know what specific information may or may not be released by ERO to facility officers. However, based on the fact AMAR was in the RHU at the time, and considering that his protracted hunger strike was a protest to his immigration standing and that a rope was previously found in his cell, at least a non-specific alert that bad news had been delivered would have been prudent. Reviewers recommend that ERO and GEO discuss how communication of adverse decisions may be shared with officers in a manner that helps assure detainee safety while not divulging information to which the officers are not entitled.
- Officers did not request that AMAR's cell door be opened until more (b)(7)(E) were present. The delay was less than a minute and inconsequential in this case; however, staff interviews point to confusion as to how many staff must be present before a cell door in the RHU may be opened. The reviewer recommends that requirements be clarified in applicable post orders and policy and that staff be trained accordingly.

- Video footage of the emergency response was viewed by leadership the following day; however, an official after-action review had not been completed at the time of ERAU's visit, more than two weeks following AMAR's death. The reviewers appreciate that the AFOD did not want to complete the internal review until external reviews were completed; however, in the interest of ensuring after action reviews are completed while memories are fresh, reviewers recommend that they be completed without delay.
- The detainee's funds totaling \$1003.86 remained in GEO's possession at the time of this review. Reviewers recommend that the funds be turned over to ERO.



## APPENDIX 1 Requests

| Date       | Request                                                                                                     | Response/<br>Disposition<br>Date | Response/Disposition                                                                                                                                            |
|------------|-------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 12/20/2017 | Reset of facial recognition for commissary ordering because he was unable to log in.                        | 12/21/2017                       | Detainee was instructed to enter his PIN correctly and make sure he is in a well-lit area when logging in.                                                      |
| 1/5/2018   | A hat from his property because his ears were cold.                                                         | 1/6/2018                         | Detainee was told no personal hats are allowed at NWDC.                                                                                                         |
| 1/18/2018  | Access to his phone in property to retrieve phone numbers.                                                  | 1/1/2018                         | Detainee was called to the property area and allowed to retrieve the phone numbers.                                                                             |
| 1/24/2018  | Barbering.                                                                                                  | 1/26/2018                        | Scheduled.                                                                                                                                                      |
|            | Postage for legal mail.                                                                                     | 1/25/2018                        | Approved.                                                                                                                                                       |
| 3/15/2018  | Russian to English dictionary. (Note: the request was dated March 4, 2018 by AMAR, apparently erroneously.) | 3/15/2018                        | Detainee was instructed to check the book cart because a Russian-English dictionary was sent to the unit for all to share.                                      |
| 3/16/2018  | Access to his phone in property to retrieve a phone number.                                                 | 3/17/2018                        | Detainee was allowed to retrieve the phone numbers.                                                                                                             |
| 3/19/2018  | Access to his stored property to retrieve a payment card number and access to his phone for a number.       | 3/20/2018                        | Detainee was told he was given access to his phone on March 17, 2018.                                                                                           |
| 3/20/2018  | Access his credit card number in order to pay his attorney who was coming to NWDC the next day.             | 3/21/2018                        | Detainee accessed the card information on March 21, 2018. (Note: the response to the request erroneously states he received the information on March 24, 2018.) |
| 4/23/2018  | A copy of his passport and birth certificate.                                                               | 4/23/2018                        | Detainee was told that the items are in his file. (Note: The request was directed to/answered by ICE.)                                                          |
|            | A phone number from his telephone.                                                                          | 4/24/2018                        | Detainee was told he accessed his phone on March 17, 2018.                                                                                                      |
| 4/24/2018  | Access to his phone because he forgot one number.                                                           | 4/25/2018                        | Detainee was told he was given access to his phone on both March 17 and 21, 2018.                                                                               |
| 4/25/2018  | A copy of his passport and birth certificate for his lawyer for court.                                      | 5/2/2018                         | Detainee was told the file would be in court. (Note: The request was directed to/answered by ICE.)                                                              |

|           |                                                            |           |                                                                                                                                                          |
|-----------|------------------------------------------------------------|-----------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| 5/2/2018  | Access to his phone to retrieve a phone number.            | 5/2/2018  | Detainee was allowed to retrieve the number.                                                                                                             |
| 5/6/2018  | Job assignment in the kitchen.                             | 5/7/2018  | Detainee was told the request was sent to medical for clearance.                                                                                         |
| 5/15/2018 | Automobile, motor car magazine.                            | 5/16/2018 | Detainee was told the request would be looked into by staff.                                                                                             |
| 6/4/2018  | Release of his cell phone from his property to his lawyer. | 6/5/2018  | Detainee was directed to submit an Authorization to Release form.                                                                                        |
| 6/5/2018  | Release of his cell phone to his attorney.                 | 6/6/2018  | Approved. Per a Property Withheld Receipt, AMAR's phone was released to his attorney, Liya Pjamilova on June 13, 2018.                                   |
| 6/10/2018 | Four Russian books.                                        | 6/12/2018 | Detainee was instructed to fill out an authorization to receive package or property form to have the books sent in to the facility.                      |
| 6/13/2018 | Russian books.                                             | 6/15/2018 | Detainee was instructed to see printed response. (Note: None was included in the record provided to reviewers.)                                          |
| 6/30/2018 | Access to his property to retrieve a phone number.         | 7/1/2018  | Detainee was given access but could not find the number sought. Instead, he requested and was given a pair of earbuds.                                   |
|           | Russian books.                                             | 7/2/2018  | Detainee was told that a Russian book would be sent to the unit for him.                                                                                 |
| 7/4/2018  | Russian book.                                              | 7/6/2018  | Detainee was told a Russian language book would be sent to the unit.                                                                                     |
| 7/9/2018  | Russian books.                                             | 7/10/2018 | Detainee was told no other Russian books were available to lend at the time.                                                                             |
| 7/19/2018 | Q-Tips.                                                    | 7/24/2018 | Detainee was referred to sick call.                                                                                                                      |
| 7/26/2018 | Russian detective book.                                    | 7/27/2018 | Detainee was told no other books in Russian were available.                                                                                              |
| 8/8/2018  | Meeting with ICE officer for collaboration.                | 8/13/2018 | Detainee was told that because he was legally represented he needed to send his questions and concerns to his attorney. (Note: The response was by ICE.) |



|            |                                                                             |            |                                                                                          |
|------------|-----------------------------------------------------------------------------|------------|------------------------------------------------------------------------------------------|
| 8/10/2018  | Reassignment to G3.                                                         | 8/11/2018  | AMAR was told moves are not made based on a detainee requests and he would not be moved. |
| 9/24/2018  | Library visit.                                                              | 9/24/2018  | Detainee was told he would be scheduled for the following day.                           |
| 9/25/2018  | Postage for two envelopes to addressed to the Board of Immigration Appeals. | 9/25/2018  | Request approved and processed.                                                          |
| 10/4/2018  | Earphones left behind in D3 103.                                            | 10/4/2018  | Detainee was instructed to complete a Loss/Damaged Property form.                        |
|            | Haircut.                                                                    | 10/5/2018  | Detainee was told staff were trying to get him to the barbershop that day.               |
|            | Russian books.                                                              | 10/5/2018  | Detainee was told that the facility hoped to get new Russian books the next week.        |
| 10/30/2018 | Haircut.                                                                    | 10/30/2018 | Detainee was instructed to sign up on his unit.                                          |
|            | Russian book.                                                               | 11/2/2018  | Detainee was told that a book was being forwarded to his unit.                           |

## APPENDIX 2

### Hunger Strike Monitoring

Beginning August 22, 2018, officers completed Information Reports documenting what food items detainee AMAR consumed from his meal tray. From August 22, 2018 through September 6, 2018 detainee AMAR consumed no food per the reports of officers. On September 7, 2018, he was observed eating mashed potatoes. On September 30, 2018, he consumed an apple at the lunch meal. The below table reflects food items officers documented AMAR consumed from September 30, 2018 through the lunch meal on November 12, 2018.

| Date               | Meal | Food Consumed |
|--------------------|------|---------------|
| September 30, 2018 | B    | None          |
|                    | L    | Apple         |
|                    | D    | Apple         |
| October 1, 2018    | B    | None          |
|                    | L    | Two apples    |
|                    | D    | Two apples    |
| October 2, 2018    | B    | None          |
|                    | L    | Two apples    |
|                    | D    | Two apples    |
| October 3, 2018    | B    | None          |
|                    | L    | Orange        |
|                    | D    | Apple         |
| October 4, 2018    | B    | None          |
|                    | L    | Apple         |
|                    | D    | Apple         |
| October 5, 2018    | B    | None          |
|                    | L    | Apple         |
|                    | D    | Orange        |
| October 6, 2018    | B    | No report     |
|                    | L    | None          |
|                    | D    | Apple         |
| October 7, 2018    | B    | None          |
|                    | L    | Two Apples    |
|                    | D    | Two Apples    |
| October 8, 2018    | B    | None          |
|                    | L    | Two Apples    |
|                    | D    | Two Oranges   |
| October 9, 2018    | B    | Two Oranges   |
|                    | L    | None          |
|                    | D    | None          |



|                  |   |            |
|------------------|---|------------|
| October 10, 2018 | B | None       |
|                  | L | None       |
|                  | D | None       |
| October 11, 2018 | B | None       |
|                  | L | Orange     |
|                  | D | None       |
| October 12, 2018 | B | None       |
|                  | L | None       |
|                  | D | Two Apples |
| October 13, 2018 | B | None       |
|                  | L | None       |
|                  | D | Apple      |
| October 14, 2018 | B | None       |
|                  | L | Two Apples |
|                  | D | Two Apples |
| October 15, 2018 | B | None       |
|                  | L | None       |
|                  | D | Apple      |
| October 16, 2018 | B | None       |
|                  | L | None       |
|                  | D | None       |
| October 17, 2018 | B | None       |
|                  | L | None       |
|                  | D | None       |
| October 18, 2018 | B | No report  |
|                  | L | No report  |
|                  | D | None       |
| October 19, 2018 | B | None       |
|                  | L | None       |
|                  | D | None       |
| October 20, 2018 | B | None       |
|                  | L | None       |
|                  | D | Apple      |
| October 21, 2018 | B | None       |
|                  | L | None       |
|                  | D | Apple      |
| October 22, 2018 | B | None       |
|                  | L | None       |
|                  | D | Apple      |
| October 23, 2018 | B | None       |
|                  | L | None       |
|                  | D | Apple      |

|                  |   |                       |
|------------------|---|-----------------------|
| October 24, 2018 | B | None                  |
|                  | L | Orange                |
|                  | D | Apple                 |
| October 25, 2018 | B | None                  |
|                  | L | Apple                 |
|                  | D | Apple                 |
| October 26, 2018 | B | None                  |
|                  | L | None                  |
|                  | D | Ate 100% of meal      |
| October 27, 2018 | B | Apple                 |
|                  | L | None                  |
|                  | D | None                  |
| October 28, 2018 | B | No report             |
|                  | L | No report             |
|                  | D | No report             |
| October 29, 2018 | B | None                  |
|                  | L | Apple                 |
|                  | D | None                  |
| October 30, 2018 | B | None                  |
|                  | L | Orange                |
|                  | D | None                  |
| October 31, 2018 | B | None                  |
|                  | L | No report             |
|                  | D | None                  |
| November 1, 2018 | B | None                  |
|                  | L | No report             |
|                  | D | Apple                 |
| November 2, 2018 | B | None                  |
|                  | L | None                  |
|                  | D | None                  |
| November 3, 2018 | B | None                  |
|                  | L | No report             |
|                  | D | None                  |
| November 4, 2018 | B | None                  |
|                  | L | Apple                 |
|                  | D | None                  |
| November 5, 2018 | B | None                  |
|                  | L | Orange                |
|                  | D | P.M. Snack (Sandwich) |
| November 6, 2018 | B | None                  |
|                  | L | None                  |
|                  | D | Apple                 |



|                   |   |                  |
|-------------------|---|------------------|
| November 7, 2018  | B | None             |
|                   | L | None             |
|                   | D | Orange           |
| November 8, 2018  | B | None             |
|                   | L | Orange           |
|                   | D | None             |
| November 9, 2018  | B | None             |
|                   | L | None             |
|                   | D | No report        |
| November 10, 2018 | B | None             |
|                   | L | None             |
|                   | D | None             |
| November 11, 2018 | B | None             |
|                   | L | Orange           |
|                   | D | None             |
| November 12, 2018 | B | No report        |
|                   | L | Ate 100% of meal |

### APPENDIX 3 Significant Hospital Logbook Entries

#### November 15, 2018

| Time       | Entry                                                              |
|------------|--------------------------------------------------------------------|
| 7:45 p.m.  | Detainee moved to ICU.                                             |
| 9:30 p.m.  | Doctors enter room to perform a bronk procedure.                   |
| 10:30 p.m. | TPD Crime Scene Investigators on scene to take photos of detainee. |

#### November 16, 2018

| Time      | Entry                                                                                                                                                                                     |
|-----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0:28 a.m. | Medical staff give cooling blanket to detainee.                                                                                                                                           |
| 0:53 a.m. | Nurses placed ice pack and gave IV fluids to help drop AMAR's core temperature."                                                                                                          |
| 2:13 a.m. | "Medical staff enter room pulse and pressure dropping".                                                                                                                                   |
| 3:00 a.m. | "Nurses in to give adrenaline drip".                                                                                                                                                      |
| 3:20 a.m. | X-Ray tech in to take chest X-Ray.                                                                                                                                                        |
| 3:49 a.m. | Officers notified the NWDC supervisor that "nurses are running out of options for things to give him" and he may make it another four hours or so.                                        |
| 8:05 a.m. | Detainee AMAR, "is maxed on all that can be done. Pass down was that an attempt to be revived will be executed but no more intervention than that."                                       |
| 8:27 a.m. | (b)(6); (b)(7)(C) calls Warden Langford requesting seizure control on detainee AMAR.                                                                                                      |
| 8:35 a.m. | (b)(6); (b)(7)(C) medical staff will not conduct CPR due to detainee Amar #802 condition being futile. (b)(6); medical staff evaluating options for seizure control as a humane gesture." |
| 9:37 a.m. | Nurse started IV anti-seizure medications.                                                                                                                                                |
| 1:00 p.m. | Blood draw and EEG conducted.                                                                                                                                                             |
| 2:50 p.m. | Detainee's mouth suctioned and a clean C-Collar put on.                                                                                                                                   |

#### November 17, 2018

| Time            | Entry                                                                                                              |
|-----------------|--------------------------------------------------------------------------------------------------------------------|
| 00:10-4:40 a.m. | Throughout the night, nursing staff drew blood, suctioned the detainee's mouth, brushed his teeth and cleaned him. |
| 5:05 a.m.       | Chest X-Ray taken.                                                                                                 |
| 6:18 a.m.       | Heating blanket placed on detainee AMAR.                                                                           |
| 11:08 a.m.      | (b)(6); (b)(7)(C) aid that ICE called and said do everything possible to keep him alive."                          |
| 12:45 p.m.      | Detainee moved to CAT Scan room.                                                                                   |
| 1:40 p.m.       | "Nurse says blood pressure dropping. Maximum medicine delivered."                                                  |
| 4:40 p.m.       | PHS (b)(6); (b)(7)(C) checked on detainee with dialysis doctor.                                                    |



**November 18, 2018**

| Time           | Entry                                                                   |
|----------------|-------------------------------------------------------------------------|
| 3:00-6:00 a.m. | Nurses drew blood, gave meds, took X-Ray and gave detainee AMAR a bath. |
| 7:42 a.m.      | Respiratory therapy in to see detainee.                                 |
| 10:30 a.m.     | Blood drawn                                                             |
| 11:50 a.m.     | IV bag changed.                                                         |
| 3:09 p.m.      | Detainee taken to nuclear medicine.                                     |
| 4:04 p.m.      | Back in room with detainee AMAR.                                        |
|                |                                                                         |
| 4:51 p.m.      | Nurses and doctors in to conduct test.                                  |
| 4:56 p.m.      | End of test. No response.                                               |
| 5:05 p.m.      | "Doctor in to confirm AMAR #802 is brain dead".                         |
| 11:44 p.m.     | Nurse in on rounds and changed IV and hoses on detainee AMAR.           |

**November 19, 2018**

| Time      | Entry                                                  |
|-----------|--------------------------------------------------------|
| 8:07 a.m. | Nurse in to remove neck brace and reposition detainee. |
| 4:46 p.m. | Detainee's IV bag changed.                             |

**November 20, 2018**

| Time       | Entry                                                                                                                                    |
|------------|------------------------------------------------------------------------------------------------------------------------------------------|
| 2:10 p.m.  | (b)(6); (b)(7)(C) and stated he talked to our people and will most likely take off ventilator tomorrow 11-21-18."                        |
| 7:16 p.m.  | Respiratory therapist checked on detainee.                                                                                               |
| 10:32 p.m. | Hospital staff making arrangements for an interpreter so they can discuss with the family of detainee AMAR what actions they want taken. |

**November 21, 2018**

| Time      | Entry                                                                                                                                                                                         |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 3:15 p.m. | Per the NWDC Sergeant, St. Joseph's hospital security staff were notified there may be a candlelight vigil outside the ER hosted by the Northwest Resistance <sup>19</sup> for detainee AMAR. |
| 6:05 p.m. | Buddhist Minister in to perform Last Rites for detainee AMAR.                                                                                                                                 |

<sup>19</sup> According to their website, the NorthWest Detention Center (NWDC) Resistance is a "grassroots undocumented led movement that works to end the detention of immigrants and stop all deportations. Under the umbrella of the national #Not 1More campaign, NWDC Resistance supports and follows the leadership of those detained at the Northwest Detention Center in Tacoma, Washington demanding better treatment and conditions and the stop to all deportations."

**November 22, 2018**

| Time            | Entry                                                                                                        |
|-----------------|--------------------------------------------------------------------------------------------------------------|
| 5:00 a.m.       | IV changed.                                                                                                  |
| 2:00-10:00 p.m. | Nursing staff cleaned the detainee's breathing tube and repositioned him several times throughout the shift. |

**November 23, 2018**

| Time      | Entry                                                                                  |
|-----------|----------------------------------------------------------------------------------------|
| 8:38 a.m. | Doctor performed tests on the detainee.                                                |
| 9:00 a.m. | Doctor is going to call detainee AMAR's family at 4:30 today to explain his condition. |





## Detainee Death Review Report

---

# Mergensana Dabaevich AMAR

Date of Death: November 18, 2018

Alien File Number: 216 269 802

Joint Integrity Case Management System (JICMS) #: 201901489

May 7, 2020

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

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## **DETAILS OF REVIEW**

From December 11 to 13, 2018, the U.S. Immigration and Customs Enforcement (ICE), Office of Professional Responsibility (OPR), External Reviews and Analysis Unit (ERAU) visited the Northwest Detention Center (NWDC)<sup>1</sup> in Tacoma, Washington (WA) to review the circumstances surrounding Mergensana Dabaevich AMAR'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 consulting firm.<sup>2</sup> As part of its review, ERAU reviewed immigration, medical, and detention records pertaining to AMAR, in addition to conducting in-person interviews of individuals employed by NWDC, ICE Health Service Corps (IHSC) staff assigned to NWDC, and the local ICE Office of Enforcement and Removal Operation (ERO) field office. AMAR was detained at NWDC from December 19, 2017 through November 15, 2018, where he remained until his transfer to the hospital. The Pierce County Medical Examiner documented AMAR's cause of death as anoxic encephalopathy<sup>3</sup> due to hanging.<sup>4</sup>

## **FACILITY PROFILE**

NWDC is owned and managed by The GEO Group, Inc. (GEO) and ERO Seattle provides oversight. NWDC is a Contract Detention Facility that is required to comply with the ICE Performance-Based National Detention Standards (PBNDS) 2011. Medical care at NWDC is provided by IHSC and supported by STG International (STG). GEO provides custody and security services for NWDC. NWDC houses male and female detainees in excess of 72 hours. On the day of AMAR's death, NWDC housed 1,310 ICE detainees.

## **IMMIGRATION AND CRIMINAL HISTORY**

On December 2, 2017, a U.S. Customs and Border Protection (CBP) officer encountered AMAR at the San Ysidro Port of Entry in San Ysidro, California (CA) because he was seeking political asylum.<sup>5</sup>

On December 3, 2017, CBP determined AMAR to be inadmissible and served him a Notice and Order of Expedited Removal (Form I-860), charging him with inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the Immigration and Naturalization Act, as an immigrant without a valid visa.<sup>6</sup>

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<sup>1</sup> This facility is also known as the Tacoma or Northwest ICE Processing Center.

<sup>2</sup> See Exhibit 1: Creative Corrections Healthcare and Security Compliance Analysis Report.

<sup>3</sup> Anoxic encephalopathy is a condition where the brain tissue is deprived of oxygen and there is a global loss of brain function.

<sup>4</sup> See Exhibit 2: Pierce County Medical Examiner's Office Postmortem Examination Report, dated November 26, 2018.

<sup>5</sup> See I-867A, Record of Sworn Statement in Proceedings under Section 235(b)(1) of the Act, dated December 3, 2017.

<sup>6</sup> See Form I-860, dated December 3, 2017.

On December 5, 2017,<sup>7</sup> although ERO San Diego accepted AMAR's file, he remained in CBP's custody until bed space was available at the San Luis Regional Detention Center in San Luis, Arizona, on December 7, 2017.<sup>8</sup>

On December 19, 2017, ERO San Diego transferred AMAR into the custody of ERO Seattle, who transferred him to NWDC.<sup>9</sup>

On January 3, 2018, a U.S. Citizenship and Immigration Services (USCIS) asylum officer conducted a credible fear interview with AMAR.<sup>10</sup> On January 4, 2018, a USCIS supervisory asylum officer rendered a positive credible fear determination in AMAR's case.

On February 1, 2018, an immigration judge determined the court had no jurisdiction in AMAR's custody hearing, because he was an arriving alien and did not meet the 180-day requirement.<sup>11</sup>

On February 25, 2018, ERO Seattle denied AMAR's parole because he lacked community ties and he posed a flight risk.<sup>12</sup>

On August 7, 2018, an immigration judge denied AMAR's application for asylum, withholding of removal, and deferral of removal under Article III of the Convention Against Torture, and ordered AMAR removed from the United States to Russia.<sup>13</sup>

On October 1, 2018, AMAR filed a notice of appeal with the Board of Immigration Appeals (BIA).<sup>14</sup> On November 2, 2018, the BIA dismissed AMAR's appeal because he did not file the appeal within 30 days.<sup>15</sup>

On November 15, 2018, ERO Seattle scheduled AMAR's removal from the United States to Russia for November 28, 2018.<sup>16</sup>

## **CHRONOLOGY OF EVENTS**

### **December 19, 2017**

At 11:05 a.m., Officer (b)(6); (b)(7)(C) admitted AMAR into NWDC.<sup>17</sup> and Registered Nurse (RN) (b)(6); (b)(7)(C) immediately completed his medical pre-screening in his native language and

<sup>7</sup> See ENFORCE Alien Removal Module (EARM), dated December 5, 2017.

<sup>8</sup> See San Luis Detention Center, Booking Report, dated December 7, 2017.

<sup>9</sup> See EARM, dated December 19, 2017.

<sup>10</sup> See Record of Determination/Credible Fear Worksheet (Form I-870), dated January 3, 2018.

<sup>11</sup> See Custody Order of the Immigration Judge, dated February 1, 2018.

<sup>12</sup> See Record of Determination/Parole Determination Worksheet (ICE Form 71-013), dated February 25, 2018.

<sup>13</sup> See Order of the Immigration Judge, dated August 7, 2018.

<sup>14</sup> See BIA Board's Decision, dated November 2, 2018.

<sup>15</sup> *Id.*

<sup>16</sup> See EARM, dated November 15, 2018.

<sup>17</sup> See Booking/Release Report, dated December 19, 2017.



documented that AMAR did not have any current health problems, was not taking any medications, and was not in any pain.<sup>18</sup>

An unknown officer issued AMAR linens, facility clothing and shoes, hygiene items, a radio, and the facility and the ICE National Detainee Handbook.<sup>19</sup> Office (b)(6); (b)(7)(C) first name unknown) completed AMAR's classification and appropriately classified him as low, and an unknown supervisor approved the classification rating.<sup>20</sup>

At 8:57 p.m., an unknown officer assigned AMAR to housing unit B1, cell 117.<sup>21</sup>

At 11:32 p.m.,<sup>22</sup> RN (b)(6); (b)(7)(C) completed AMAR's medical and mental health intake assessment using interpretation services and documented the following:<sup>23</sup>

- She reviewed the medical transfer summary from SLRDC.<sup>24</sup>
- AMAR's vital signs were within normal limits.<sup>25</sup>
- AMAR stated he felt good and denied being in any pain.
- AMAR denied any medical or mental health issues and taking medications.

(b)(6); (b)(7)(C) reviewed the purified protein derivative (PPD) skin test<sup>26</sup> from SLRDC, which was negative for active tuberculosis.<sup>27</sup> (b)(6); (b)(7)(C) educated AMAR on obtaining access to medical care and the grievance process, and medically cleared him for custody.

## December 20, 2017

At an unknown time, an unknown officer inventoried AMAR's funds and personal property and listed personal clothing, headphones, official documentation, a passport, an identification card, a social security card, two bank cards, a cellphone with a case, 21 foreign coins, toiletries, and a micro SanDisk card.<sup>28</sup> ERAU notes the officer did not identify and enumerate 21 foreign coins.

## December 23, 2017

<sup>18</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated December 19, 2017.

<sup>19</sup> See NWDC Property Receipt, dated December 19, 2017.

<sup>20</sup> See Detainee Classification Worksheet, dated December 19, 2017.

<sup>21</sup> See Housing History, dated November 30, 2018.

<sup>22</sup> 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 AMAR. When citing medical entries within this report, ERAU utilized timestamps for vital signs, electronic signatures, or specific times documented by medical staff within the medical record.

<sup>23</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated December 19, 2017.

<sup>24</sup> See SLRDC Medical Transfer Summary, dated December 18, 2017.

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

<sup>26</sup> A PPD skin test occurs when a solution is injected into the skin to determine whether a person has been infected with tuberculosis.

<sup>27</sup> See PPD Skin Test Results, dated December 8, 2017.

<sup>28</sup> See Property Withheld Receipt, dated December 20, 2017.

At 1:41 p.m., (b)(6); (b)(7)(C) completed AMAR's initial physical examination using interpretation services and documented his vital signs were within normal limits and that he denied a history of medical, mental health, and dental problems.<sup>29</sup> (b)(6); (b)(7)(C) assessment findings were normal.

### **December 24, 2017 through August 16, 2018**

During this period, there were no significant medical or security events. The following are summarized events:

- On January 21, 2018, (b)(6); (b)(7)(C) assessed AMAR for a cold symptom complaint and prescribed him 4 milligrams (mg) of chlorpheniramine maleate<sup>30</sup> and 325 mg of acetaminophen<sup>31</sup> tablets for three days.<sup>32</sup>
- On April 24, 2018, IHSC Lieutenant (Lt.) Commander, (b)(6); (b)(7)(C) assessed AMAR for a broken tooth filling and recommended a tooth extraction.<sup>33</sup> AMAR refused the recommendation and signed a refusal form.
- On July 28, 2018, IHSC Commander, Nurse Practitioner (NP) (b)(6); (b)(7)(C) assessed AMAR for pain in his right ear, diagnosed him with an ear infection, and prescribed keep-on-person ear drops.<sup>34</sup>
- AMAR submitted 27 detainee requests in English ranging in requests for Russian language books, access to his property to obtain phone numbers, housing unit change to G3,<sup>35</sup> and the release of his cell phone to his attorney. The facility responded to all requests in a timely manner.
- On March 8, 2018 and June 14, 2018, officers reassessed AMAR's classification; he remained in low custody.<sup>36</sup>

### **August 17, 2018**

At 9:52 a.m., RN (b)(6); (b)(7)(C) completed a mental health wellness check on AMAR using interpretation services after he went to sick call complaining of feeling depressed because there was no one in his dorm who speaks Russian and documented the following:<sup>37</sup>

- AMAR stated he requested a transfer to housing unit G3 with no success.<sup>38</sup>

<sup>29</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated December 23, 2017.

<sup>30</sup> Chlorpheniramine maleate is a medication used to relieve symptoms of allergy, hay fever, and the common cold.

<sup>31</sup> Acetaminophen is a medication used to treat minor to moderate pain and reduce fever.

<sup>32</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated January 21, 2018.

<sup>33</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated April 24, 2018.

<sup>34</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated July 28, 2018.

<sup>35</sup> During interview with (b)(6); (b)(7)(C) on December 12, 2018, he stated that housing unit G3 had Russian speaking detainees.

<sup>36</sup> See Detainee Classification Worksheet, dated March 8, 2018. An unknown officer completed the June 14, 2018 reassessment on the March 8, 2018 classification worksheet.

<sup>37</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated August 17, 2018.

<sup>38</sup> AMAR submitted a detainee request for placement in housing unit G3; however, the facility denied AMAR's detainee request because housing changes are not made upon requests. See Detainee Request Form, dated August 10, 2018.



- AMAR reported feeling safe in his dorm, but he did not participate in any activities or interact with other detainees because he had no desire to do so.
- AMAR acknowledged feeling stressed because of immigration and legal issues.
- AMAR denied thoughts of self-harm, suicidal or homicidal ideation, and auditory and visual hallucinations, and reported eating, drinking, and sleeping well.
- AMAR's vital signs were within normal limits.

(b)(6); (b)(7)(C) assessment findings were that AMAR was alert, calm and relaxed, oriented, made good eye contact, and his thought process was logical. She informed AMAR to submit a grievance regarding the housing change. (b)(6); (b)(7)(C) instructed AMAR to continue his daily activities, engage in regular exercise, participate in activities to help with his depression, and eat something at every meal. (b)(6); (b)(7)(C) stated that although AMAR stated he was eating, instructing patients to eat is a component of the standardized plan for depression.<sup>39</sup> (b)(6); (b)(7)(C) confirmed that housing unit G3 houses Russian speaking detainees. (b)(6); (b)(7)(C) a facility psychologist, reviewed (b)(6); (b)(7)(C) progress note and concurred with her findings and documented no mental health appointment was indicated at this time.<sup>40</sup>

## August 22, 2018

At 7:25 a.m., (b)(6); (b)(7)(C) evaluated AMAR using interpretation services because he stated he was not going to eat and documented the following:<sup>41</sup>

- AMAR stated his immigration case was taking too long and he would like to be released from the facility into the United States.
- AMAR denied suicidal and homicidal ideation.
- AMAR's vital signs were within normal limits.

(b)(6); (b)(7)(C) examination findings were normal; AMAR was not in acute distress, and he was well developed and nourished. (b)(6); (b)(7)(C) treatment plan included placing AMAR in segregation and beginning meal monitoring, and AMAR verbalized understanding.

At 7:30 a.m., (b)(6); (b)(7)(C) completed AMAR's medical segregation clearance using interpretation services and documented his vital signs were within normal limits, he had spontaneous speech and answered questions appropriately, and he did not have active psychosis, mania, or suicidal or homicidal ideations.<sup>42</sup>

At 8:00 a.m., an unknown officer completed AMAR's segregation order and documented the reason for placement in segregation was for medical observation due to AMAR declaring a hunger strike.<sup>43</sup> An unsigned Special Needs Form documents AMAR's admission to administrative

<sup>39</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

<sup>40</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated August 17, 2018.

<sup>41</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated August 22, 2018. ERAU notes it is unknown who notified medical that AMAR was not going to eat.

<sup>42</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated August 22, 2018.

<sup>43</sup> See Administrative Detention Order, dated August 22, 2018.

segregation as single cell occupancy, no commissary food or beverages, and documentation of all food and beverage intake.<sup>44</sup>

At 8:32 a.m., Office (b)(6); (b)(7)(C) transferred AMAR to segregation unit D3 and placed him in cell 103.<sup>45</sup>

### August 23 to 24, 2018

During this time, officers maintained a daily log of AMAR's activities and documented he attended recreation on August 24, 2018 but refused all other recreation opportunities, showers, and meals.<sup>46</sup> (b)(6); (b)(7)(C) completed daily segregation rounds for AMAR.<sup>47</sup> (b)(6); (b)(7)(C) documented AMAR refused his fifth meal on August 24, 2018 but was not in acute distress, and he did not have active psychosis, mania, or suicidal or homicidal ideations. ERAU notes that although RN (b)(6); (b)(7)(C) progress notes state that he communicated with AMAR in his native language, during his interview he stated he does not speak Russian, and he did not use interpretation services during these encounters.

### August 25, 2018

At 5:15 a.m., an unknown D3 housing unit officer documented that AMAR refused his ninth meal and notified medical.<sup>48</sup> At 9:19 a.m., (b)(6); (b)(7)(C) conduct a nursing round in housing unit D3 and documented that AMAR spoke English fluently.<sup>49</sup> (b)(6); (b)(7)(C) documented AMAR's speech was spontaneous, and he answered questions appropriately, he was not in any acute distress, and he did not have any suicidal or homicidal ideations. ERAU notes that although (b)(6); (b)(7)(C) did not document a referral to a provider, a provider assessment is routine protocol for hunger strike.

At an unknown time (b)(6); (b)(7)(C) evaluated AMAR using interpretation services because he had declared a hunger strike and documented the following:<sup>50</sup>

- AMAR had missed his ninth meal and was on a hunger strike because he wanted to be released into the United States.
- AMAR reported experiencing dizziness and lightheadedness for the past two days as a result of his hunger strike.
- AMAR refused to be examined or have his vital signs taken.

<sup>44</sup> See Special Needs Form, dated August 22, 2018.

<sup>45</sup> See Housing History, dated November 30, 2018.

<sup>46</sup> See Daily Log of Special Housing Detainee, dated August 22, 2018.

<sup>47</sup> See eCW Progress Notes by RN (b)(6); (b)(7)(C), dated August 23 and 24, 2018.

<sup>48</sup> See D3 Logbook, dated August 25, 2018. The officer's initials in the D3 Logbook are illegible.

<sup>49</sup> See eCW Progress Note by RN (b)(6); (b)(7)(C) dated August 25, 2018. ERAU not (b)(6); (b)(7)(C) was not interviewed because she no longer worked at NWDC.

<sup>50</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated August 25, 2018.



(b)(6); (b)(7)(C) ordered intake and output monitoring<sup>51</sup> every eight hours, daily weight checks, a dipstick urinalysis,<sup>52</sup> orthostatic vital signs,<sup>53</sup> and laboratory tests.

At 11:06 a.m., an unknown D3 housing officer documented that AMAR was transferred to the Medical Housing Unit (MHU) for hunger strike monitoring.<sup>54</sup>

At 2:03 p.m., (b)(6); (b)(7)(C) completed AMAR's admission to MHU and documented the following:<sup>55</sup>

- AMAR spoke English fluently.
- AMAR refused to have his vital signs taken, provide a urine sample, or sign a refusal form.
- AMAR denied being in any pain and he appeared alert, well hydrated, and not in distress.
- AMAR was instructed of the potential health problems he may experience if he continued not to eat and he nodded to verbalize understanding.

(b)(6); (b)(7)(C) treatment plan was to:

- Obtain vital signs and intake and output monitoring every shift, and daily weight checks and orthostatic vital signs.
- Ensure an adequate supply of water and other beverages at all times.
- Ensure three meals per day were delivered to the detainee and delivery of meals is documented.
- The detainee was not allowed to purchase food from commissary while on hunger strike.
- All food not authorized was to be removed from the detainee's room.
- Only a clinical director or physician could release the detainee from hunger strike monitoring.

(b)(6); (b)(7)(C) completed a Care Plan for Weight Loss to ensure AMAR maintained adequate hydration, urine output was greater than 30 milliliters per hour, and mucous membranes were moist.<sup>56</sup>

### **August 26, 2018 through September 3, 2018**

During this period, AMAR maintained hunger strike status and multiple RNs documented attempts to follow the treatment plan, to include taking vital signs, weight checks, and monitoring intake and output every shift. Medical providers, including the Clinical Director, saw him almost daily, and a mental health professional saw him twice a week. On repeated encounters, AMAR stated

<sup>51</sup> Intake and output are measurements of fluids and nutrients a patient takes in to determine whether there is adequate output of urine and defecation.

<sup>52</sup> A dipstick urinalysis is a test done on a sample of urine with a thin plastic strip treated with chemicals. The chemicals on the stick react and change color if levels are above normal.

<sup>53</sup> Orthostatic vital signs are a series of vital signs of a patient taken while in a lying position then again while standing to determine changes in results and symptoms.

<sup>54</sup> See Daily Log of Special Housing Detainee, dated August 22, 2018.

<sup>55</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated August 25, 2018.

<sup>56</sup> See Care Plan for Weight Loss, dated August 25, 2018.

his hunger strike was a protest he would not end until allowed to remain in the United States. AMAR refused to cooperate with medical staff when asked to take his vital signs or otherwise assess him. Periodically, AMAR would answer questions about pain and other symptoms, reporting dizziness, weakness, lightheadedness, and pain in his lower body. The officers documented AMAR did not eat and fluid intake monitoring was not possible because he refused to drink from the pitcher of water provided. Officers occasionally observed AMAR covertly drink from the sink while washing his face or brushing his teeth, but medical staff were unable to monitor his output because he refused to use collection cups for measurement.

### September 4, 2018

At approximately 9:15 a.m., (b)(6); (b)(7)(C) evaluated AMAR using an interpreter and documented the following:<sup>57</sup>

- AMAR refused intake and output monitoring and to have his vital signs checked.
- AMAR complained of pain in his lower body that began approximately one to two weeks ago.
- AMAR appeared ill, thin, withdrawn, had dry eyes, and was lying under a blanket refusing to get up.
- AMAR had symptoms of dehydration.

(b)(6); (b)(7)(C) treatment plan was to request forced monitoring, feeding, and hydration from the court. (b)(6); (b)(7)(C) informed ICE of AMAR's condition, and ICE agreed to speak with him later that day. ERAU was unable to determine who from ICE (b)(6); (b)(7)(C) spoke to.

### September 6, 2018

ICE filed a motion to provide AMAR involuntary medical treatment and the U.S. District Judge approved the motion.<sup>58</sup> The motion specifically authorized involuntary hydration through intravenous (IV).<sup>59</sup> fluids, physical examinations with daily weight assessments, frequent vital sign checks, and laboratory testing every 48 to 72 hours.

### September 7, 2018

At approximately 9:15 a.m., (b)(6); (b)(7)(C) Assistant Field Office Director (AFOD) (b)(6); (b)(7)(C) and an unknown ICE official discussed the court order with AMAR.<sup>60</sup> (b)(6); (b)(7)(C) explained that being on hunger strike had been detrimental to his health, and he needed to be evaluated. The ICE official read the court order to AMAR using interpretation services and provided him a copy. AFOD (b)(6); (b)(7)(C) introduced himself and asked AMAR if he understood the court order, and AMAR acknowledged that he understood and agreed to medical treatment.

<sup>57</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated September 4, 2018.

<sup>58</sup> See U.S. District Court for the Western District of Washington at Tacoma, Emergency Ex Parte Motion, dated September 6, 2018.

<sup>59</sup> IV is the delivery of fluids directly into a vein.

<sup>60</sup> See Court Order Reading Video Surveillance, dated September 7, 2018.



At approximately 9:45 a.m., <sup>61</sup> (b)(6); (b)(7)(C) evaluated AMAR and documented the following: <sup>62</sup>

- AMAR's blood pressure was low at 88/61, his heart rate was elevated at 111 bpm, and he lost 21 pounds since beginning hunger strike.
- AMAR drank Pedialyte <sup>63</sup> but continued to refuse meals.
- AMAR reported pain in his lower body and rated it as a level six on the standardized pain scale. <sup>64</sup>
- AMAR appeared alert and oriented and was not in distress.

(b)(6); (b)(7)(C) ordered laboratory tests and prescribed a bottle of Pedialyte three times a day for four days. In the following days, AMAR cooperated with medical staff by allowing staff to evaluate him and take his vital signs. He also drank Pedialyte but continued to refuse meals.

### September 13, 2018

At 11:41 a.m., (b)(6); (b)(7)(C) completed a hunger strike assessment on AMAR using interpretation services and documented the following: <sup>65</sup>

- AMAR expressed concern about "heart" pain.
- AMAR's heart rate and blood pressure were low at 46 bpm and 91/53, respectively.
- AMAR reported a pain level of four on the standardized pain scale.
- AMAR's dipstick urinalysis and electrocardiogram <sup>66</sup> were within normal limits, and he was complying with the court order.

(b)(6); (b)(7)(C) prescribed AMAR a tablet of thiamine <sup>67</sup> 100 mg twice a day for five days to be given with Boost <sup>68</sup> and instructed him to notify medical if symptoms worsened, and he verbalized understanding.

### September 14, 2018 through October 15, 2018

During this time, AMAR continued to drink Pedialyte and Boost, but he refused meals. On September 30, 2018, officers documented that AMAR began to eat one to two pieces of fruit per day. By October 9, 2018, AMAR was consuming approximately 1,800 calories a day, but only in fruit, Pedialyte, and Boost, and not losing weight. (b)(6); (b)(7)(C) offered AMAR to return to general population. He stated he did not wish to end his hunger strike.

### October 16, 2018

<sup>61</sup> See Daily Log for Medical ISO dated September 7, 2018.

<sup>62</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated September 7, 2018.

<sup>63</sup> Pedialyte helps prevent dehydration and replaces nutrients and electrolytes.

<sup>64</sup> The standardized pain scale allows patients to report their pain level from zero to ten, with ten being the worst.

<sup>65</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated September 13, 2018.

<sup>66</sup> An electrocardiogram is a test that measures the electrical activity of the heartbeat.

<sup>67</sup> Thiamine is vitamin B1 and is found in foods such as whole grains, legumes, and some meats.

<sup>68</sup> Boost is a liquid nutritional supplement.

At 2:45 p.m., (b)(6); (b)(7)(C) evaluated AMAR and documented that he ate a complete sack lunch and stated he wanted to continue eating and drinking adequate calories while remaining on hunger strike.<sup>69</sup> (b)(6); (b)(7)(C) informed AMAR that he did not need to be housed in MHU any longer and asked if he had a housing unit preference after discharge. AMAR asked to be moved to housing unit D3 instead of returning to general population. (b)(6); (b)(7)(C) stated she did not discontinue AMAR's hunger strike status once he began consuming Pedialyte, Boost, and eating fruit in hopes that if he believed his hunger strike was recognized, he would continue to consume the items, gain weight, and maintain hydration.<sup>70</sup>

At 3:28 p.m., (b)(6); (b)(7)(C) (first name unknown) completed AMAR's segregation order into protective custody and documented he refused to provide any statement other than he did not want to go back to general population.<sup>71</sup>

At 4:25 p.m., (b)(6); (b)(7)(C) completed AMAR's medical segregation clearance and documented his speech was spontaneous and questions were answered appropriately, he was not in distress, and he did not appear to have active psychosis, mania, or suicidal or homicidal ideations.<sup>72</sup> (b)(6); (b)(7)(C) medically cleared AMAR for segregation.

At 6:47 p.m., Officer (b)(6); (b)(7)(C) assigned AMAR to segregation unit D3 and placed him in cell 109.<sup>73</sup>

## October 17 to 25, 2018

During this period, there were no significant medical or security events. The following are summarized events:

- On October 17, 2018, officers moved AMAR to segregation unit H.<sup>74</sup>
- On October 19, 2018, (b)(6); (b)(7)(C) evaluated AMAR for a tooth complaint and documented that AMAR had a canal infection and a broken tooth and scheduled him for a tooth extraction.<sup>75</sup>
- On October 22, 2018, (b)(6); (b)(7)(C) visited AMAR in segregation unit H because he refused to go to medical for an evaluation and was refusing to drink his Boost in front of the nurses.<sup>76</sup> During this encounter, AMAR refused to be weighed or have his blood pressure checked.
- On October 24, 2018, AMAR refused to cooperate during a mental health round with Licensed Clinical Social Worker (LCSW) (b)(6); (b)(7)(C).<sup>77</sup> An officer informed LCSW (b)(6); (b)(7)(C) there were no observed mental health concerns but stated that AMAR

<sup>69</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated October 16, 2018.

<sup>70</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 11, 2018.

<sup>71</sup> See Administrative Detention Order, dated October 16, 2018.

<sup>72</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated October 16, 2018.

<sup>73</sup> See Housing History, dated November 30, 2018.

<sup>74</sup> *Id.*

<sup>75</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated October 19, 2018. ERAU notes a date for the tooth extraction was not documented on the progress note.

<sup>76</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated October 22, 2018.

<sup>77</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated October 24, 2018.



was angry that he was not allowed to continue his hunger strike in MHU. LCSW (b)(6); (b)(7)(C) did not document a mental health diagnosis.

- On October 25, 2018, (b)(6); (b)(7)(C) interviewed AMAR regarding his protective custody assignment and documented that AMAR stated he did not want to live in general population and restated his hunger strike declaration.<sup>78</sup> (b)(6); (b)(7)(C) recommended retention of administrative segregation status.

## October 26, 2018

At 4:00 p.m., while AMAR was at recreation, Officer (b)(6); (b)(7)(C) searched AMAR's cell in accordance with the Restricted Housing Unit Post Order and found a six to seven-foot rope under the mattress.<sup>79</sup> He placed the rope in the Lt.'s office and notified the shift supervisor, Sergeant (Sgt.) (b)(6); (b)(7)(C) and Medical Officer (b)(6); (b)(7)(C).<sup>80</sup> Officer Stanifer notified the nurses in the clinic and RN (b)(6); (b)(7)(C) who speaks Russian, went to housing unit H to speak with AMAR. (b)(6); (b)(7)(C) stated she held up the rope and asked AMAR if he was trying to commit suicide, and he denied any suicidal ideation, stating he was going to use the rope as a belt.<sup>81</sup>

(b)(6); (b)(7)(C) notified (b)(6); (b)(7)(C) of her encounter with AMAR and (b)(6); (b)(7)(C) Shen, a facility psychologist.<sup>82</sup> (b)(6); (b)(7)(C) asked the housing unit officers to bring AMAR to medical for an assessment, and the officers informed her that AMAR had refused to go to medical and they would have to force him to do so by way of cell extraction.<sup>83</sup> (b)(6); (b)(7)(C) instructed (b)(6); (b)(7)(C) to return to housing unit H to speak with AMAR. When RN (b)(6); (b)(7)(C) returned to medical, AMAR was accompanying her, and (b)(6); (b)(7)(C) introduced herself to him, but he refused to speak with her. (b)(6); (b)(7)(C) stated it was not reasonable for the rope to be used as a belt, as it was too long and wide, and even if the rope were smaller, she planned to place AMAR on suicide watch given the high risk setting he was in.<sup>84</sup>

At 7:28 p.m., (b)(6); (b)(7)(C) placed AMAR on suicide watch as staff found a long, hand-made rope of bedding in his cell.<sup>85</sup> (b)(6); (b)(7)(C) did not document her encounter with AMAR and did not co-sign RN (b)(6); (b)(7)(C) progress note but confirmed she directed AMAR's placement on suicide watch.<sup>86</sup>

At 7:31 p.m. an officer escorted AMAR to MHU, cell 1.<sup>87</sup>

At 10:40 p.m. (b)(6); (b)(7)(C) completed AMAR's Special Needs Form and documented that he was placed on one-on-one suicide watch with safety smocks, a blanket, a mattress on the floor, and food with no plastic wrap or utensils.

<sup>78</sup> See Administrative Detention Review, dated October 25, 2018.

<sup>79</sup> See Evidence/Search Report, dated October 26, 2018.

<sup>80</sup> See Information Report by Officer (b)(6); (b)(7)(C) dated October 26, 2018.

<sup>81</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

<sup>82</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated October 26, 2018.

<sup>83</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

<sup>84</sup> *Id.*

<sup>85</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated October 26, 2018.

<sup>86</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

<sup>87</sup> See Housing History, dated November 30, 2018.

## October 27, 2018

At an unknown time, (b)(6); (b)(7)(C) completed a suicide watch round of AMAR using interpretation services and documented that he would not respond to her questions, he only smiled and laughed.<sup>88</sup>

At 10:46 a.m., (b)(6); (b)(7)(C) a facility psychiatrist, completed AMAR's comprehensive suicide risk assessment using an interpreter and documented the following:<sup>89</sup>

- AMAR did not display self-harm behavior, and officers did not report observing suicidal ideation.
- AMAR was cooperative and pleasant with fair eye contact.
- AMAR reported sleeping well and eating.<sup>90</sup>
- AMAR denied hallucinations, delusions, or suicidal or homicidal ideations. He also denied a history of psychiatric hospitalization or counseling, a family history of mental illness, and a history of suicide attempts, depression, or psychosis.
- AMAR stated he made the rope because he had nothing to do.

(b)(6); (b)(7)(C) discontinued AMAR's suicide watch and placed him on mental health observation with 10-minute checks by officers on an irregular basis, a nursing round each shift, and a provider round and vital signs once per day.<sup>91</sup> AMAR was also permitted commissary and personal property in his cell, including a TV, radio, and telephone access.

## October 28, 2018

At 4:15 p.m., an unknown officer escorted AMAR to housing unit H for MHU overflow,<sup>92</sup> where he remained until his suicide attempt on November 15, 2018.<sup>93</sup> AMAR remained on mental health observation until November 5, 2018. During this time, medical staff completed rounds as required<sup>94</sup> and documented AMAR consistently denied suicidal or homicidal ideations but refused to have his vital signs taken or otherwise cooperate with attempts to assess him. AMAR refused meals but ate fruit and drank Boost and Pedialyte.

## October 29, 2018

<sup>88</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated October 27, 2018.

<sup>89</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated October 27, 2018.

<sup>90</sup> (b)(6); (b)(7)(C) did not mention AMAR's hunger strike or that his food intake was minimal.

<sup>91</sup> See Special Needs Form, dated October 27, 2018.

<sup>92</sup> Health Services Administrator (HSA) (b)(6); (b)(7)(C) stated when MHU reaches capacity, detainees that are determined to be in need of MHU are given priority for housing in the unit and other detainees are moved to segregation and identified as MHU overflow patients. ERAU interview with HSA (b)(6); (b)(7)(C) dated December 11, 2018.

<sup>93</sup> See Housing History, dated November 30, 2018.

<sup>94</sup> In housing unit H (b)(6); (b)(7)(E) are assigned on every shift and conduct security rounds every 30 minutes at irregular intervals. The security rounds are electronically recorded using the pipe system and are documented in the housing unit H Segregation Logbook. Facility staff informed ERAU there is an alarm that sounds when a security round is due, so rounds are not missed when things get busy in the unit. A daily supervisory review of video surveillance is also required to verify that officers have completed security rounds.



At 8:00 a.m., a day after AMAR was placed in segregation, (b)(6); (b)(7)(C) completed a segregation order and documented AMAR requested protective custody.<sup>95</sup> (b)(6); (b)(7)(C) documented that medical released AMAR from constant watch, and he was given the option to be housed in general population, but he declined.

### October 30, 2018 and November 3, 2018

AMAR went to recreation; however, there are no records that officers searched or inspected his cell while he was at recreation.<sup>96</sup>

### November 4, 2018

At 6:15 p.m.,<sup>97</sup> AMAR went to recreation and (b)(6); (b)(7)(C) searched his cell and found a sheet torn in thirds and empty milk containers and Pedialyte bottles.<sup>98</sup> (b)(6); (b)(7)(C) disposed of the items by placing them in the trash; however, she neither notified medical or the shift supervisor, nor did she write an information report or document the search in the housing unit logbook.<sup>99</sup>

### November 5, 2018

At 1:17 p.m. (b)(6); (b)(7)(C) evaluated AMAR and documented that he declined the use of an interpreter.<sup>100</sup> AMAR denied any suicidal or homicidal ideation, then refused to engage with her further. LCSW (b)(6); (b)(7)(C) documented there was no current mental health diagnosis.

At 3:31 p.m., LCSW (b)(6); (b)(7)(C) evaluated AMAR and documented the following:<sup>101</sup>

- AMAR covered his head with a blanket and refused to respond to questions despite repeated attempts to engage him.
- During the earlier encounter with LCSW (b)(6); (b)(7)(C) AMAR denied any suicidal or homicidal ideations, and officers reported he had not presented any mental health concerns.
- AMAR refused meals but accepted fruit, Boost, and Pedialyte.
- The mental health team reviewed AMAR's case and concluded that since (b)(6); (b)(7)(C) notes indicated AMAR did not have any mental health issues, and all staff that interacted with AMAR reported that he did not have any suicidal or homicidal ideation or audio or visual hallucinations, AMAR could be discharged from mental health observation.
- A follow-up appointment with mental health was scheduled for the next day.<sup>102</sup>

<sup>95</sup> See Administrative Detention Order, dated October 29, 2018.

<sup>96</sup> See Daily Log of Special Housing Detainee, dated October 30, 2018 and November 3, 2018.

<sup>97</sup> See Daily Log of Special Housing Detainee, dated November 4, 2018.

<sup>98</sup> See Evidence/Search Report, dated November 4, 2018.

<sup>99</sup> Beginning on August 22, 2018, officers were required to complete an Information Report documenting what, if anything, the detainee consumed. It is unknown who gave this order, but as documented within the report, all other officers complied with this requirement.

<sup>100</sup> See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated November 5, 2018.

<sup>101</sup> See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated November 5, 2018.

<sup>102</sup> ERAU notes the follow-up appointment with mental health was not completed.

LCSW (b)(6); (b)(7)(C) discharged AMAR from mental health observation and documented the following:<sup>103</sup>

- AMAR displayed safe behaviors, reported future focus, a sense of resiliency, and a belief system that discourages suicide watch.
- AMAR agreed to the treatment and safety plan.
- AMAR was assessed for risk factors and deemed to be a low suicide risk.

ERAU notes AMAR consistently refused to speak with mental health providers; therefore, it's unclear on what basis LCSW (b)(6); (b)(7)(C) determined that AMAR reported future focus, had a sense of resiliency, and a belief system that discourages suicide watch, or that he agreed to a treatment plan. Additionally, ERAU notes the facility did not return AMAR to general population presumably because he was on protective custody concurrent with mental health observation. When AMAR's mental health observation ended, his protective custody status continued; however, there is no documentation of communication between medical and security personnel regarding the termination of mental health observation.

At 4:40 p.m.,<sup>104</sup> AMAR went to recreation; however, there is no record that officers searched or inspected his cell while he was at recreation.

### **November 6 to 14, 2018**

Over the next nine days, AMAR remained in housing unit H for protective custody. The following are noteworthy events that occurred during this period:

- Nurses completed all required segregation rounds and documented AMAR's consumption of fruit and supplements.
- On November 8, 2018, (b)(6); (b)(7)(C) completed AMAR's segregation review and documented he interviewed AMAR concerning his placement on protective custody.<sup>105</sup> AMAR stated he did not want to live in general population. The warden and ICE Officer in Charge approved (b)(6); (b)(7)(C) recommendation for continuation of protective custody.<sup>106</sup>
- On November 12, 2018, AMAR began accepting all meals.
- AMAR went to recreation each day.<sup>107</sup>
- On November 13, 2018, (b)(6); (b)(7)(C) completed the first weekly segregation round since mental health observation was discontinued and documented that AMAR denied any mental health issues or concerns and then refused to engage in further conversation.<sup>108</sup>

### **November 15, 2018 – Day of the Emergency**

<sup>103</sup> See eCW Progress Note by (b)(6); (b)(7)(C) dated November 5, 2018.

<sup>104</sup> See Daily Log of Special Housing Detainee, dated November 5, 2018.

<sup>105</sup> See Administrative Detention Review, dated November 8, 2018.

<sup>106</sup> The signatures of the warden and ICE Officer in Charge are illegible.

<sup>107</sup> On November 7, 2018, officers searched AMAR's cell while he was at recreation; this was the last documented search of AMAR's cell prior to the medical emergency on November 15, 2018.

<sup>108</sup> See eCW Progress Note by LCSW (b)(6); (b)(7)(C) dated November 13, 2018.



At 9:00 a.m., (b)(6); (b)(7)(C) completed AMAR's segregation review and documented that AMAR requested removal from protective custody.<sup>109</sup> The warden signed the form approving (b)(6); (b)(7)(C) recommendation that AMAR be returned to general population; however, an ICE official did not sign the form.

(b)(6); (b)(7)(C) stated he reported AMAR's request to move to general population later that day during the weekly administrative meeting where detainees in segregation are discussed. The warden, assistant warden, (b)(6); (b)(7)(C) IERO personnel, and IHSC medical and mental health staff were in attendance.<sup>110</sup> AFOD (b)(6); (b)(7)(C) requested the opportunity to have a Deportation Officer (DO) meet with AMAR before he was transferred to general population to inform him he had lost his appeal and was going to be deported.<sup>111</sup> AFOD (b)(6); (b)(7)(C) stated he wanted the information conveyed in a controlled environment in case AMAR did not react well to the news. ERAU notes there is no documented or reported information that the mental health staff in attendance arranged to meet with AMAR after he was told he lost his appeal.

At 1:19 p.m., (b)(6); (b)(7)(C) emailed AFOD (b)(6); (b)(7)(C) and Supervisory Deportation and Detention Officer (SDDO) (b)(6); (b)(7)(C) that once AMAR's transfer to housing unit A3 was approved, he would move him.<sup>112</sup> (b)(6); (b)(7)(C) indicated there were three detainees in housing unit A3 from Romania, Russia, and Nepal that AMAR could socialize with. At 1:31 p.m., SDDO (b)(6); (b)(7)(C) emailed (b)(6); (b)(7)(C) would meet with AMAR to inform him of his appeal.

At 1:40 p.m., DO (b)(6); (b)(7)(C) arrived at housing unit H and proceeded to AMAR's cell.<sup>113</sup> Officers (b)(6); (b)(7)(C) placed AMAR in handcuffs and escorted him to the Lt.'s office to speak with (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) asked AMAR whether he knew about his immigration status and the most recent appeals decision.<sup>114</sup> AMAR replied that he had not received any updates on his case. (b)(6); (b)(7)(C) then informed AMAR that the BIA had dismissed his appeal and pursuant to a final order of removal, arrangements would be made to proceed with his removal from the United States to Russia. AMAR acknowledged that he understood. At 1:54 p.m., Officers (b)(6); (b)(7)(C) escorted AMAR to his cell and (b)(6); (b)(7)(C) left the housing unit.

Officers (b)(6); (b)(7)(C) did not inform them what the meeting with AMAR was about.<sup>115</sup> DO (b)(6); (b)(7)(C) stated facility officers are not sworn law enforcement officers and only staff with a need to know are kept apprised of deportation information.<sup>116</sup>

At 1:57 p.m., (b)(6); (b)(7)(C) that DO (b)(6); (b)(7)(C) met with AMAR and asked to be informed when his transfer to housing unit A3 could proceed.<sup>117</sup> At 2:17 p.m., SDDO (b)(6); (b)(7)(C)

<sup>109</sup> See Administrative Detention Review, dated November 15, 2018.

<sup>110</sup> It is unknown which mental health staff attended the meeting.

<sup>111</sup> ERAU interview with AFOD (b)(6); (b)(7)(C) dated December 12, 2018.

<sup>112</sup> See Email by (b)(6); (b)(7)(C) dated November 15, 2018.

<sup>113</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>114</sup> See Memorandum by DO (b)(6); (b)(7)(C) dated November 21, 2018.

<sup>115</sup> ERAU interviews with Officers (b)(6); (b)(7)(C) dated December 12, 2018 and December 27, 2018, respectively.

<sup>116</sup> ERAU interview with DO (b)(6); (b)(7)(C) dated December 11, 2018.

<sup>117</sup> See Email by (b)(6); (b)(7)(C) dated November 15, 2018.

replied that AMAR's transfer had been approved. (b)(6); (b)(7)(C) stated that since it was close to shift change, he decided to move AMAR after the shift change.<sup>118</sup> AMAR's suicide attempt occurred before officers transferred him to housing unit A3.

At 2:39 p.m., Officer (b)(6); (b)(7)(C) began the final security round of her shift.<sup>119</sup> Officer (b)(6); (b)(7)(C) began her round at the first cell on the lower tier across from the entry door. As she moved along the tier, she looked into each window and inserted the pipe into the sensor on the cell doors to log her rounds.<sup>120</sup> At 2:40 p.m., she activated the pipe sensor at AMAR's cell (cell 106) and moved quickly past the cell. Officer (b)(6); (b)(7)(C) stated that she quickly moved past his cell because AMAR was standing up and looking at her.<sup>121</sup> She stated that if she does not pause at a cell it is because the occupant is clearly visible and alert. ERAU notes that (b)(6); (b)(7)(C) performed a thorough security round.

At 3:00 p.m., Officer (b)(6); (b)(7)(C) arrived at housing unit H and relieved Officer (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C) briefed Officer (b)(6); (b)(7)(C).<sup>122</sup> At 3:04 p.m., Officer (b)(6); (b)(7)(C) arrived and relieved Officer (b)(6); (b)(7)(C).

At 3:06 p.m., (b)(6); (b)(7)(C) exited his office and proceeded to the exit door to leave for the day as (b)(6); (b)(7)(C) began his security round.<sup>123</sup> ERAU notes the pipe system activated the sensor at cell 106 at 3:06 p.m., 26 minutes after Officer (b)(6); (b)(7)(C) last security round.<sup>124</sup> When Officer (b)(6); (b)(7)(C) arrived at cell 106, he observed AMAR sitting on the cell floor with his feet towards the cell door and a clothing item over his face with a rope made from a sheet wrapped around the top bunk down to his neck.<sup>125</sup> Officer (b)(6); (b)(7)(C) immediately told (b)(6); (b)(7)(C) who had not exited the unit yet, to bring the Life Knife.<sup>126</sup> and radioed central control to activate the Incident Management System (IMS).<sup>127</sup> for a detainee engaged in self-harm. At 3:07 p.m., central control activated IMS.<sup>128</sup> Lt. (b)(6); (b)(7)(C) immediately returned to his office and put down the items he was carrying. He then returned to the exit door which opens to the housing unit's sally port where the Life Knife is maintained. Simultaneously, Officer (b)(6); (b)(7)(C) went to cell 106 and then to the lieutenant's office to retrieve a plexiglass shield pursuant to standard operating procedure.<sup>129</sup>

<sup>118</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 12, 2018.

<sup>119</sup> See GEOTour Hourly Log, dated November 15, 2018.

<sup>120</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>121</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated December 12, 2018.

<sup>122</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>123</sup> *Id.*

<sup>124</sup> See GEOTour Hourly Log, dated November 15, 2018.

<sup>125</sup> See Information Report by Officer (b)(6); (b)(7)(C) dated November 15, 2018.

<sup>126</sup> A Life Knife is a J shaped knife that allows for safe and quick cutting of most fabrics and is used to cut a detainee down without causing further injury it is commonly referred to as a cut down tool.

<sup>127</sup> The IMS is a three-level response system designed to ensure that the right personnel and equipment are present for an emergency response. For each level, designated staff respond to the emergency. Level I incidents include medical emergencies involving two or less detainees. Level II incidents include escapes, disturbances involving a group of detainees, and a possible hostage situation. Level III incidents include large scale hostage situations, demonstrations, or natural disasters.

<sup>128</sup> See Master Control Logbook, dated November 15, 2018.

<sup>129</sup> A Plexiglas shield is used for segregation cell entries to fend off a combative detainee or a weapon, if present, and provides safety to the other officers responding.



At 3:07:03 p.m., (b)(6); (b)(7)(C) returned to cell 106 but did not ask central control to open the cell door.<sup>130</sup> At 3:07:14 p.m., (b)(6); (b)(7)(C) returned to the housing unit, put on gloves, and arrived at cell 106. Although there were three officers present, the cell door remained closed. At 3:07:20 p.m., three additional officers entered the housing unit. (b)(6); (b)(7)(C) handed the Life Knife to one of the officers as they passed the sally port door. At 3:07:38 p.m., Officer (b)(6); (b)(7)(C) radioed central control to open the door to cell 106.<sup>131</sup>

According to (b)(6); (b)(7)(C) are assigned to segregation and the facility policy requires a third officer to be present before a cell door is opened.<sup>132</sup> ERAU notes that policy 3.4.1 states that if a detainee in segregation attempts suicide, staff must wait for at least one additional staff member to arrive before entering the cell to assist the detainee. However, a review of the segregation post orders identified conflicts with this interpretation. First, the post orders state that two officers must be present when a segregation cell door is accessed. Second, the post orders include a specific section on suicide prevention for detainees, which states that if an officer sees a detainee in the process of attempting to commit suicide, it is their responsibility to preserve the life of the detainee by taking immediate, appropriate action. Procedures for fulfilling that responsibility further specify that if the incident occurs in segregation or the medical isolation unit, they must wait for at least one additional staff member to arrive before entering the cell.

Upon opening of the cell door, Officer (b)(6); (b)(7)(C) entered the cell first with the shield, cleared the cell and placed the shield to the side as the other officers entered.<sup>133</sup> Officers observed the rope tied around the back-top corner of the bunk bed. Officer (b)(6); (b)(7)(C) lifted AMAR to relieve the pressure on his neck while Officer (b)(6); (b)(7)(C) cut the noose from the bunk bed first, then from around AMAR's neck.<sup>134</sup> Officer (b)(6); (b)(7)(C) stated the rope was very tight and he could barely get his fingers between the rope and the detainee's neck.<sup>135</sup> (b)(6); (b)(7)(C) stated that AMAR's face was blue, and his lips were white when he was cut down.<sup>136</sup> At 3:07:57 p.m., the officers pulled AMAR outside of the cell and into the dayroom.<sup>137</sup> (b)(6); (b)(7)(C) used the Life Knife to remove AMAR's sweatshirt and T-shirt. Officer (b)(6); (b)(7)(C) stated he was going to begin cardiopulmonary resuscitation (CPR) when Physician Assistant (PA) (b)(6); (b)(7)(C) arrived.<sup>138</sup> At 3:08:51 p.m., (b)(6); (b)(7)(C) entered the unit with a wheelchair.<sup>139</sup>

(b)(6); (b)(7)(C) observed AMAR lying unresponsive on the floor and not breathing.<sup>140</sup> (b)(6); (b)(7)(C) checked AMAR's airway for obstruction, a sternum rub elicited no response,<sup>141</sup> and he found no pulse. (b)(6); (b)(7)(C) initiated chest compressions. (b)(6); (b)(7)(C) stated that when she arrived on

<sup>130</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>131</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>132</sup> ERAU interview with Lieutenant (b)(6); (b)(7)(C), dated December 12, 2018.

<sup>133</sup> See Information Report by Officer (b)(6); (b)(7)(C), dated November 15, 2018.

<sup>134</sup> See Information Report by Officer (b)(6); (b)(7)(C), November 15, 2018.

<sup>135</sup> ERAU interview with Officer (b)(6); (b)(7)(C), dated December 13, 2018.

<sup>136</sup> ERAU interview with Officer (b)(6); (b)(7)(C), dated December 11, 2018.

<sup>137</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>138</sup> ERAU interview with Officer (b)(6); (b)(7)(C), December 13, 2018.

<sup>139</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>140</sup> See eCW Progress Note by (b)(6); (b)(7)(C), dated November 15, 2018.

<sup>141</sup> A sternum rub is the application of painful stimulus with the knuckles of a closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli.



scene, officers were trying to rouse AMAR.<sup>142</sup> She stated AMAR was still warm but very pale and completely lifeless. (b)(6); (b)(7)(C) attached the automated external defibrillator (AED) pads<sup>143</sup> on AMAR's chest; the AED did not advise for a shock to be delivered.<sup>144</sup> She then placed the ambu-bag<sup>145</sup> over AMAR's nose and mouth, but it was difficult to get air into his lungs. RN (b)(6); (b)(7)(C) stated that AMAR's abdomen was rising but not his chest. At 3:11:51 p.m., three unknown medical staff arrived with a gurney and backboard.<sup>146</sup> Medical and security staff completed four to five cycles of CPR before Emergency Medical Services (EMS) responders arrived and assumed care.<sup>147</sup>

Simultaneously, additional security staff responded to the IMS call; among the staff that responded were (b)(6); (b)(7)(C) and Officer (b)(6); (b)(7)(C). (b)(6); (b)(7)(C) instructed (b)(6); (b)(7)(C) to call 911 because he had immediate access to AMAR's identification card.<sup>148</sup> At 3:11 p.m.,<sup>149</sup> four minutes after IMS was activated, (b)(6); (b)(7)(C) called 911. (b)(6); (b)(7)(C) also responded to the IMS call. (b)(6); (b)(7)(C) stated he assigned Officer (b)(6); (b)(7)(C) and (b)(6); (b)(7)(C) to escort the detainee to the hospital.<sup>150</sup>

At 3:16 p.m., nine EMS and fire department responders arrived and entered the housing unit.<sup>151</sup> The fire department responders observed that AMAR was unresponsive, pulseless, and not breathing.<sup>152</sup> His skin was warm, dry, and pale, and he had obvious ligature marks around his neck. EMS responders immediately placed an IV and administered two doses of saline and epinephrine.<sup>153</sup> EMS responders intubated AMAR and after approximately four minutes, they removed the airway tube, and placed an ambu-bag over his mouth and nose.<sup>154</sup> Shortly thereafter, EMS responders were able to detect a pulse.

At 3:25 p.m., EMS responders left the housing unit and returned with their gurney.<sup>155</sup> At 3:27 p.m., EMS responders placed AMAR on the gurney and exited the housing unit at 3:28 p.m. At 3:36 p.m., the ambulance departed the facility, followed by the fire truck.<sup>156</sup> Officer (b)(6); (b)(7)(C) accompanied AMAR in the ambulance, and Officer (b)(6); (b)(7)(C) followed in the chase vehicle.

<sup>142</sup> ERAU interview with (b)(6); (b)(7)(C), dated December 13, 2018.

<sup>143</sup> An AED is a portable electronic device that analyzes the heart rhythm and sends a shock to the heart to restore a normal rhythm.

<sup>144</sup> See Handheld Video Surveillance, dated November 15, 2018. ERAU notes the handheld video is not timestamped; therefore, it is unknown at what time the handheld video recording began.

<sup>145</sup> An ambu-bag is a handheld device commonly used to provide ventilation to patients who are not breathing or not breathing adequately.

<sup>146</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>147</sup> See eCW Progress Note b (b)(6); (b)(7)(C) dated November 15, 2018.

<sup>148</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 12, 2018.

<sup>149</sup> See Tacoma Fire Department Report, dated November 15, 2018.

<sup>150</sup> ERAU interview with (b)(6); (b)(7)(C) dated December 13, 2018.

<sup>151</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>152</sup> See Tacoma Fire Department Report, dated November 15, 2018.

<sup>153</sup> See Tacoma Fire Department Report, dated November 15, 2018. Saline is a solution of salt and water. Epinephrine is a chemical that narrows blood vessels and opens airways in the lungs.

<sup>154</sup> See Handheld Video Surveillance, dated November 15, 2018.

<sup>155</sup> See H3 Video Surveillance, dated November 15, 2018.

<sup>156</sup> See Master Control Logbook, dated November 15, 2018.



At 3:42 p.m., the ambulance arrived at St. Joseph Medical Center (CHI Franciscan Health).<sup>157</sup> Hospital staff were able to regain a heart rhythm following two rounds of CPR and one dose of epinephrine.<sup>158</sup> Hospital staff intubated AMAR because he was in respiratory failure, then transferred him to the intensive care unit for further care and treatment. At 5:17 p.m., a doctor stated that AMAR was not breathing on his own, and he was brain dead.<sup>159</sup>

### November 16 to 23, 2018

During this time, AMAR remained in the hospital and officers made appropriate entries in the transport logbook throughout his hospitalization; however, facility medical staff did not document any hospital updates in AMAR's medical record. During his hospitalization, AMAR remained non-responsive. On November 18, 2018, following tests for brain activity, (b)(6); (b)(7)(C) Aruca signed the certification of brain death.<sup>160</sup> On November 21, 2018, CHI Franciscan Health (b)(6); (b)(7)(C) conducted two conference calls using interpretation services with AMAR's parents in Russia to discuss their son's medical care and prognosis.<sup>161</sup> On November 23, 2018, (b)(6); (b)(7)(C) conducted a third conference call with AMAR's parents to discuss their son's prognosis.

### November 24, 2018

At 8:10 a.m. (b)(6); (b)(7)(C) advised vigil officers that he would be calling the family at 4:00 p.m.<sup>162</sup> Throughout the day, hospital staff changed AMAR's IV, and cleaned and repositioned him.

At 3:00 p.m., Officers (b)(6); (b)(7)(C) (first name unknown) assumed hospital vigil duty. At 3:30 p.m., a nurse cleared AMAR's airway and documented that his blood pressure was low.<sup>163</sup> At 4:45 p.m. (b)(6); (b)(7)(C) conducted a fourth conference call with AMAR's parents to discuss withdrawal of care.<sup>164</sup>

At 5:52 p.m., a nurse removed AMAR from the ventilator.<sup>165</sup> At 6:05 p.m., (b)(6); (b)(7)(C) pronounced AMAR deceased.<sup>166</sup> At 6:11 p.m., the vigil officers notified (b)(6); (b)(7)(C) that AMAR had expired, and (b)(6); (b)(7)(C) instructed them to end their hospital duty and return to the facility.<sup>167</sup> Officer (b)(6); (b)(7)(C) stated that before they left, hospital staff arrived with a body bag and tags and informed them hospital security staff would move the body to the morgue.<sup>168</sup>

### Post-Death Actions

<sup>157</sup> See Transport Logbook, dated November 15, 2018.

<sup>158</sup> See CHI Franciscan Health, ED Notes, dated November 15, 2018.

<sup>159</sup> See Transport Logbook, dated November 15, 2018.

<sup>160</sup> See Brain Death Determination Checklist, dated November 18, 2018.

<sup>161</sup> See CHI Franciscan Health Discharge Summary, dated November 24, 2018.

<sup>162</sup> See Transport Logbook, dated November 24, 2018.

<sup>163</sup> See CHI Franciscan Health Flowsheet, dated November 24, 2018.

<sup>164</sup> See CHI Franciscan Health Discharge Summary, dated November 24, 2018.

<sup>165</sup> See Transport Logbook, dated November 24, 2018.

<sup>166</sup> See CHI Franciscan Health Discharge Summary, dated November 24, 2018.

<sup>167</sup> See Transport Logbook, dated November 24, 2018.

<sup>168</sup> ERAU interview with Officer (b)(6); (b)(7)(C) dated December 13, 2018.

As of ERAU's onsite review, the facility had not completed an after-action review. HSA Nussbaum stated they did not want to interfere with OPR's review.<sup>169</sup> Additionally, AMAR's personal property and funds remained in NWDC's custody.

On February 22, 2019, the Pierce County Medical Examiner (b)(6); (b)(7)(C) documented AMAR's cause of death as anoxic encephalopathy due to hanging.

On February 28, 2019, the State of Washington, Department of Health, issued AMAR's death certificate and documented AMAR's cause of death as anoxic encephalopathy due to hanging.<sup>170</sup>

## **FINDINGS**

ERAU reviewed the medical care NWDC provided AMAR, as well as the facility's efforts to ensure that he was safe and secure while detained at the facility. ERAU found NWDC failed to comply with 6 of the requirements of the ICE PBNDS 2011. In this report, ERAU has included other areas of concern that are not covered by the PBNDS 2011. 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. ***Emergency Plans, Section (V)(D)(7):*** "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.'"
  - Although NWDC had five handheld cameras available to use during the emergency, three camera batteries failed during the response.
2. ***Funds and Personal Property, Section (V)(G)(1):*** "For recordkeeping and accounting purposes, use of the G-589 Property Receipt form or its equivalent is mandatory to inventory any funds removed from a detainee's possession, and a separate G-589 form or its equivalent is required for each kind of currency and negotiable instrument. Removal and inventory of detainee funds shall be conducted by at least two officers and in the presence of the detainee. Separate documentation should be made for each kind of currency and negotiable instrument and should include detainee identification information and a description of the amount and type of currency or other negotiable instrument inventoried. Officers should then deposit the funds with a copy of the documentation in the drop safe or similarly secured depository."
  - On December 20, 2017, AMAR arrived to NWDC with 21 foreign coins; however, the intake officer did not describe the type and amount of the currency.
3. ***Significant Self-Harm and Suicide Prevention and Intervention, Section (V)(I):*** "...medical staff shall complete an Incident Report Form within 24 hours, and all staff who came into contact with the detainee before the suicide attempt or death shall submit a statement describing their knowledge of the detainee and the incident."

<sup>169</sup> ERAU interview with HSA Nussbaum, dated December 13, 2018.

<sup>170</sup> See Exhibit 3: State of Washington Certificate of Death, dated February 28, 2019.



- (b)(6); (b)(7)(C) responded to the emergency but did not submit Information Reports.
4. **Special Management Units, Section (V)(A)(2):** “A written order shall be completed and approved by the facility administrator or designee before a detainee is placed in administrative segregation, except when exigent circumstances make such documentation impracticable. In such cases, an order shall be prepared as soon as possible. a) Prior to a detainee’s actual placement in administrative segregation, the facility administrator or designee shall complete the administrative segregation order (Form I-885 or equivalent), detailing the reasons for placing a detainee in administrative segregation. b) In an emergency, the detainee’s placement in administrative segregation may precede the paperwork, which the facility administrator or designee shall prepare as soon as possible after the detainee’s placement.”
- On October 28, 2018, AMAR was assigned to administrative segregation; however, Lt. (b)(6); (b)(7)(C) did not complete a written order until the following day and there were no known exigent circumstances.
5. **Special Management Units, Section (V)(R)(2)(c):** “Extreme detainee behavior, such as destroying clothing or bedding or harmful behavior to self or others, must be documented, made part of the detainee’s file with the facility, and reported to the Field Office Director to implement necessary efforts to protect and care for the detainee.”
- On October 26, 2018, Officer (b)(6); (b)(7)(C) found destroyed bedsheets in his cell; however, there is no documentation that the facility notified the Field Office Director.
6. **Terminal Illness, Advanced Directives and Death, Section (V)(F):** “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.”
- Three weeks following AMAR’s death, NWDC was still in possession of his personal property and funds totaling \$1,003.86.

## **AREAS OF CONCERN**

Although not violations of the ICE PBNDS 2011, ERAU noted the following concerns regarding AMAR’s medical care, safety, and security at NWDC:

1. GEO Policy Restricted Housing Unit Post Order states, “Cell searches will be conducted anytime a detainee is moved from their cell. The search will be annotated in the RHU logbook... Whenever a detainee vacates a cell (for showers, recreation, a visit, etc.), staff are to conduct a cell inspection to include all walls, vents, and property.”

- On November 4, 2018, Officer (b)(6); (b)(7)(C) searched AMAR's cell but did not document it in the housing unit logbook.
  - In the week preceding AMAR's suicide attempt, officers did not search AMAR's cell. The last search was conducted on November 7, 2018, allowing AMAR ample time to make the rope he used to hang himself with on November 15, 2018.
2. During AMAR's detention at NWDC, medical providers typically used interpretation services or asked (b)(6); (b)(7)(C) to interpret. However, the use of interpretation services by nurses was variable and many documented AMAR understood English.
  3. On June 5, 2018, AMAR authorized the release of his cell phone to (b)(6); (b)(7)(C) who picked it up on June 13, 2018. However, on November 25, 2018, after AMAR's death, an unknown officer inventoried AMAR's property and noted a cell phone.
  4. On November 4, 2018, Officer (b)(6); (b)(7)(C) documented the discovery of torn bed sheets in AMAR's cell in the Evidence/Search Report; however, search reports are not reviewed by the segregation Lt., and a disciplinary charge does not ensue. Based on staff statements, the destruction of clothing and bed sheets for craft projects is a common occurrence among detainees; however, the Contraband standard specifically classifies a rope as a hard-contraband item because it could aid in an escape. Furthermore, a rope may also be used for assault, and as proven by AMAR, as a method to self-harm. Although NWDC has reporting requirements in place related to this issue, staff's inconsistent application of these procedures resulted in this pertinent information not being routed to the appropriate supervisory and medical staff for review and action.
  5. On the morning of his attempted suicide, mental health staff were among the staff made aware that AMAR's appeal had been denied. Arrangements were not made for a mental health professional to see AMAR after he was notified that he would be deported. Given his lengthy hunger strike in protest to his immigration case, an evaluation of AMAR's mental state upon receiving the news was warranted.
  6. After (b)(6); (b)(7)(C) informed AMAR his appeal had been denied, (b)(6); (b)(7)(C) did not inform housing unit officers that he had delivered bad news, stating that because they are not law enforcement, detention officers are not privy to deportation information. However, given that AMAR was in segregation at the time and considering that his protracted hunger strike was a protest to his immigration case and that a rope was previously found in his cell, at least a non-specific alert that bad news had been delivered would have been prudent. ERAU recommends that ERO and NWDC discuss how communication of adverse decisions may be shared with officers in a manner that helps assure detainee safety while not divulging information that officers are not entitled.
  7. On November 15, 2018, officers did not request that AMAR's cell door be opened until more than (b)(7)(E) were present. The delay was less than a minute; however, staff interviews point to confusion as to how many staff members must be present before a cell door in



segregation may be opened. ERAU recommends that requirements be clarified in applicable post orders and policy, and that staff be trained accordingly.

8. Although facility leadership viewed video surveillance of the emergency response the following day, an after-action review had not been completed at the time of ERAU's site visit. In the interest of ensuring after action reviews are completed when memories are fresh, ERAU recommends that it is completed without delay.

## **EXHIBITS**

1. Creative Corrections Healthcare and Security Compliance Analysis Report.
2. Pierce County Medical Examiner's Office, Postmortem Examination Report, Dated November 26, 2018.
3. State of Washington, Certificate of Death, dated February 28, 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)  
Division Chief, Inspections and Detention Oversight

SUBJECT: Detainee Death Review Findings – Mergensana Dabaevich AMAR  
JICMS (b)(6); (b)(7)(C);  
(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 Mergensana Dabaevich AMAR, a 40 year-old citizen of Russia, who died on November 18, 2018, at Northwest Detention Center (NWDC)<sup>1</sup> in Tacoma, Washington (WA), while in the custody of ICE. The Pierce County Medical Examiner documented AMAR's cause of death as anoxic encephalopathy<sup>2</sup> due to hanging.<sup>3</sup>

#### Abbreviated Chronology<sup>4</sup>

On December 2, 2017, a U.S. Customs and Border Protection (CBP) officer encountered AMAR at the San Ysidro Port of Entry in San Ysidro, California (CA) because he was seeking political asylum.

On December 3, 2017, CBP determined AMAR to be inadmissible and served him a Notice and Order of Expedited Removal, charging him with inadmissibility pursuant to section 212(a)(7)(A)(i)(I) of the Immigration and Naturalization Act, as an immigrant without a valid visa.

On December 5, 2017, although the San Diego office of the Office of Enforcement and Removal Operations (ERO San Diego) accepted AMAR's file, he remained in CBP's custody until bed space was available at the San Luis Regional Detention Center in San Luis, Arizona, on December 7, 2017.

<sup>1</sup> Also known as Tacoma ICE Processing Center.

<sup>2</sup> Anoxic encephalopathy is a condition where the brain tissue is deprived of oxygen and there is a global loss of brain function.

<sup>3</sup> See Pierce County Postmortem Examination Report, dated November 26, 2018.

<sup>4</sup> See accompanying Detainee Death Review for complete chronology.

On December 19, 2017, ERO San Diego transferred AMAR into the custody of ERO Seattle, who transferred him to the NWDC. Upon arrival to NWDC, medical staff conducted a timely medical screening which identified no current or past medical or mental health problems.

On August 17, 2018, a nurse conducted a mental health wellness check on AMAR after he complained of feeling depressed. The facility psychologist documented review and discussion of the assessment with the RN on the same date and concurred with the assessment, intervention, and plan of care.

On August 22, 2018, AMAR declared hunger strike, and medical staff began monitoring his meals and placed him on medical observation.

On August 25, 2018, after AMAR declined his ninth meal, medical staff initiated hunger strike protocols and moved him to the Medical Housing Unit (MHU) for hunger strike monitoring. AMAR continued to decline medical assessments and refused to eat until September 6, 2018.

On September 7, 2018, medical staff obtained a court order to permit involuntary medical monitoring and hydration from a U.S. District Judge. Once presented with the court order, AMAR began to drink Pedialyte and allowed medical monitoring. A physician noted AMAR's blood pressure had decreased, and he lost 21 pounds since he began hunger strike.

From September 13 to October 15, 2018, AMAR drank Pedialyte, Boost, and ate fruit; he was consuming approximately 1,800 calories a day and not losing weight.

On October 16, 2018, medical staff removed AMAR from hunger strike watch and moved him to administrative segregation upon his request.

On October 26, 2018, an officer conducted a search of AMAR's cell and found a rope under his mattress. Medical staff re-admitted AMAR to MHU for one-on-one suicide watch.

On October 27, 2018, a psychiatrist evaluated AMAR and determined he had no suicidal ideations. The psychiatrist removed AMAR from suicide watch and placed him on 10-minute mental health observation checks with daily provider rounds in administrative segregation.

On November 4, 2018, an officer conducted a search of AMAR's cell and found a torn sheet but did not alert medical or the shift supervisor.

On November 5, 2018, medical staff removed AMAR from mental health observation and cleared him for general population, but AMAR requested to stay in administrative segregation on protective custody.

On November 15, 2018 at 1:40 p.m., a Deportation Officer informed AMAR that he had lost his immigration appeal. At 3:06 p.m., an officer conducted a security round and found AMAR hanging from a noose made of bed sheets. At 3:08 p.m., medical staff arrived on scene, began cardiopulmonary resuscitation, and requested Emergency Medical Services (EMS). At 3:16 p.m., EMS responders arrived and assumed life saving measures. Once EMS responders detected a



pulse, they placed AMAR on a gurney and exited the housing unit. At 3:36 p.m., the ambulance departed the facility en route to CHI Franciscan Health. At 3:42 p.m., the ambulance arrived at CHI Franciscan Health and hospital staff initiated patient care.

On November 18, 2018, tests showed AMAR did not have brain activity and the doctor pronounced AMAR brain dead.

On November 21, 2018, hospital staff notified AMAR's parents of their son's prognosis.

On November 24, 2018 at 4:45 p.m., hospital staff spoke with AMAR's parent to discuss withdrawal of care and at 5:52 p.m. removed AMAR from the ventilator. The doctor pronounced him officially dead at 6:05 p.m.

On February 28, 2019, the State of Washington issued a Certificate of Death and documented AMAR's cause of death was anoxic encephalopathy by hanging.

### **Identified Deficiencies with ICE Detention Standards**

ERAU reviewed the medical care NWDC provided AMAR, as well as the facility's efforts to ensure he was safe and secure while detained at the facility. ERAU found six deficiencies in NWDC's compliance with the ICE Performance-Based National Detention Standards (PBNDS) 2011.

1. ***Emergency Plans, Section (V)(D)(7):*** Although NWDC had five handheld cameras available to use during the emergency, three camera batteries failed during the response.
2. ***Funds and Personal Property, Section (V)(G)(1):*** On December 20, 2017, AMAR arrived to NWDC with 21 foreign coins; however, the intake officer did not describe the type and amount of the currency.
3. ***Significant Self-Harm and Suicide Prevention and Intervention, Section (V)(I):*** A sergeant and two officers that responded to the emergency did not submit Information Reports.
4. ***Special Management Units, Section (V)(A)(2):*** On October 28, 2018, AMAR was assigned to administrative segregation; however, the shift lieutenant did not complete the written order until the following day and there were no known exigent circumstances.
5. ***Special Management Units, Section (V)(R)(2)(c):*** On October 26, 2018, an officer found destroyed bedsheets in AMAR's cell; however, there is no documentation that the facility notified the Field Office Director.
6. ***Terminal Illness, Advanced Directives and Death, Section (V)(F):*** Three weeks following AMAR's death, NWDC was still in possession of his personal property and funds totaling \$1,003.86.

Although not violations of the ICE PBNDS 2011, ERAU noted 8 areas of concern regarding AMAR's medical care, safety, and security at NWDC.

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) t (202) 732- (b)(6); (b)(7)(C)

*Enclosure*

Mergensana Dabaevich AMAR Detainee Death Review Report